Horn of Africa Journal of AIDS

Volume VI • Issue I

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ICASA
ADDIS ABABA ETHIOPIA
4-8 December 2011

Own, Scale-up & Sustain

PEOPLE TO PEOPLE

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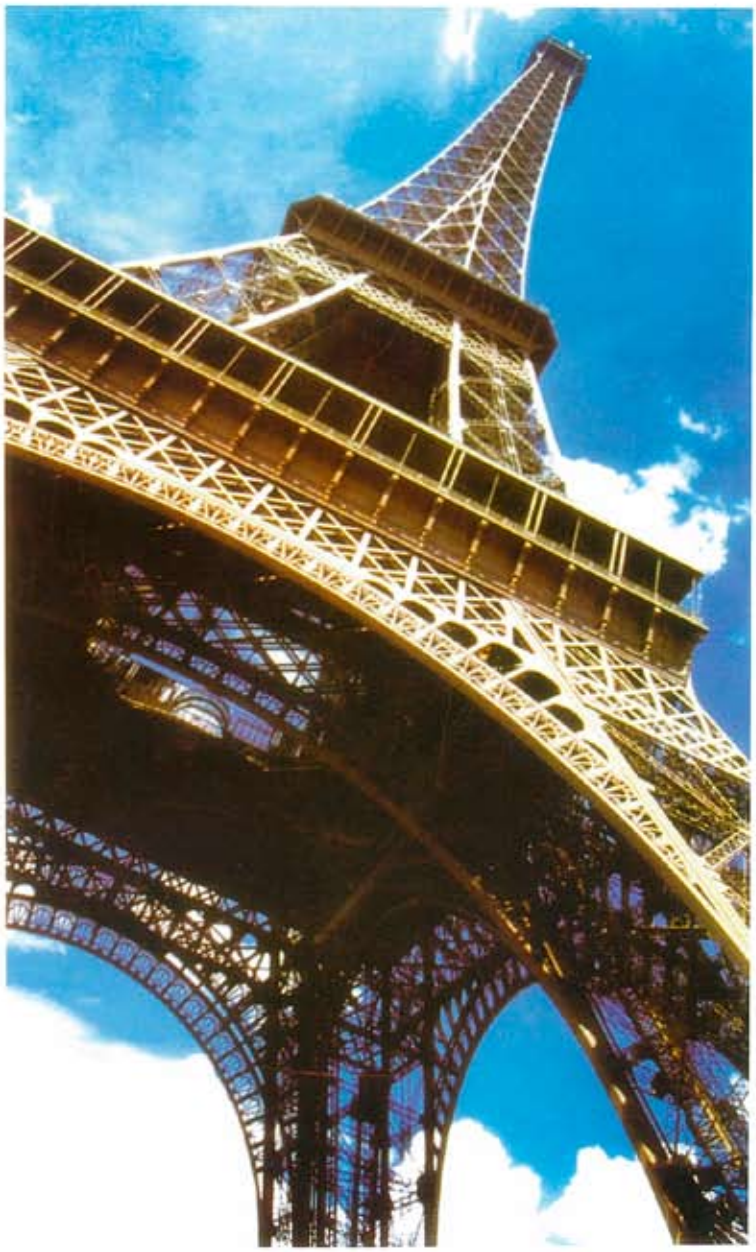

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Enawgaw Mehari, MD
Editor in Chief
Consulting Neurologist
St. Claire Regional Medical Center

HIV/AIDS is still a daily holocaust of epidemic proportion

The HIV/AIDS epidemic is still an enormous global health burden, particularly in Sub Saharan Africa, in addition to poverty and limited access to the already overstretched basic health, education and other social services.

Within the last decade, with concerted global effort, millions of PLHIV are accessing life-saving HIV treatment. Globally AIDS-related mortality has significantly declined over the years, concurrent to scale up of HIV treatment in several low and middle income countries. However, despite increased access to ART, the coverage is still low. If the cocktail medicines were offered to every one that tested positive for the virus, the treatment of HIV/AIDS would have exceeded the entire gross national product of each African country. Without access to drugs death and suffering from the disease is inevitable.

While celebrating achievements so far, it is very important that we continue to respond to the psychosocial, developmental, and economic need of orphans as integral part of the response to the HIV epidemic. At no time in the period of human history is this more relevant than today where children are losing both of their parents to this epidemic and they may in some cases carry the disease themselves as well. I would like each and every one of us to think about how we might be able to respond to these pressing needs of orphans. Community-based, grass-root, initiatives have several benefits in meeting the multifaceted needs of orphans. We all could support and participate in such initiatives and orphan care programs or organizations to make a lasting impact through voluntarism, donations or choice of activities that generates resources for caring for orphans and advocate for a national program to deal with the issue.

Ralph Waldo Emerson an American writer and poet is credited for a quote to remember: “You can not do a kindness too soon for you never know how soon it will be too late”.

The multi-faceted issues related to HIV and STIs, the socio-economic and developmental needs of orphans, and the impact of AIDS on communities as much as researches and access to HIV prevention, treatment and care for Africans will be major concerns and high up on the platform of The International Conference of AIDS Society for Africa (ICASA).

With this in perspective p2p has dedicated its present periodic journal “Horn of Africa Journal of AIDS” to the 16th Session of ICASA- held in Addis Ababa Ethiopia, December 4 to 8, 2011.

