



Bulletin 105

Medicus Mundi Schweiz

Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All



AUGUST 2007

POSITIVE MUTTERSCHAFT

POSITIVE MOTHERHOOD
MATERNITÉ POSITIVE

Reader zur Tagung vom 26. April 2007 in Bern

IMPRESSUM

MEDICUS MUNDI SCHWEIZ
Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All

Bulletin Nr. 105, August 2007
Positive Mutterschaft

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 Die gemeinsame und verbindende Vision der Mitglieder des Netzwerks Medicus Mundi Schweiz ist Gesundheit für alle: ein grösstmögliches Mass an Gesundheit für alle Menschen, insbesondere auch für benachteiligte Bevölkerungen. Medicus Mundi Schweiz vernetzt die Organisationen der internationalen Gesundheitszusammenarbeit, fördert den Austausch von Wissen und Erfahrungen, vermittelt ihnen Impulse für die Weiterentwicklung ihrer Tätigkeit und macht ihre Tätigkeit einem weiteren Publikum bekannt. Das Bulletin von Medicus Mundi Schweiz erscheint viermal jährlich. Jede Ausgabe ist einem Schwerpunktthema gewidmet und enthält aktuelle Hinweise und Informationen. Medicus Mundi Schweiz profitiert in seiner Arbeit von der langjährigen Partnerschaft mit der schweizerischen Direktion für Entwicklung und Zusammenarbeit DEZA, die auch die Herausgabe des vorliegenden Bulletins mit einem grosszügigen Beitrag unterstützt.

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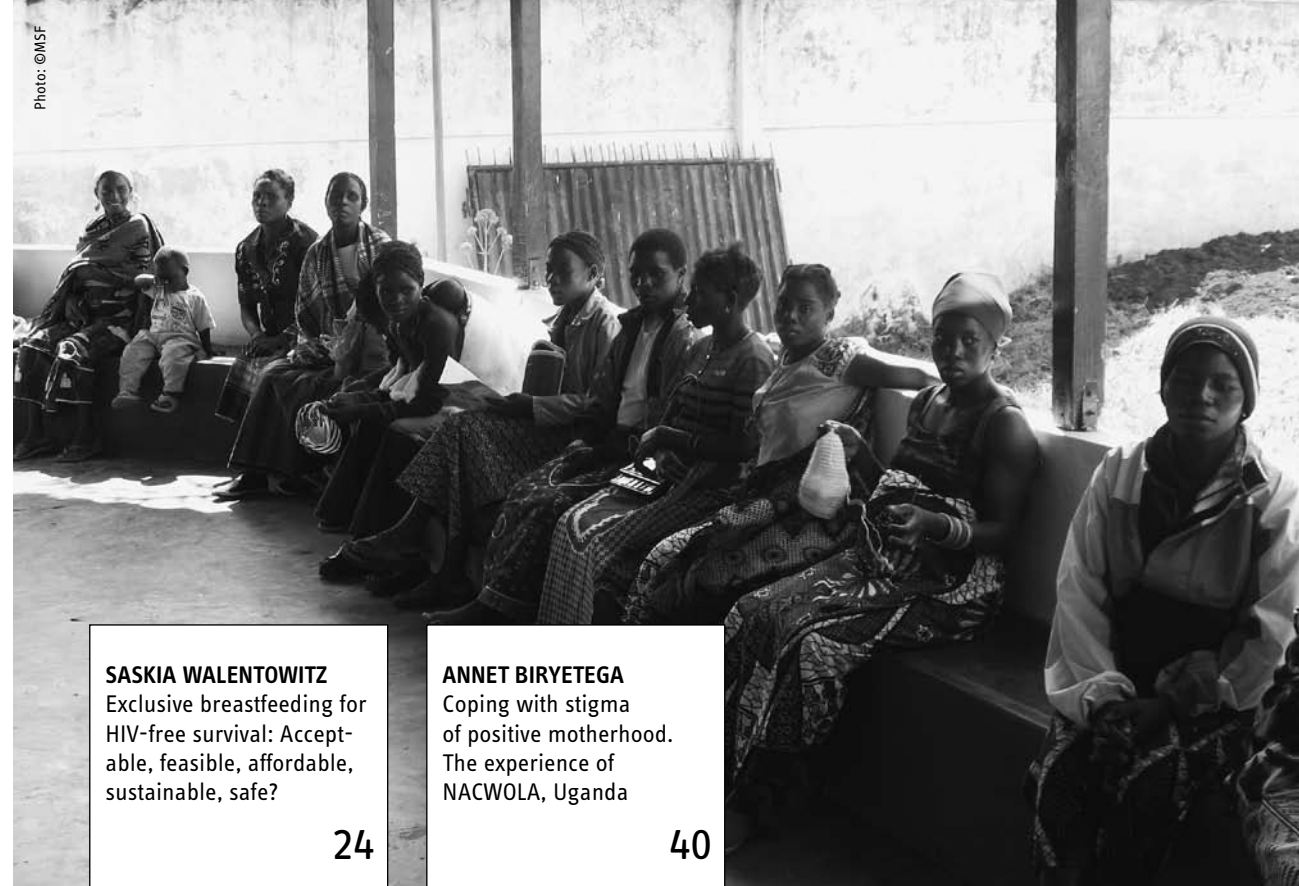
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Auf welchen Ressourcen und Stärken von werdenden Müttern können Programme zur Prävention der vertikalen HIV-Übertragung aufbauen? Dies ist eine der Fragen, die in den lebhaften Diskussionen an der Fachtagung von aidsfocus.ch zu «Positiver Mutterschaft» vom 26. April 2007 in Bern aufgeworfen wurden. Doch wie wir bald merken, wird diese Frage bei der Entwicklung von Strategien und Programmen zur Prävention der Übertragung des HI-Virus aufs Kind kaum jemals gestellt.