Palliative Care, an integral component of HIV/AIDS management

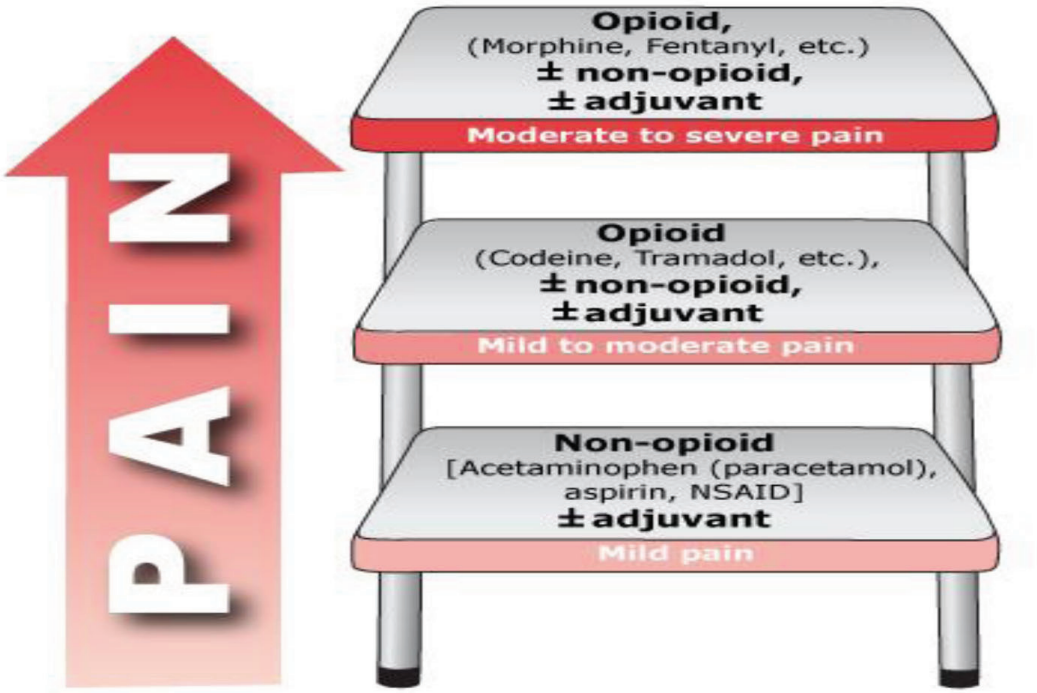
Anteneh Habte, MD

HIV/AIDS has been the worst epidemic of the 20th century claiming more than 35 million lives. At the end of 2010, there were more than 34 million people living with the disease, with sub-Saharan Africa being home to approximately 66% of the cases. The mortality statistics is also similarly disproportionate, with 1.3 million of the estimated 1.9 million deaths in 2009 occurring in this region. The last decade has been one of significant progress with great strides being made in prevention and treatment. More people than ever are receiving antiretroviral (ART) therapy and the disease trajectory is increasingly resembling that of a typical chronic disease, especially in the developed countries.

Despite the tremendous progress made in prevention and treatment, HIV/AIDS remains a major cause of morbidity and mortality worldwide. The most productive segments of the population are predominantly affected, making the crisis economically devastating. HIV/AIDS has overwhelmed the capacities of resource-limited countries and made apparent the inadequacy of their health care delivery system.

Comprehensive management of HIV/AIDS mandates the recognition that the disease continues to be life threatening and those afflicted have a high symptom burden during the course of illness. Common distressing symptoms include pain, depression, weight loss, nausea, vomiting, diarrhea, fatigue and other constitutional symptoms. As disease specific treatment is being sought, it is vital that the symptoms are also addressed in a timely fashion. Multiple domains including physical, psychological, spiritual, and social have been identified as a source of pain and suffering. Family members, who often assume the care

WHO Step ladder approach in pain management



giving role, also have multiple needs that should be addressed.

Palliative Care is comprehensive medical care that should be provided as part of the continuum of HIV/AIDS care and not only at the end of life. The fact that the disease has become increasingly more difficult to prognosticate with the advent of ART and effective opportunistic infection (OI) treatment, should not deter us from vigilantly addressing distressing symptoms. Palliative care in HIV/AIDS, like in other chronic life threatening illnesses, should be provided while disease modifying treatment is being offered. It is a misconception to think that it is only relevant for those approaching death or where "no other treatment" can be offered. Pain and other distressing symptoms occur early in HIV/AIDS and this has been attributed to progression of the disease itself, ART, and OI among other factors. Despite the considerable improvement in drug availability, to date only one third of patients diagnosed with HIV/AIDS have access to ART. The median survival of patients with advanced HIV and a CD4 count of less than 50/mm3 is 12 to 18 months in the absence of ART.

Dr. Cicely Saunders introduced the concept of "total pain" which emphasizes the need for an inter-disciplinary approach to address the complex needs of patients with a life threatening illness and their families. This is in recognition of the holistic approach required to meet the needs of these patients and their families.

Countries should incorporate Palliative Care into their national health policy and ensure the availability and accessibility of drugs essential for effective treatment of distressing symptoms. As the care of patients with chronic life threatening illnesses becomes increasingly deinstitutionalized, it is critical that these drugs are available in clinics and home settings and not only in hospitals. The WHO recommends morphine and other opioids for the effective treatment of moderate to severe pain. Few African countries have morphine available for these settings, and by this matrix alone, it is reasonable to conclude that pain is not adequately addressed in the majority of patients with advanced disease.

It is also vital to incorporate Palliative Care into the curriculum of medical schools and other allied health professions. Multiple studies have shown that the majority of health professionals are not familiar with the concept of palliative care and are not trained in effective symptom management of patients with chronic life threatening illnesses. Task shifting and educating non-physician health professionals in the safe and effective use of opioids is the only way to realistically bring pain relief to the homes of these patients.

The medical profession has to recognize that its role is not just to heal, as this is often elusive, but also to alleviate pain and suffering and ensure dignity and comfort of patients and their families at the most vulnerable phase of their lives. As we gather in Addis Ababa for the 16th International Conference on AIDS and STIs in Africa (ICASA 2011) and take stock of the state of HIV/AIDS today, let us also renew our commitment to aggressively combat the high symptom burden of the disease with comprehensive palliative care starting early in its trajectory. As we heed the call to "Own, Scale-up and Sustain", we should also lift up Palliative Care as an integral component of HIV/AIDS management.

Reflections on HIV/AIDS in Africa

David H. Shinn, PhD

While Africa remains the area of greatest concern for HIV/AIDS, there has been significant progress over the last two decades in reversing the adult prevalence rate. I first took an interest in the problem while serving as ambassador to Ethiopia from 1996 to 1999. The threat of HIV/AIDS during those years was becoming a truly scary challenge. With the benefit of hindsight, statistics on HIV/AIDS prevalence rates were misleading, especially in the early years when they were understated and then probably overstated in the late 1990s and during the first years of the 21st century. With more and improved sampling techniques in most African countries, the rates being used today are more accurate.

Ethiopia is a case in point. The Ministry of Health estimated the adult prevalence rate at 1 percent in 1989, 3.2 percent in 1993 and 5.2 percent in 1996. UNAIDS had the rate at 9.3 percent in 1997 but reduced it to 6.4 percent by 2002. The *CIA World Factbook*, on the other hand, put the rate at just under 11 percent in 2001 and 2002 before reducing it to 4.4 percent in 2004 and 2.1 percent in 2010. It is highly unlikely that counter measures alone, although they became substantial by the beginning of the 21st century, reduced the adult prevalence rate by such large amount. Better statistical data probably accounted for much of the reduction. Before I finished my tour in Ethiopia in 1999, there was a widespread fear that HIV/AIDS would overwhelm the country. Following massive intervention by UNAIDS, WHO, UNICEF, the international donor community, especially the United States, a host of non-governmental organizations such as People to People Inc. and the Packard Foundation and a stronger Ethiopian government response, this fear has disappeared. While HIV/AIDS remains a serious threat in Ethiopia, the prevalence rate is in decline.

A similar situation exists in most other African countries. According to the *CIA World Factbook*, the prevalence rate in Nigeria varied between 5 and 6 percent from 2001 through 2008, fell to 3.1 percent in 2009 but bumped back up to 3.6 percent in 2011. The countries of southern Africa have been the hardest hit globally. Botswana reached a peak of almost 40 percent in 2003 but declined to about 25 percent in 2011. South Africa's prevalence rate stayed at 21.5 percent from 2004 through 2008 before declining to 17.8 percent in 2011. Uganda, long touted as an HIV/AIDS success story, had an 8.3 percent prevalence rate in 2001, declined to 4.1 percent from 2004 through 2008 but climbed back to 6.5 percent in 2011. Uganda is a reminder that governments, non-governmental organizations and the international donor community should never become complacent about the ability of HIV/AIDS to make a comeback. Combatting the disease requires constant vigilance.

The stigma of being HIV positive was one of the most difficult hurdles that countries had to overcome to counter the disease. For some reason, this challenge seemed especially difficult in Africa. Denial lasted longer than was the case in many other parts of the world. A combination of educational efforts and the wider availability of anti-retroviral medication were instrumental in overcoming the stigma problem. Persons were willing to be tested because they knew even if they were found to be HIV positive, there was treatment that would permit a semblance of a normal life.

Much of the international HIV/AIDS resources have gone into anti-retroviral programs. As the anti-AIDS campaign moves forward, this has become an issue. Funding to combat the pandemic is finite and donor countries are under increasing financial strain because of the global financial crisis and economic downturn that began in 2008. Once a patient begins anti-retroviral medication, there is no stopping until death. As more persons begin the regimen and those who are already on it live longer, the costs increase. At some point, the huge anti-retroviral program will become unsustainable. There is an added problem. After taking anti-retrovirals for several years, the virus is beginning to mutate with most new infections not reacting to traditional drugs. New mutant strains might compromise the gains made against HIV.

While the loss of life, reduced productivity and slowing of economic development throughout most of Africa caused by HIV/AIDS has been enormous, I prefer to see the situation as a glass half full. I wrote a piece on HIV/AIDS in Ethiopia in July 2001 for the Center for Strategic and International Studies in Washington. I quoted in that article an Ethiopian doctor in Jimma who told me during a visit there earlier in the year that the disease is setting back development and "making a poor country poorer." An American in Addis Ababa who headed a non-governmental organization said during the same visit that "development is going to pot" because the implementers are dying.

HIV/AIDS continues to take an enormous toll, especially in southern Africa, but these kinds of gloom and doom statements are heard less frequently in Africa today. African governments, the international community and civil society stepped up and had positive impact. Much remains to be done. The twenty countries in the world with the highest adult prevalence rates are all in Africa, ranging from a high of about 26 percent in Swaziland to more than 3 percent in Chad. While this is not a tolerable situation, I would rather think of the children alive today because the disease was not passed by their infected mothers, the educational programs that convinced many young people to change their behavior and those who tested at an early stage and began an anti-retroviral regimen.

Finally, congratulations to the *Horn of Africa Journal of AIDS* for all of its efforts since 2004 to inform both specialists and lay people about this disease.

HIV - Protecting the Child from an infection in the Mother; Are we there Yet?

Kinfe Gebeyehu MD, MPH

A book by John Iliffe, *A History of the African AIDS Epidemic* I read for the first time while preparing this article, states that the earliest convincing evidence of the existence of the Human Immunodeficiency Virus was gathered in 1959. Out of 672 frozen blood samples taken for malaria testing in central Africa in 1959 and preserved in the lab and tested for HIV in the mid 80's, one tested positive and was confirmed by the western blot technique. While such information may be just an information for the general public, it must have been an exciting and at the same time puzzling finding for the epidemiologist, the infectious disease specialist, the medical practitioner and the medical historian. Unfortunately that led us no where as far as scientifically naming the index case or indisputably tracing the origin of the virus.

Even though it took over 2 decades for the virus in the blood from the frozen 1959 sample to be tested together with multiple other fresh samples in the mid 80's, retrospective reviews had shown many patients to have manifested similar clinical pictures of AIDS long before virological or immunological identification of AIDS were possible.

Identifying immunological response and later on viral culturing have immensely helped detection of mother to child transmission in newborns and infants even in the short time before discharge from the hospital after childbirth. Scientific ventures both in agent identification, immunologic response and transmission has progressed fairly rapidly and drugs arresting activities of the virus have not lagged far behind either for prevention and denying the virus access to the body. Have we missed the opportunity to immunologically and virologically identify infected babies in the early 1980's. Yes we did. I recall as a young attending pediatrician in the early 1980's in the pediatric wards of my Hospital in Chicago, the puzzling cases of infants with recurrent or chronic diarrhea and significant weight loss or inadequate gain, some with fever lasting days and others not so sick presenting with lumpy neck and groin glands, large enough to cause us worry, yet not much else in a way of supurative signs or of prolypherative consistency.

In the very early years of the life of HIV infection many at least in the US tried to impress on everyone in their writings that AIDS was identified with the four H's: Homosexuals, Hemophiliacs, Haitians and Heroine users. It has been quite a while since such assertions have given way to the reality and the need for a focus on women as it is rather women that have the highest rate of infection. We all know what this in actuality mean; that for one we should be raising up our attention to women's issues in many aspects, including HIV infection and to their pregnancy, childbirth and child care. That is why I was interested in looking more closely into HIV infection in women and more specifically in mother to child transmission of HIV and in reviews of successes and strategies in preventing mother to child transmission.