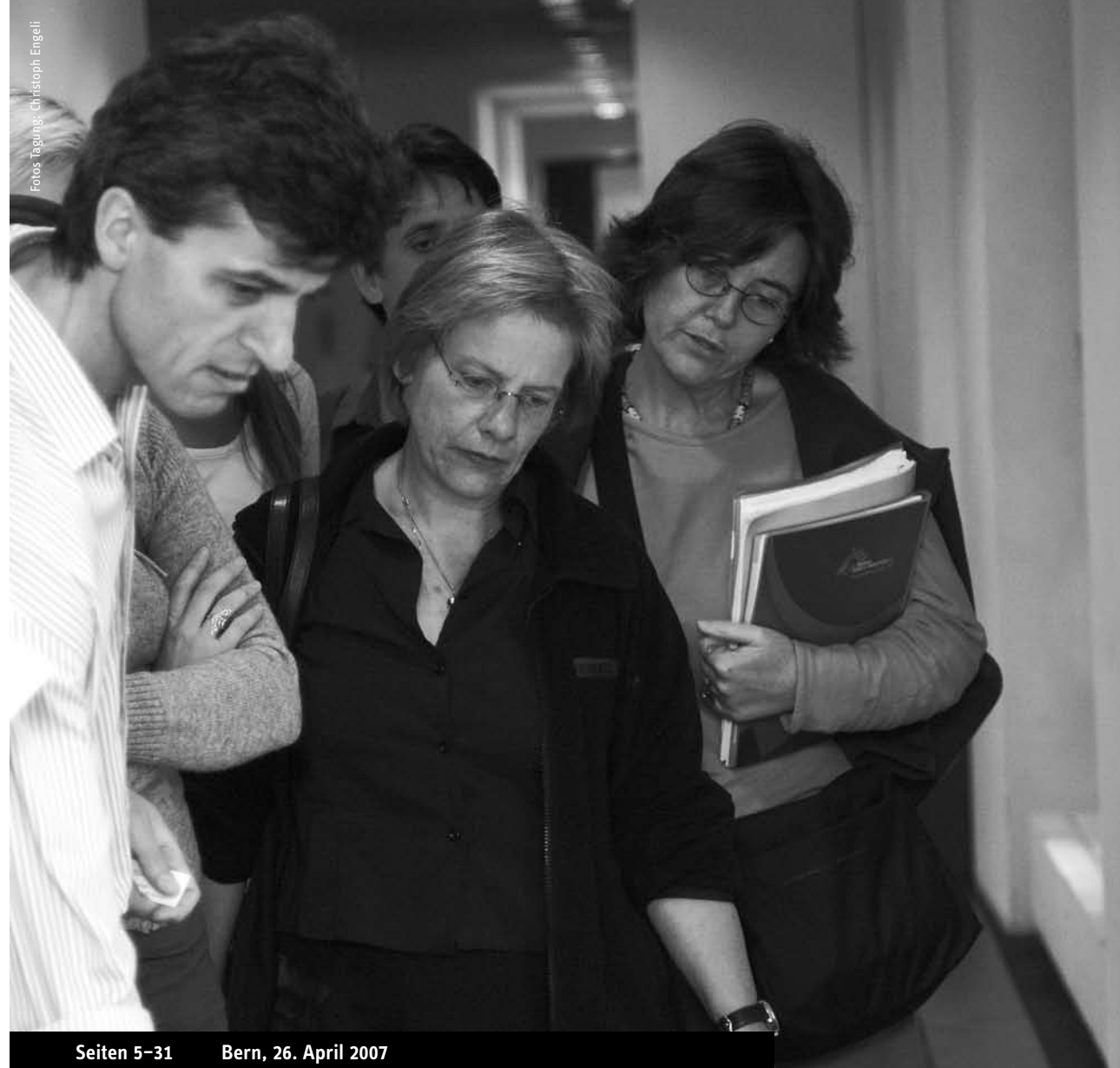
Es ist der sehnlichste Wunsch jeder werdenden Mutter, einem gesunden Kind das Leben zu schenken, und sie würde dafür alles dafür tun. Doch ebenso stark sind der Wunsch und die Notwendigkeit, innerhalb der Familie und der Gemeinschaft akzeptiert und aufgehoben zu sein, und diese Zugehörigkeit mag eine der stärksten Ressourcen der werdenden Mutter sein. Gerade in den Ländern Afrikas und Asiens ist es nicht die individuelle Frau, die für sich entscheidet, ob sie ein Kind haben möchte oder nicht, ob sie den HIV-Test macht und falls notwendig Medikamente zur Prävention der HIV-Übertragung nimmt. Es ist auch nicht sie, die allein entscheidet, ob sie ihr Baby ausschliesslich stillt oder mit Babyahrung füttert, in einer Gemeinschaft, in der Stillen die Norm ist, und in der alle dem Kleinen zusätzlich zu essen geben. Die Angst vor dem «Entdecktwerden», der Stigmatisierung und der Ausgrenzung kann dazu führen, dass eine junge Mutter wider bessern Wissens handelt. Diese Angst kann zur treibenden Kraft werden. Und dies ist die Tragödie.