Developed countries and countries with adequate resource allocation policies have started reporting virtual elimination of mother to child transmission. In the US and many European countries the average figure in 2011 is less than 5% meeting the WHO definition of virtual elimination. This may not come as a surprise because in these countries every risk for transmission is targeted right from early detection of pregnancy through birth of the child and later neonatal and period of infancy by adhering to the following principles in MTCT

A. The public is informed and educated about HIV.

B. Public and private funding and programs to keep levels of information and education high is much utilized.

C. Prenatal care and Prenatal clinic attendance is close to 100%.

D. FP to reduce unintended pregnancies is effectively used.

E. Prenatal HIV screening is almost universal.

F. Counseling and preventive use of highly active ARV drugs commonly after the 14th week of pregnancy through the course of pregnancy and labor is adequately adhered to.

G. The newborn is routinely given ARV drug with good follow-up

H. Delivery by C-section is a recommended approach and much utilized.

I. Formula feeding rather than breast feeding of the infant is a routine practice.

The odds for resource limited countries to fully implement these proven yet inseparable virtual transmission elimination determinants are understandably too heavy.

Estimates of 15 – 30% of mother to child transmission of HIV infection during pregnancy and labor and another 5 - 20% through breast feeding have been known as early as the first part of the decade of the 90's in resource limited countries. Trials and experimentations and later on clinical applications to prevent mother to child transmission have progressed with varying yet steady successes and promising strides in resource limited countries to significantly reduce the incidence.

A 2010 joint progress report by WHO, UNAIDS and UNICEF on scaling up priority HIV/AIDS interventions in the health sector proposes a target of 90% global reduction of MTCT by 2015. This can only be achieved if countries with the highest incidence of burden of MTCT accelerate their efforts duly addressing their weakest and important points in the progress scale. The joint report takes examples of countries and of target areas of emphasis they need to make to score points in the MTCT reduction strategy:

- Ethiopia – Enhanced prenatal care and accelerated skilled care child delivery utilization up from the present 28% to 90%. *
- Uganda - To increase the availability of family planning so that contraceptive use will increase from the present 27% to 67%. *
- Lesotho – To reduce the high incidence rate of HIV in pregnant women from the present 26% to 13%. *

Three decades of exposure to the most complex infection with its social, emotional economic and behavioral tags has possibly prepared leaders and policy makers of countries heavily affected to address these nations burdens. International support with resources, technologies and research has made unprecedented presence. Such combined experiences among others have helped resource limited countries to study variation of ARV drugs or combinations that will give the lowest rate of MTCT. The Thailand study of maternal use of Zidovudine with added single use of Nevirapin at onset of labor and to the newborn 2 days after birth has shown a significant rate reduction to 2% from 6%. When prenatal Zidovudine alone was used through the course of pregnancy starting on the 28th week, a short course of Zidovudine plus Lamivudine with single dose of Intrapartum Nevirapin to the mother and newborn has brought down rate of transmission to 5% in Cote d'Ivoire. **These are encouraging results and indicators that it can be done if we give it all it deserves. The most recent WHO guide line regarding reduction of the 10-20 % breast feeding transmission risk empasises that in resource limited countries the benefits of breast feeding and minimization of diarrheal catastrophies that otherwise may follow unhygienic furmula feeding out weigh the risk of transmission. With appropriate family guidance, supervision and breast feeding education, and with continuation of ARV medication for the mother as dictated by viral load and immune response when it can be done breast feeding is an alternative of choice during infancy.**

Clinical studies documented in a 1999 issue of the Lancet has revealed that the rate of mother to child transmission in Europe in the late 90's were significantly reduced from 10.5% to 1.8% when elective c-sections were implemented. Thus present approaches in elimination of mother to child transmission in industrialized countries is using potent antiretroviral combination drugs during pregnancy combined with elective C-section if viral replication is not fully controlled by the end of pregnancy. It is unfair to expect similar results from resource limited countries in the short term but equally important to hold governments policy makers public and private organizations to the test to establish a road map or a strategy that reasonably aims at meeting anticipated goals. Out of the nine criteria developed nations adhere to in their virtual elimination of Mother to Child transmission the ones resource limited countries cannot afford not to work on consistently and hard enough are:

A. Informing and educating the public in all corners and all about HIV infection more closely targeting pregnant families and those in child bearing ages. Utilization of well informed educated and prepared community leaders and elders have in many instances proved to be assets in seeking and leading the community to participate in a program, be it construction of pit latrines, mass immunization or prophylactic medication. Pregnancy child birth and childcare has for generations remained a community affair in the Ethiopian culture demanding such an approach to gain success. Mind you HIV is only a small though important part of the focus on prenatal programs

   Prenatal care – Access to prenatal care by establishing service within reach of the community rather than expectations for expectant mothers to travel several Kms. The old system of extended village prenatal and MCH services that in many growing nations contributed to reduction in infant and under five mortality and morbidity is a system to be built up more for Prenatal care and PMTCT. It will be interesting to see if the health extension worker program that started a few years ago in Ethiopia will address this important aspect of strategy of PMTCT

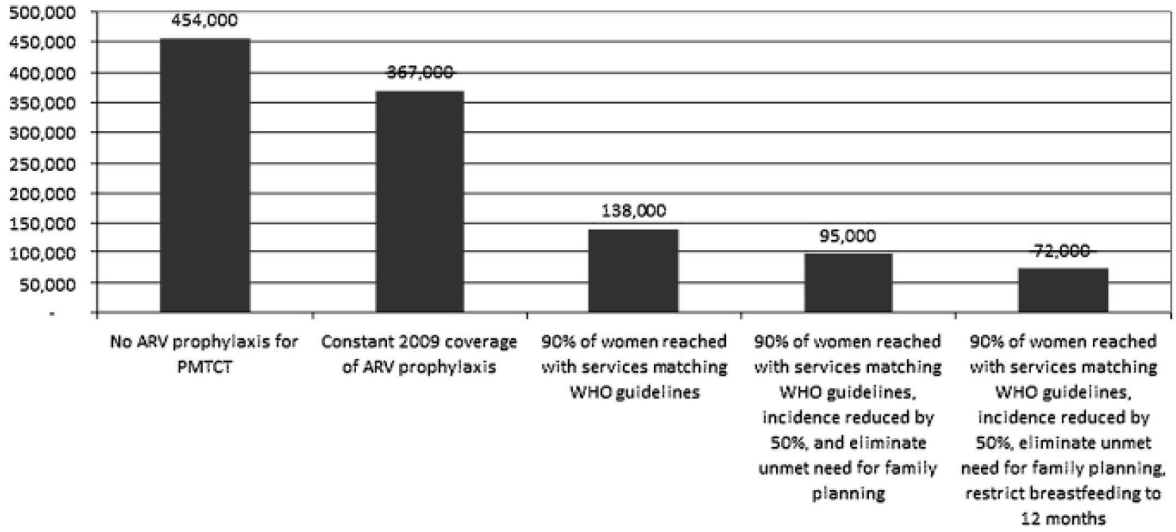
B. Access to prenatal care of course also means access to screening for HIV and counseling and planning

ARV prophylaxis prenatally, during child birth and after birth for the newborn.

C. Postnatal supervision and assisting in minimizing risk of transmission through breast feeding.

D. FP to reduce unintended pregnancies by a couple with HIV infection

New HIV infections through mother to child transmission, 25 countries most in Sub Saharan Africa in the year 2015 – sti.bmj.com Jan 20, 2011



New HIV infections through mother to child transmission, 25 countries most in Sub Saharan Africa in the year 2015 – sti.bmj.com Jan 20, 2011

As we assemble in Addis Ababa for ICASA and share our experiences, we realize that it is not as much of what we have not yet known about HIV/AIDS and prevention of mother to child transmission that slows our progress, it is rather not implementing enthusiastically and consistently what we already know. Let each nation's policies and approaches sore, let the stream that is keeping international aid for drugs and technology keep flowing heavily and let efforts to involve the public and the community flourish for the virtual elimination of mother to child transmission by 2015.

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A Look Back in Time: A reflection of the past 20 years in the fight of AIDS

Dawd Said Siraj MD, DTM&H, MPH

Soon after my graduation from medical school in 1992, I started to practice and see HIV/AIDS patients. I clearly remember my first patient. A young, recent University graduate in his mid twenties who has been having weight loss and chronic diarrhea. The HIV test came back positive and the post test counseling that followed was tantamount to a death sentence. Society to the most was unaware and silent, medication was unavailable and patients were left alone with no support or hope. I felt really sad to be the messenger of this devastating news but that was all I can do. At such a young age, it was very difficult for me to take that. I remember the shock, sadness, and helplessness that that young educated patient of mine was going through. The question of "why me" seemed to overwhelm him.

I started to see many more patients soon; young and old, educated and farmers, business people and students affected by this ravaging disease. Society kept decidedly silent and so did the government. There was no planned mass education or media dissemination and no brochures to give out to patients. Married couples and those having stable heterosexual relations who seemed to be at low risk to acquire the disease, started to be primary victims that we saw in our clinics and hospital. Slowly, core families seemed to disintegrate from the physical, social, and emotional effects of the disease. We were screaming alone with no supportive responses. The response of the society, which seemed to be blaming the patient and the family for the infection, was another challenge patients had to endure. On occasions, we heard about vindictive patients who moved across society deliberately infecting others.

Those were difficult times. A favorite line I used to repeat at every occasion to the community who seemed to take it that this was not their problem and also for those infected and lost hope was "for better or worse, we are in the same boat, either we will sail together or we will sink fighting together. No question we had to be sympathetic and take care of the sick and show them our concerns. In return we expected for them to respect our efforts by participating in the control of the spread of the disease. For a costly long period of time it seemed our messages were falling on deaf ears. Around those periods of desperation, an Ethiopian TV anchor working on a documentary on HIV and blood transfusion came to Axum and asked me to give him an interview. I discussed the issue with a determined objective of increasing awareness of the disease by society and seeking community compassion in caring for those already affected. It seemed that everyone was complacent at that time. Many did not see the raging fire and that it was about to explode. Words of prevention seemed to have lost traction in those difficult days. I always wondered: when you do not have effective means of intervention for the sick, how can you convince individuals to be tested for this deadly disease? I had myself to struggle then to see the need for testing leave aside the community who did not see it as a problem. Some colleagues used to argue, "when you cannot offer treatment and do not know how to effectively prevent it, is screening any effective tool? I do not blame them.

The break through, at least for the western society, came in 1995-6 with the introduction of the so called "cocktail regimen" against HIV. I clearly remember the time. I was listening to the BBC radio in one of the evenings after work and here comes a breaking news and analysis. Dr. Scott Hammer from USA was being asked about the significance of this treatment. It felt so distant and irrelevant to me and my immediate patients. I do not know why but his name remains ached in my memory. For us, in Ethiopia and most of Africa, this has to wait till mid 2004-05. The only reason was money; affordability.

Little did I know that I will be immigrating to USA in a year and practicing in New York City. I started using those very medications I heard on BBC when I was in Axum, Ethiopia. The cost of those so called cocktail regimen was prohibitive. More than any time, it becomes clear to me that Africa will not see those extra ordinarily expensive medications. For those in Africa, both care givers and patients, those were desperate moments, tough times. This unjust and cruel rule of just the haves benefiting has to continue for years at the cost of young lives in Africa. Money was clearly the issue. Governments prefer to avoid the issue looking at the high price tag associated with those medications. Who would in the right mind blame them? As I was not part of the fight through those difficult times, I can only imagine what went through the mind of physicians, politicians and patients? Knowing how difficult it was in the early days, I feel the pain, illusion and desperate measure by all sides in the height of HIV epidemics, in the late 90's and up to 2004. The break through, window of opportunity came around 2004 when an Indian drug company by the name of CIPLA dropped the price of the cocktail regimen to around $32 dollars a month

per patient. It was around this time that Ethiopians in the Ethiopian North American Health Professionals Association (ENAHPA) asked me to work with them in trying to open an HIV clinic in Ethiopia. This was my dream and my vision of contributing but clearly we had no idea as to how to realize this wish and dream. Series of teleconferences with interested individuals and leadership of ENAHPA followed. Through those discussions, what came clear to me was that there are seriously dedicated individuals who want this to happen and I was delighted to be part of the team. The whole idea in Ethiopia of our free clinic, and its foundation, rested on one visionary and a man of substance. A fighter, who has dedicated his life to the cause of this disease in Ethiopia: Dr. Yigeremu Abebe. To those of us who were involved in this case, there was one clear conclusion: without the effort and presence of Dr. Yigeremu, this clinic would not have been a reality.