Wie sieht vor diesem Hintergrund eine Strategie aus, die auf Stärken von Frauen aufbaut? Gewiss ist es wichtig, Frauen zu ermutigen, sie zu stärken und sie bei einem positiven HIV-Testresultat auf ihrem Weg zu begleiten. Auch der Mütter-zu-Mütter-Ansatz, bei dem HIV-positive Mütter einander als Mentorinnen und Freundinnen unterstützen, ist wirkungsvoll. Aber ebenso wichtig ist ein familienzentrierter Ansatz, der den Partner, die Familie und die Gemeinschaft in Massnahmen zur Verhinderung der vertikalen HIV-Übertragung einbezieht. Insbesondere sollen Männer zu verantwortungsvoller Elternschaft ermutigt werden, denn Fragen rund um reproduktive Gesundheit, Familienplanung, Säuglingspflege, freiwillige und vertrauliche HIV-Beratung und Testung betreffen auch sie.

Helena Zweifel ist Co-Geschäftsführerin des Netzwerks Medicus Mundi Schweiz und Koordinatorin der Fachplattform aidsfocus.ch



Die vorliegende Bulletinausgabe ist Reader der [aidsfocus](http://aidsfocus.ch)-Fachtagung «Positive Mutterschaft» vom 26. April 2007 in Bern. Die Tagungsdokumentation sowie eine Ressourcensammlung zum Thema finden sich auf der Website der Fachplattform www.aidsfocus.ch.



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Bern, 26. April 2007

“We commit ourselves to work together with our partners towards the goal of a future generation of children born without HIV and AIDS.”

CLOSING THE GAP IN A GLOBALISED WORLD



In the wealthy countries of the “North” interventions are routinely available that reduce the risk of vertical HIV transmission – that is the infection of the newborn in the womb, or during delivery or breastfeeding – to less than 2%. However, the prevailing inequities that continue to scar our globalised world result in half a million of children being infected with HIV every year- the great majority through vertical transmission. Only 11% of pregnant women in resource poor countries today have access to effective prevention of mother to child transmission or antiretroviral treatment services. Main challenges remain: Should opt-out or opt-in testing replace voluntary testing and counselling? How can weak health systems be strengthened so that the new WHO proposed regimen for prophylaxis and treatment becomes feasible? Which infant feeding policy to propose? How to offer comprehensive prevention, treatment and care using a multisectoral approach?

By Claudia Kessler Bodiang and Helen Prytherch*

FEELINGS of motherhood are probably the oldest, deepest and globally most shared form of human love. For women around the globe, pregnancy and motherhood are a time of joy and bring fulfilment to a woman’s life.

Sadly, however, this is not always the case. HIV/AIDS has cast dark clouds over motherhood for many women and their partners – particularly in the most affected countries. Today, with the increasing feminisation of the epidemic, being female and of reproductive age assigns one to a group at high risk of HIV infection. Should a pregnant woman be HIV positive then the further tragedy of the virus being transmitted to her baby is in these countries all too real.

In a country like Switzerland, HIV testing is strongly recommended to all pregnant women as a routine during antenatal checks. Here, to be infected with HIV and to wish to have a child are not irreconcilable. It is medically possible and no longer viewed as irresponsible on the part of the parents: their child has a very high chance of being born HIV negative and antiretroviral therapy means that parents can still expect to live long lives and care for the child as it grows up, despite their infection. In 2006 the Swiss Federal Office of Public Health reported just one case of mother to child transmission – the mother had not been aware of her HIV infection. Not a single case of vertical HIV transmission amongst pregnant women who had known about their HIV sta-

tus has been reported since 2004. Near universal screening for HIV, antiretroviral prevention or combination therapy given to the mother during pregnancy and to the newborn following delivery, primary elective caesarean section around week 38 and the recommendation to refrain from breast feeding form the package of measures offered to HIV positive pregnant women in Switzerland. In a country like ours these interventions have brought the transmission rates from HIV positive mothers to their babies down to below 2%.

Why is it then, that every year, around half a million children under the age of 15 die of AIDS related illnesses – most of them in resource poor countries and infected through vertical HIV transmission? The reasons are manifold – but if we try to summarise, they boil down to the prevailing inequities that continue to divide our world: inequities between the rich and the poor, between men and women, between rural and urban populations, between the educated and those who have no access to information, between those who do have access to good quality health care and those who do not.

Globally, 18 million women are HIV positive. Since 2002, the number of women living with HIV has increased in every region of the world. The problem is not limited to Sub Saharan Africa: East Asia experienced the sharpest increase in the number of women being infected with HIV with 56% in two years, followed by Eastern Europe and Central Asia with 48%. In Sub Saharan Africa women account for 59% of all those infected – and the proportion is even higher amongst younger age groups. Most of these women are not even aware of their status due to limited access to HIV testing and fear of using such services.

The world is far from reaching the global commitments as agreed in the 2001 UN Declaration of Commitment on HIV/AIDS (UNGASS), a commitment to which Switzerland also subscribed. The aim then was to achieve an 80% coverage of antiretroviral prophylaxis for HIV positive pregnant women by 2005 – this compares poorly to what has been achieved to date. According to latest UN reports, only around 11% of pregnant women in resource poor countries have access to services that help prevent transmission of HIV to their infant. In 2005, more than a quarter (25%) of infants born to HIV infected mothers in the most af-

ected countries resulted in being infected. If we remember that in the absence of any intervention, some 15–30% of babies born to HIV positive women will become infected during pregnancy and delivery and a further 5–20% of them during breastfeeding, we become painfully aware that very little – far too little – has been achieved in this field. The 25% just about reflect the transmission rates we had in Switzerland before effective prevention became available in 1994.

Today, vertical transmission of HIV – that is the infection of the newborn in the womb, or during delivery or breastfeeding – is a problem that can be nearly eliminated with effective prevention measures that are also cost effective. A comprehensive strategy of prevention to eliminate vertical HIV transmission combined with the provision of care for the parents’ health should be a top priority of the AIDS response, particularly in low income countries. Currently, however, those prepared to engage in promoting safe motherhood and preventing vertical transmission in the context of high prevalence of HIV are faced with several fronts of heated debate.

DEBATE NUMBER 1: HIV TESTING

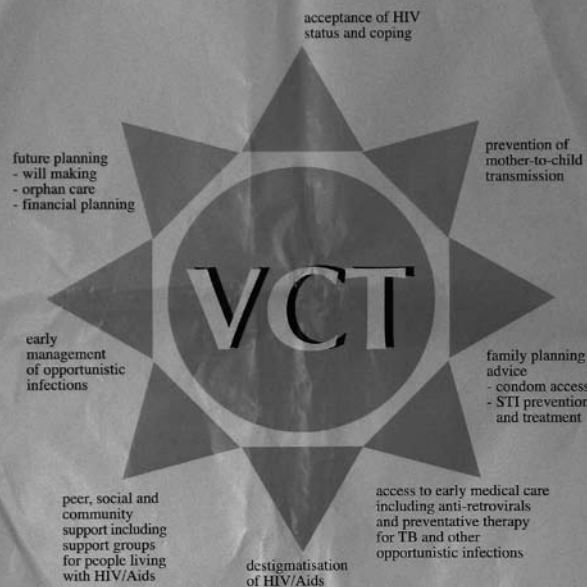
HIV testing can be undertaken through three main strategies: voluntary, mandatory or routine testing. Even though we know that worldwide over 90% of people currently living with HIV are unaware of their status, mandatory testing is not an acceptable public health approach for pregnant women – neither in the North nor in the South. *Voluntary testing and counselling (VCT)* has long been seen as the gold standard, offering the greatest protection of human rights. Individuals voluntarily elect to undergo HIV testing, which is accompanied by pre- and post-test counselling under conditions of full confidentiality.

However, the limits to this approach are magnified in societies where acceptance of VCT is low and the stigma associated with HIV infection is high. To what degree can VCT contribute to reducing HIV prevalence in such a setting? Is the personal autonomy of the individual hereby valued at the expense of the human rights of many others? Is there a case for introducing a more proactive solution when societal and cultural factors prevent women from exercising their voluntary choice?

VCT IS AN ENTRY POINT FOR HIV PREVENTION AND CARE

VCT TRIES TO ENSURE THAT IF YOU ARE HIV NEGATIVE YOU STAY THAT WAY, AND IF YOU ARE HIV POSITIVE YOU LOOK AFTER YOURSELF AS WELL AS POSSIBLE.

Photo: AVERT, www.AVERT.ch



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Promoting VCT at a HIV centre in KwaZulu Natal, South Africa

Routine testing could be such a strategy. There are two ways in which routine testing can be offered: *opt-in* and *opt-out*. Opt-out is where a test is performed in all cases except for when the woman explicitly chooses for this not to be done. This is the strategy that was introduced in Botswana in 2004. It has resulted in an impressive increase in testing rates (19% in the one year interval between 2004 and 2005). Opt-in is basically the model offered to pregnant women in Switzerland.

As a public health decision maker in one of the most affected countries, you face a difficult choice when having to decide on a testing strategy for your health system. Some of

the questions you need to answer are: How can individual rights be protected while safeguarding public health? How can your system offer quality counselling, which is free of coercion? How can you ensure that those tested positive are not subjected to stigma and discrimination? How can we avoid creating a situation where only HIV positive mothers are cared for and HIV negative mothers – who need support to remain that way – are neglected? Is there sufficient antiretroviral treatment and care to provide for everyone who is tested and found to be positive? What will each strategy cost your health budget?

Johanna Kehler of the AIDS legal network makes the point that in the societal contexts in which HIV testing takes place in most resource poor countries, the question has less to do with which HIV testing strategy to propose, than with creating an enabling environment for HIV testing in general.

A first step in this direction is the call for a change in wording when talking about the issue at the heart of today's conference. "Prevention of Mother to Child Transmission" (PMTCT) puts the blame on the mother. It is suggested to replace this wording with "prevention of vertical transmission" or "prevention of paediatric HIV".

DEBATE NUMBER 2: WHICH ANTIRETROVIRAL PROPHYLAXIS?