After many discussions via email and on the telephone, the plan started to emerge. With the leadership of Dr. Ingida Asfaw (the president of ENAHPA), Dr. Haregua Getu and Dr. Getachew Asresahegn, and with assistance from Dr. Carol A. Harris, Dr. Asqual Getaneh and Dr. Zelalem Temesgen, in a very short time, we wrote a grant proposal to open this very first free HIV/AIDS clinic in Ethiopia. An ambition which did not see where the money and funders were going to come from but believed that someone is going to listen. I vividly remember the countless hrs of telephone discussions I had with Dr. Getachew Asresehegne and Dr. Yigeremu Abebe to refine this proposal. The answer came in an amazingly short time: once the proposal was completed and was circulating among donors and anyone who seemed interested, with a very big persuasive argument from the leadership of ENAHPA, a generous, forward looking small charity by the name of Christian Children's Fund of Canada (CCF-C) took us seriously and challenged us to the task. With small seed money of $200,000 they wanted to see this clinic opened and working. The promise was if we do it right, more money will come. There was no time to waste. At the time when there were less than 4000 HIV patients on therapy throughout the country, even to treat few of those for free was a driving force powerful enough to propel us into action. We set our ideas in motion. Dr. Yigeremu, after a serious look at the hospitals in Addis and after discussing with leadership of the hospitals quickly decided that ALERT hospital will be the best place to house our free AIDS clinic. An agreement was quickly signed with the MOH and ALERT and few rooms released for this noble cause. This has not been tried before. We immediately started designing the clinic and at the same time working on how to acquire medication and ship it to Ethiopia. With the money available, we decided to start treatment for around 300 AIDS patients in the first year. The uncertain issue of sustainability, selection of patients and running the clinic were real and difficult challenges ahead of us. Though we were cognizant of all those challenges, what we as a group were determined about was that we cannot let all those patients miss this opportunity. We decided to continue to pursue the fight to deliver HIV therapy in the hope that some more supporters will see the work and help. We wanted to remain in action and fight rather than stand in the side contemplating the ramifications and ifs of a potential failure.

With the arrival of the first shipment of the HIV medication from India, the clinic started treating patients. Dr. Yigeremu, together with the staff at ALERT took the challenging task of sorting out whom to treat and whom not to. We in the US were holding our breath and waiting for the calls from Ethiopia. Dr. Yigeremu has started the clinic. The plan was to enroll not more than 50 patients a month to give the health care providers time for "a learning curve". What shocked us all was the unprecedented demand of this service by patients, just in the first month, over 300 patients were enrolled and started therapy! Everyone, I must say except Dr. Yigeremu was apprehensive as to our capacity to handle such a volume of patients and as to where to get the money to buy the medicine with such an increased demand? At times a thought of whether opening the clinic in the first place was the right thing to do crossed my mind. Many of us had many sleepless nights considering sustainability of the program. The words of pessimists used to ring in my ears occasionally: "this should not have been started without a proper planning of sustaining it". Well, if there is a will there is a way. CCF Canada was determined to succeed at this fight together with us. Once the clinic starts its service, the leadership of CCF Canada, together with a Canada TV crew, traveled to Ethiopia to visit the clinic. What they saw was extraordinary care delivered with minimum investment. What they filmed was actually more extraordinary and the day it was aired in Canada, an anonymous donor, who I should say is blessed for eternity, pledged to double all the efforts undergoing. An emergency teleconference was held to request to double the purchase of HIV medication and the service overnight. I remember quite clearly the words of Mr. Dan Stevens and Todd Sinclair, the leaders of CCF-Canada: "per the pledge we had yesterday, it seems money is not going to be our challenge to the driving issue to run our clinic. How many patients can we take care of in the clinic without compromising the service that we are giving?" For us this was the best music to hear. At the end of the year, over 1000 HIV/AIDS patients were getting free HIV medication and over 4000 HIV patients were being followed in the clinic.

With the hope of expanding this clinic, we had many meetings with donors and one of those meetings was with President Clinton's organization. It is after such a meeting and a visit to our free clinic at ALERT, that President Clinton's organization presented to ENAHPA a donation of over $200,000 to build a HIV Pediatrics wing at ALERT and also to open an office in Ethiopia to continue to work with us. To this day, Clinton Foundation remains engaged in the care of HIV in Ethiopia.

Shortly after, the arrival of global fund and PEPFAR were a great relief to us because the long term sustainability of such a big clinic was always our number one concern. ALERT HIV clinic remains to be the biggest HIV clinic in Ethiopia to this day. Thanks to the visionary policies of those two big investments on humanity, the fate of HIV patients in Ethiopia and throughout Africa has been changed forever. These days, HIV is not a death sentence as it used to be some years back. It is rather a chronic disease which when treated properly has a life expectancy as any chronic disease if not better than many. To swing from what was a desperate moment to such a prospect in life in such a short time is nothing short of a miracle.

Throughout our involvement with this clinic, early on, we came to realize that one of the biggest impediments to upscale such a service was the shortage of skilled manpower. There were very few physicians, nurses, pharmacists and social workers who were trained to take care of HIV patients. It is this challenge that propelled us to start the bi monthly video conference on HIV and also the virtual clinic with P2p. In 2004, what started as a training of physicians and pharmacists on HIV care and therapeutics via video conference from USA quickly turned to a regular bimonthly extensive discussion and learning experience with providers in Ethiopia. Subsequently, Johns Hopkins hospital, Mayo Clinic, East Carolina University and NIH from USA became regular contributors and attendees and physicians in Addis Ababa, Jimma University and Hawassa University started to connect and participate in those discussions. We have recently discussed our 245th case. Those discussions are regularly recorded and distributed throughout Ethiopia and also video recorded and archived at Johns Hopkins Hospital website for future use.

In addition to this, around the same time, I was asked by P2p leader and tireless advocate of HIV care, Dr. Enawgaw Mehari to work on virtual HIV clinic where we will receive HIV related questions and give pertinent and timely answers. We organized a network of HIV care givers throughout USA to work on this and launch our web clinic. The day to day questions of patients, physicians and other HIV care givers were constantly answered with in a 24 hr window period. All those were filed, organized and maintained at the P2P website for anyone interested to look at the questions and review the comments. This has at one time become a popular website with as much as 5 questions being entertained a day.