Firstly, it is important not to confuse ARV prophylaxis in pregnancy with the long term use of antiretrovirals to treat the mother's HIV infection. After years of having nothing to offer to HIV positive pregnant mothers in developing countries for either scenario, studies conducted in the nineties in Thailand, Uganda and Ivory Coast gave rise to hope in the prevention of vertical transmission. A single dose of the drug Nevirapine (Viramune) given to the mother in the initial delivery stages and to her newborn in the first 72 hours after birth was shown to be a low-cost intervention, easy to administer and medically not very complex.

However, even this comparatively "easy" solution has not succeeded in going to scale in the context of resource-limited health systems. In addition, its effectiveness has been increasingly questioned and concerns about drug resistance surrounding the use of this mono therapy option have grown. The current consensus is

that single dose Nevirapine should only be used when no alternative drug regimen is available.

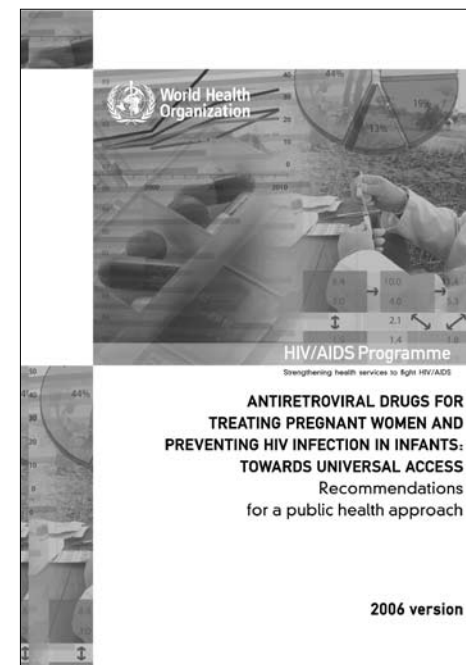
According to the 2006 guidelines of the World Health Organisation the regimen recommended for preventing vertical HIV transmission in resource limited settings uses a combination of drugs over a much longer period of time. The woman needs to start taking Zidovudine (AZT) from 28 weeks of pregnancy onwards. In addition to a single dose of Nevirapine, she needs to receive AZT and Lamivudine (3 TC) during labour and for a week after delivery. Her baby should receive a single dose of Nevirapine right after birth, followed by a seven-day course of AZT. It is already apparent that this is much more complicated than the initial single-dose Nevirapine intervention. Regimes become even much more complex when we look at PMTCT+ programmes which, beyond preventing vertical transmission, aim to safeguarding the mother's health, by offering her antiretroviral treatment if she qualifies for it, and – ideally – also addressing her partner's HIV status and treatment needs.

Countries like Tanzania or Uganda have already shifted their official policy to be in line with the new WHO recommendations. Uganda

is one of the poorest countries to have reached the 3 by 5 goal (providing three million people living with HIV/AIDS with ART by the end of 2005) when country-level statistics are taken. However, the reality on the ground shows itself to be very more complex, marked by an important urban-rural gap. In one of the rural districts of the country, Iganga, some of the health workers have been trained in using the new combination regimen. However, the drugs are still not being delivered through the logistical pipeline to such remote rural areas. Only Nevirapine is available – and even this doesn't reach all the women in need. If the new drugs were to arrive, the problem would still be far from solved. In Iganga district the majority of women deliver at home. This poses the challenge of how to facilitate their access to the needed medication. Health workers have thought about providing the drugs to be taken at home, but concerns prevail due to the drugs potentially serious side-effects. In addition, stigma forces many women to hide such drugs from their relatives and husbands. The arrival of PMTCT programmes in decentralised health services, in addition, poses huge challenges on the resources of the system. Midwives are turned into counsellors, lab facilities are short of what is needed, the competition over the allocation of meagre health budgets is growing and human resources are strained even further than they were before. The result is that most women in a context like rural Uganda have little chance to access such services.

Not just Uganda is faced with a dilemma. The choice between providing a simplified, cheap and easy to administer solution or attempting to upgrade to the more complicated combination option recommended by WHO is a truly challenging one.

In the North we would never accept the first solution on the grounds of its limited effectiveness, the threatened drug resistance and the associated public health hazard that this presents. Yet, when weak health systems have struggled to make even the easier option widely available how can they be seriously expected to handle even more complex and resource intensive strategies? One more and very strong argument for speeding up and intensifying investments in an effective strengthening of health systems in resource limited countries.





DEBATE NUMBER 3: CAESAREAN SECTION FOR ALL HIV POSITIVE MOTHERS?

Elective caesarean section performed before the onset of labour and before the membranes rupture reduces the risk of transmission of HIV to the newborn. A caesarean section is therefore the recommended delivery option for HIV positive mothers in a country like Switzerland. In the developing world this benefit has to be balanced against the risk to the woman of the surgical procedure. Maternal mortality and morbidity are greater after a caesarean section than after vaginal delivery. And, of course, access to a caesarean section is not given in many health systems in poor countries. In many rural regions of Africa there is a lack of health staff and equipment needed to perform this operation. Families cannot afford transport to referral hospitals and most women in need of emergency obstetric care die somewhere on the way to the next hospital. Performing elective surgery at 38 weeks – the norm for preventing vertical transmission in Switzerland – sounds utopian in such a setting and will clearly not be a feasible policy option in the near future.

DEBATE NUMBER 4: WHICH INFANT FEEDING POLICY?

It is widely recognised that formula feeding is not a feasible option for most women in resource poor countries. Research from South Africa just published in the Lancet suggests that exclusive breast feeding for six months followed by rapid weaning has a lower risk of HIV transmission as compared to so-called mixed feeding. The results support those who call for a revision of the WHO/UNICEF guidelines on infant feeding. Dr Coovadia of the University of KwaZulu Natal stresses, however, that this does not mean we have found a solution. There are many societies, like the South African one, where mixed feeding is a cultural practice that goes back hundreds, if not thousands of years. Recommendations for exclusive breastfeeding in such societies put women at risk of becoming stigmatised, not to speak of the confusion that will be created when changing the recommendation after telling HIV positive mothers for years that they should abstain from breastfeeding.

TOWARDS A COMPREHENSIVE STRATEGIC APPROACH

These, however, are not the only challenges faced when developing an effective response to preventing vertical transmission and promoting safe mother/parenthood. The response has to go far beyond the medical sector. What is needed is a comprehensive strategic approach embracing primary prevention, so that women and men do not become infected with HIV in the first place, as well as ways to reduce the numbers of unintended and unwanted pregnancy and create access to safe motherhood. Socio-economic, cultural and factors linked to education are as crucial to these issues as they are to questions of preventing vertical transmission and providing appropriate and accessible treatment, care and support to mothers, their partners, and most crucially to their children. Besides the strengthening of health systems we need conducive legal frameworks and policies, adequate and safe nutrition, socio-economic development and – most of all – we need to combat stigma and work towards supportive societies where the discrimination of people living with HIV becomes a thing of the past.

There are no magic bullets or quick wins in this field. This reflects the complex reality we are living and working in. However, solutions are available which are cost effective and have been shown to have an impact both at the public health level AND at reducing unnecessary human suffering at the individual level. The international community – and the partners of aidsfocus.ch – must step up efforts to overcome the inequities that surround positive motherhood in order to move towards Universal Access.

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“A WOMAN’S DISEASE”

The implementation of a successful program for reduction of HIV transmission from mother to child depends upon many factors. In our experience we can highlight a few of them that are significant within the context of northern Mozambique. Some of them are in relation to the patients’ lives, while others are related to the organisation of the services and the human resources available.



By Marleen Dermaut*

HIV/AIDS is one of the biggest problems Mozambique is facing at the moment, with an overall prevalence of 16 percent in the reproductive age group. The government of Mozambique has taken action to fight the problem only over the past few years, and policies have been formulated – not least with pressure and support from Médecins Sans Frontières (MSF).

THE LICHINGA PROJECT

Lichinga is located in one of the most isolated provinces of Mozambique, Niassa, in the northern part of the country. MSF was the first actor to provide medical care to persons infected with HIV. The Lichinga project of MSF aims to improve access to and quality of care for HIV positive patients, as well as reduce transmission of HIV. The set-up of the project was designed in such a way that step-by-step activities would be integrated into and finally handed over to the existing Ministry of Health structure.

The project started in July 2001 with the rehabilitation of the facilities for the Voluntary Confidential Counselling and Testing (VCCT), staff recruitment, training and activities to improve hospital hygiene. The VCCT centre, situated next to the paediatric ward in the Provincial Hospital of Lichinga, has been functional since January 2002. The program for reduc-

tion of HIV transmission from mother to child (PMTCT) began in October 2002: mother and baby are given antiretroviral drugs in order to reduce the risk of transmission. Both receive care for one and a half years with medical, psychological and nutritional support. At the end of May 2003 a second VCCT for PMTCT was opened at the city’s Health centre next to the prenatal consultations, which increased the number of pregnant women counselled and tested. Since November 2003 antiretroviral treatment (ART) is offered to patients in an advanced stage of the disease. Since the beginning of the program almost 2.617 files for HIV positive patients have been opened and 775 patients initiated ART: of these, 528 are still being successfully followed (as of December 2006).

As for non-medical activities, training has taken place for various target groups, i.e. hospital staff, other health workers and community leaders. Information, Education and Communication activities have been integrated into the program such as for e.g. theatre plays in rural contexts and “palestras” (health talks) for various target groups.

Medical and non-medical activities have increased steadily throughout the project period, although the current perception of the field team is that more could be done with the existing resources. There are three MSF expa-

triate volunteers currently working in Lichinga (medical doctor, midwife, field coordinator), and approximately 20 national staff (not including guards and domestic staff). It must be noted that a number of human resources problems, gaps in expatriate volunteers’ positions and fluctuations occurred in the Lichinga HIV project. In terms of funding, the project is financed by the Irish Cooperation as well as MSF funds.

THE PMTCT PROGRAM

Since October 2002, 369 pregnant women have gained access to the program for reduction of HIV transmission from mother to child. The prevalence of HIV in the antenatal care service is of 6.6%. From 2005 onwards, the care provided within the program follows the Ministry of Health protocol, which is subdivided into the three following steps:

Prenatal care: Voluntary Confidential Counselling and Testing is offered to all pregnant women at first consultation using an ‘opt-out’ strategy. When the test result is positive, CD4 count is done and decision making is based upon the CD4 count value. Women in need of antiretroviral treatment are then referred to the HIV clinic, where they receive the full package of ART care, including adherence support, biological and medical follow up.