Those involvements of distant learning and training have taught me something valuable. In the era of brain drain, where significant expertise of African descent are residing outside of Africa, rather than always talking about a single solution and concern, which is how to stop the unstoppable, the constant human influx, it is rather productive to think of a solution on how to better use this energy. Technology is growing by the leaps and bounds. African countries have to position themselves to use this opportunity to its maximum. Many of us here will be able to spend hrs per week to connect and help back home. If this is properly organized, streamlined for a maximum impact and benefit in Africa, after all it will create a light at the end of the tunnel. Donors and policy makers who are working in issues of African concern must involve the Diaspora in such endeavors. Without proper investment and adequate preparation, this opportunity as many in the past, will come and go. Whether Africa will develop smart policies to absorb this untapped resources and power or not is the question to be answered over time and I hope the answer will be a resounding yes!

Three decades of HIV/AIDS: Lessons and Emerging Challenges in Africa

B. T. Costantinos, PhD

At the outset, congratulations are in order to P2P for a decade of accomplishment in our common goal to save the plight of the millions suffering from poverty and the diseases of poverty. It has taken on the task of frontloading People's resources to the unfolding human tragedy resulting from AIDS, its impact on human development and its consequences on national development that are indeed too ghastly to contemplate. The challenge simply stated, underpinned the need to connect to the energies of people that is the requisite basis for individuals, families and communities to go through major behavioural changes.

Paradoxically, though, Africa already possesses most of the "tools" – if not all the resources – needed to change the course of the epidemic. Communities and countries across the continent have pioneered, developed and tested many successful responses to HIV/AIDS, with an impressive dossier of best practice, proof that the continent is not powerless against the epidemic. Such a response has demanded strong and creative leadership from all sectors and parts of society as much as increased community ownership of the problem and of its solution. In 22 countries in SSA, the epidemic has decreased by 25%. Nevertheless, while the epidemic appears to be stabilizing, such a success story secretes half-truths.

- Beneath the apparent constancy of improving prevalence-levels lie shocking realities, especially in southern Africa, accounting for a third of all AIDS deaths globally, with over 35% of the total number of people living with HIV worldwide found here and where the epidemics are diverse in terms of the scale and pace at which they evolve. (http://www.unaids.org/en/regionscountries/regions/).

- Africa is still home to the majority of adults and children living with HIV in the world, most of whom still have inadequate access to even basic health care. It has lost 75% of the more than 20 million people worldwide who have died of AIDS. Sexual abuse and violence, much, but if not all, directed against females, are serious evils that transcend economic, social, ethnic and geographical lines.

- The AIDS epidemic affects everyone's quality of life and the stigma attached to it adds an extra layer of suffering to the already difficult lives of those infected with the virus, and the lives of those close to them. Another of its pernicious results is that it hinders HIV-infected individuals from participating in the processes of finding solutions to combat the AIDS epidemic. This is not to deny that people living with the virus have already contributed greatly at all levels of the response, instead it is to underpin the fact that their involvement has often been at great personal cost due to stigma, discrimination and what has been termed a culture of silence. As children lose their parents and teachers, as schools, hospitals, farms and factories close, the epidemic had become a full-blown development crisis.

- Nor has the general population been mobilized to own the issue and therefore act on it. This is especially tragic given that Africa has most of the tools (if not all the resources) needed to turn the epidemic around.

Two issues stand to deserve more attention by people's organisations such as P2P and the global civil society that must train themselves to deal with the increasing challenges of the diseases of poverty in conflict and post-conflict situations:

1. Getting the AIDS message out to broad populations in conflict areas: Neither citizens nor governments can respond to HIV/AIDS without awareness of the problem and the solutions. A country in which denial flourishes is a country whose population is vulnerable to the silent spread of HIV. Yet getting the message out is not enough. Sometimes, even when the level of basic knowledge is very high among certain populations, people do not alter their risky sexual behaviour – the implicit goal of most awareness campaigns. In sub-Saharan Africa, community-based programmes are the only practical way to bring health care to many HIV-infected people and support to their families. Home care is the field in which civil society has shown both leadership and great creativity. Besides the direct benefits to patients and their families, AIDS care and support programmes have important spin-offs for the rest of the community. They make the epidemic more visible and help people to take the HIV threat more seriously. Communities are also best placed to identify needy families, vulnerable children and orphans;

2. Making displaced people less vulnerable to HIV infection in conflict and post-conflict situations: Vulnerability is a measure of the ability to control the risk of infection. Personal factors, factors affect-

ing access to relevant information and services, and societal factors including social, economic, political and cultural situations may either mitigate or exacerbate vulnerability. Women – and in particular young women – are especially vulnerable to HIV infection. They may be less able than men to avoid non-consensual or coercive sexual relations. Rural communities may be vulnerable because of lower levels of literacy and less access to information and services. While women's vulnerability to HIV is increasingly well known, it is less often recognised that cultural beliefs and expectations also heighten men's vulnerability.

Social policy is essential to provide a conceptual framework for vulnerability reduction. Addressing the societal forces that determine vulnerability to HIV requires engagement at the policy level and political will and resources. Effective social policy reform is a long-term agenda, but even small-scale and incremental steps can send important messages about political commitment to reducing the vulnerability of individuals and communities to HIV. As we stand on the watershed of the old and new African Millennium, P2P has contributed to this in an exemplary way to enrich the demands for greater popular participation and to augment the remit of accountability of statal and international actors - a fundamental premise of peoplecentred development that people have basic and universal human rights - including the right to education, healthy life style and longer existence; as proclaimed by a bold and revolutionary vision The Universal Declaration of Human Rights.

HIV/AIDS – The spark that lit People to People

Habtamu Belete, MD, MPH

Background: People to people (P2P). Inc. is a nongovernmental organization founded in April, 1999 in USA. It comprises people armed with spirit of compassion to bring hope to those who find themselves in despair due to various calamities. P2P is globally emerging as bridge and network of the Ethiopian diaspora committed and willing to give back whatever support they can afford to render. The organizations was established with primary objectives of making a positive contribution towards reducing the spread of HIV/AIDS and caring for those who have been affected by the disease, provide support to improve the Ethiopian health care system through mobilizing expertise and, finance, and also Ensure transferring of technologies and best practices. The philosophy and the core belief of the organization is to save and improve lives of the vulnerable and disadvantaged and add meaning to one's life.

Accomplishments: People to people Inc. was founded during the time when HIV/AIDS pandemic had been rampant in Ethiopia and the magnitude of population including children infected and affected by the disease was very huge. The following were therefore the major accomplishment of P2P with regard to HIV/AIDS care and support and also other related areas.