Women, who do not need antiretroviral treatment for their own health, receive the antiretroviral drug Azidothymidine (AZT) from 32 weeks onwards, and one tablet of another antiretroviral drug, Nevirapine, is given to the women to take home at 36 weeks. Once the women receive the tablet, it is important to explain that they have to take said tablet at the onset of labour.

Intrapartum care: during delivery women receive extra doses of AZT every three hours and extra care is taken to make sure that the women take their tablet of Nevirapine. Invasive manouvers are avoided during delivery to reduce the risk of HIV transmission. Soon after delivery, the newborn receives a single dose of Nevirapine; mother and baby then go home with the necessary doses of AZT for a week. AZT is given to the mother to reduce the risk of induction of Nevirapine resistance, whereas the baby receives AZT as part of the post-exposure prophylaxis to avoid HIV transmission.

Post partum follow up: positive mothers will be followed in the HIV clinic while the babies should come regularly to the child clinic for follow-up. During the monthly visits, the newborns are checked for normal growth and early detection of opportunistic infections. At six weeks the cotrimoxazole prophylaxis is started and at 18 months a rapid test is offered to detect eventual transmission of HIV. Exclusive breastfeeding is recommended for positive women until six months.

MAIN DIFFICULTIES AND CONSTRAINTS

The implementation of a successful PMTCT program depends upon many factors. During pregnancy women are requested to come regularly to follow-up visits, something that is complicated by the many constraints of their daily lives. The efficacy of prophylactic treatment is very much dependent on good adherence to the daily intake of antiretroviral drugs. Factors influencing adherence vary during time and with respect to the social context of the women, as in e.g. the involvement and support given by the women’s partners. Such support is an important factor that can help these women to maintain their adherence to the antiretroviral treatment program. However, in this specific context, adherence is difficult to maintain due to the weak social position of these women: often they are scared to disclose their status to their partner and/or family due to fears related to rejection.

In Mozambique the last WHO recommendations are not yet included in the national protocol: therefore MSF with other implementing actors are advocating towards the Ministry of Health to update said protocol. Staff working in the antenatal care is often not enough and/or not sufficiently trained. To make things worse, low salaries and high workload contribute to low motivation and high absenteeism.

The possibilities of intervention during delivery depend upon the attendance of the women to health services, which in rural areas is far from being common practice. In general, women prefer to deliver at home attended by family members and an untrained traditional birth attendant.

Another difficulty is related to nutrition: the optimal feeding option to avoid transmission – applied in rich countries – is total substitution of maternal breast with artificial milk. The cost

and the little feasibility of AFASS conditions (affordability, feasibility, acceptability, sustainability, safety) proposed by WHO to have safe replacement feeding forces the Ministry of Health and implementing partners to give little possibility of choice to these women. This inevitably leaves as sole option exclusive breastfeeding. Such a choice is complicated by cultural and social constraints, since the women are used to introduce at a very early stage other liquids or solid food.

In order to improve our activities, we realised that we needed to have a clearer idea on the patients' perception of our services. MSF therefore set up an anthropological study related to local cultural and social constraints.

One of the major points that came out of this anthropological study was that the perception and knowledge of HIV and AIDS amongst the general population is still very much associated with death. The information they have is mainly about the ways of contagion, preventive measures and the fact that one can die from such a disease. There seems to be still very little knowledge about the evolution of the disease and of a possible treatment. Many men arrive late to the Lichinga HIV-clinic and die even before initiating ART. New Information Education Communication strategies have been elaborated to increase the knowledge and change the perception of the disease in terms of acceptability, to convince people to come to get tested and treated.

This study also revealed that AIDS is very much perceived as a "woman's disease", because the prevalence is higher among women. Women are considered to be responsible for its transmission, are the main target group (in Information Education Communication programs, within the health system and from the empowerment point of view) as well as being the first and more visible AIDS sufferers (PMTCT visibility). Women are often young, married and under fertility pressure. The socio-cultural obligation to have children appears to outweigh fears and risks associated with the prospects of deteriorating health, of giving birth to infected infants and the fear of leaving children orphaned. Information Education Communication projects therefore need to change this way of thinking. The position of women should be

highlighted in a positive manner when fighting discrimination and giving messages to the population.

INTEGRATION INTO THE ROUTINE HEALTH CONSULTATION

Until the end of August 2006, the PMTCT program managed by MSF was facing an important rate of patients lost to follow-up. The suspected reasons for this situation were problems related to the structural organisation of the services, as well as the unfavourable social condition of women. As a consequence, both problems were addressed by the program.

Structural organisation of the services: After August 29th, 2006, the PMTCT program was officially integrated into the routine mother and child health consultation given in the Lichinga Health Centre. Before, the program was physically located in rooms next to the routine consultations, therefore women were advised to go there after the prenatal consultation. As a consequence, many women either did not come to test themselves for HIV, or if they did, they would not come back for a following consultation. Since the integration, MSF workers noticed that practically no women were denying to take the HIV test and were also going quite regularly to prenatal consultations (see below Table 1). Therefore the physical integration of PMTCT activities into the routine prenatal consultations of the Health Centre has significantly reduced the risk of stigma.