HIV prevention and Supply of necessary drugs for AIDS patients

In collaboration with Pfizer and NIH, P2P has started fighting AIDS in Ethiopia primarily by delivering systematic health education to high school students in 20002 and by forming Anti AIDS clubs to further strengthen HIV prevention activities in 2004. In 2005, through partnership program with Pfizer, P2P freely supplied the drug Fluconazol to the Ministry of Health to be used for the treatment of Opportunistic systemic fungal infections in AIDs patients. The support has brought about significant steps in the management of AIDS patients during the time when delivery of free ART program was not started.

Care and support for AIDS orphans

Hearing the voiceless with our ears and loving heart

In Ethiopia, as in many affected nations in Africa, there were situations where significant number of children orphaned by AIDs were left to be raised by siblings in what was known as 'child headed household'. These children are forced to nurture their younger siblings by making food, clothing and shelter available through their efforts. To address some of the problems faced by child headed households in Addis Ababa, P2P in partnership with war child Canada has been utilizing unique and inclusive intervention strategies since 2004.

Hearing the voices of children affected by HIV/AIDS, p2p support program made efforts to make the life of children affected and infected by HIV a little easier. providing support for health care , school supplies , vocational training opportunities, counselling services , health education, provision of food items at regular intervals, and on holidays such as Christmas and ID Alfeter lunch and gift programs at the same time honouring sponsors and individual supporters.

It is well known that HIV/AIDS in the family, places a tremendous emotional burden on children and families. It is often difficult for families and including children to talk about the complexities of their situations because of fear, stigma, and discrimination.

One of the major challenges for AIDS orphans living in child headed households is the psychological and stressful situations they face. Significant number of orphans suffered from depression, hopelessness, frustration and anxiety. Many needed group and family counselling. The staff at P2P tried hard to offer individual, and household group counselling services together with attempts to keep up with their physical needs. Issues such as disclosure, grief and loss, expression of symptoms of illnesses, future care plans in child headed family life and sibling relationships and responsibilities were the areas in focus in the counselling sessions. The guiding principle in this regard was that the orphans needed loving care, and hope as much as food, shelter protection, and education and health services.

The intervention was able to replace despair with hope, hate with love frustration with inspiration, depression with motivation and encouragement. Vocational training of the youth which helped a large number of orphaned children to be self-supportive and independent was what p2p believed in and put to task.

It always seems impossible until its done

— Nelson Mandela

Boarding school for Girls: as an extension of the concept of care to AIDS orphans, P2P established a boarding school for 60 orphan girls selected on the basis of their academic performance in one of the rural towns of North West Ethiopia. Besides regular schooling in the program, the students are exposed to activities such as farming, bee keeping, cattle raising, vegetable growing and use of bakery and grinding mill.

Horn of Africa Journal of AIDS: This is the first regional scientific peer reviewed journal devoted to HIV/AIDS. It is published by people to people biannually and distributed free of charge to the medical community in Ethiopia and to medical schools in East Africa.

Neurology training program: The high demand of having a sub specialty training program in Neurology with in the School of Medicine of the Addis Ababa university, was realized in 2006 through strong collaborative efforts of P2P with the University. The training program is currently producing neurologists that the country needs critically.

People to people clinic in Morehead Kentucky: The clinic was opened in 2005 through the tireless effort of volunteers, charitable organizations and citizens inspired by Dr Mehari, and supported by Morehead Medical centre to serve the uninsured and underinsured families.

Collaboration to Establish emergency department and training centre at Black Lion hospital: Through partnership with School of Medicine of the Addis Ababa University, People to people, the University of Wisconsin in the USA and through support from the US Twinning program, an emergency department and training centre is established at premises of Black Lion hospital which is actively working to provide emergency care including emergency care to HIV/AIDS patients and sub speciality training on emergency medicine to residents, including training to nurses and students.

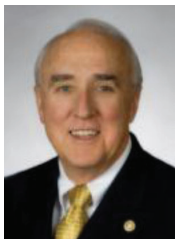
P2P is still looking forward to further boost its efforts towards establishing a stronger bridging system between the resourceful Ethiopian Diaspora professionals and expatriate supporters on one hand and the heavy demand Ethiopia faces in building the capacity of newly emerging Medical schools to improve medical care service delivery on the other.

I call on everyone to play their part. Success will come when we focus our attention and resource on people not their illness; on health, not disease. with the right policies , adequate and fairly distributed funding and a relentless resolve to deliver to those who need it most- we can and will make a life-changing difference for current and future generation.

— Ban ki moon

Ongoing challanges of HIV/AIDS

Michael Finkel, MD



In three decades, HIV/AIDS has progressed from the slowing evolving, always fatal plague of the century into a manageable chronic infectious disease-where medications are available and affordable. Africa faces the twin dilemmas of changing genetically determined biological reproductive impulses for prevention of the disease, while finding funding for those who are already infected.

Societies must erect a series of circumferential bulwarks of prevention around the illness. The first line of defense is education of the public about the transmission of the disease so that precautions will be taken to prevent transmission of the disease when conforming to biological imperatives. The second ring of defense is to develop a strong system of medical education simultaneously with a strong system of medical research. The third bulwark is widely dispersed, accessible and affordable medical services and medications.

The New Medical Education Initiative will fortify the second ring of defense by producing the clinicians, nurses, laboratory personal, educators and social services providers who are needed throughout the country in order for the educational defensive line will not crumble. As new individuals mature and become sexually active, they do not have the generational memory from those who experienced the agonies of the first decade. At the same time, post menopausal individuals tend to drop barrier protections because they feel safe from insemination, forgetting that HIV/AIDS is an infection spread by still pleasurable acts of procreation.

The influence of drug culture varies from land to land, depending on the availability of drugs and the local preferences. The Horn of Africa suffers from the habitual use of the highly addicting drug khat (*Catha Edulis*), and reports are only now appearing that explore the influence of khat on unsafe sexual behaviors and on the entry of women into the sex trades. (Beckerleg S. J Ethnopharmacol 2010 Dec 1;132(3):600-6. Epub 2010 Sep 9). Such studies will benefit from the new medical institutions that can perform the epidemiological, basic science and clinical investigations locally, by individuals familiar with the languages and the culture.

The December 2011 International Conference of the African Society of AIDS (ICASA 11) will bring the dedicated work of P2P to the eyes of the participants, who will see the potential for progress in preventing HIV/AIDS that the years of hard, committed work have produced for Ethiopia.

Horn of Africa Journal of AIDS

peoplepeople.org