Mother and child at the Health Centre, Lichinga, 2006

2006	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OKT	NOV	DEC
Mother and Child Health Care program 1 st consultations	328	289	380	354	345	353	398	343	309	301	268	268
HIV/AIDS Voluntary Confidential Counselling and Testing	129	133	149	134	182	193	221	255	252	214	186	170
Women using VCCT compared with health care consultations	39%	46%	39%	38%	53%	55%	56%	74%	82%	71%	69%	63%
Consultations PMTCT program	20	24	25	24	22	17	15	20	49	54	53	52
Women entering program compared with PMTCT consultations	40%	62%	54%	40%	29%	23%	27%	32%	108%	57%	75%	58%

TABLE 1: PMTCT program compared with Lichinga Health Centre Mother to child health care program 1st consultations (in grey: months after integration) Source: Lichinga Health Centre and MSF statistics.

Unfavourable social condition of women: The hypothesis was that the social condition of women did not allow them to freely choose whether they wanted to take the HIV test and if positive, to commit to a medical follow-up. However we later realized that this first hypothesis was partially biased from a westernized approach. The concept of giving a choice to women to decide whether they want to undergo the HIV test or not, is an occidental, imported concept, more related to the individual rights that partially form patient/medical staff relations in westernized countries. For historical reasons, the afore-mentioned relationship is clearly asymmetric. In the case of Lichinga, nurses are generally considered to be the ones who know what pregnant women should do. It is therefore normal for them to integrate into their routine recommendations for the pregnant women to also take the HIV test. An example:

“The woman, who is pregnant, told us that in the CS the HIV test is compulsory and that she thought it was a good thing in order to protect the baby health.” (reported by a nurse of our Lichinga local staff concerning one of the patients)

Integration has also got other effects. On the one hand, with a media of 55 consultations per day divided between three nurses, counselling has decreased both in time and quality. On the other, because of the shortage of health professionals in the national health system, there are fluctuations on the number and quality of knowledge of the nurses attending the services.

Moreover, the new “opt out” protocol of routine HIV testing, based upon WHO recommendations, states that “women must indicate in the case she does not want to be tested for HIV” (Ministry of Health 2006). Such an approach allows for the maintaining of a degree of choice for pregnant women, in a context where beneficiaries are used to accept and not to decide. Therefore, HIV testing can, in this

way, be normalized like the rest of blood testing, nutritional supplements and malaria prophylaxis. By “normalised”, we intend the increase of its frequency, its inclusion into mainstream prenatal protocol and in the normative perception that women have of HIV testing.

CONCLUSION

Looking back to the experience of this PMTCT intervention, MSF can draw some lessons concerning the set-up of this kind of services. Integration of HIV care for pregnant women into the usual routine antenatal care definitely helps in ensuring an optimal acceptability and a feeling of reduced discrimination.

However, to do so it is important that the health staff involved in the implementation exists in due number, is well trained and fully aware of the social constraints for positive women. Community awareness is fundamental in creating an enabling environment through the involvement of partners as well as the participation of pregnant women who have successfully followed the program, who may pass the message to other women at the beginning of the process.

Finally, it must not be forgotten that full and active participation of all actors such as members of the aidsfocus.ch network to the scaling up of PMTCT programs is pivotal to a future generation free of AIDS.

SUPPORTING MOTHERS TO MAKE INFORMED CHOICES



The HIV/AIDS pandemic and the fact that HIV can be transmitted via breastfeeding have brought about one of the most painful dilemmas of the last two decades in the field of public health. Suddenly, breastfeeding, so well known and appreciated for saving lives and improving overall health prospects of babies and their mothers everywhere in the world, came to be regarded as a culprit. Because it could transmit a virus for which there was no cure, it seemed that all its myriad benefits were temporarily forgotten.

By Lída Lhotská*

IT HAS BEEN estimated that, without any intervention with antiretroviral drugs, the rate of the additional transmission of HIV through breastfeeding might be between 10 and 20% if a baby were to be breastfed for two years. It is interesting to note that exactly the same transmission rate was attributed to the approximately 24-hour period of labour and delivery, making it the single time point of greatest risk. The transmission rate during pregnancy was determined to be 5–10%.

The calculation of 10–20% HIV transmission rate through breastfeeding was based on the data from cohorts of breastfed children. However, throughout the 1990s breastfeeding experts tried to alert the HIV/AIDS research and public health community that it was vital to specify the pattern of breastfeeding practiced by HIV-infected women.

PATTERNS OF BREASTFEEDING

There was some evidence that exclusive breastfeeding was important for maturation of the intestinal mucosa because the introduction of infant formula or any other fluid, or substance

that was not breastmilk, to young infants might cause micro bleeding of the gut or other negative effects. This was likely to facilitate the virus to get across the baby’s gut wall. They were saying that breastfeeding practices (exclusive versus predominant or partial) could be an important determining factor for the rates of HIV transmission.

Yet, in most studies concerned with HIV transmission from mothers to babies, this information was not collected and even where it had been, this was often without using the standard WHO definitions for breastfeeding patterns. Exclusive breastfeeding was not defined as nothing but breastmilk with the exception of drops or syrups consisting of vitamins, mineral supplements or essential medical drugs. Commonly non-milk liquids and solid foods (such as cereal-based gruels) were allowed in the definition of exclusive breastfeeding, whereas WHO definitions would have categorised this type of feeding as “partial breastfeeding” or “mixed feeding”.

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The first analysis looking closely at the possible impact of different patterns of breastfeeding on HIV transmission was a randomised controlled trial (RCT) in South Africa. The main focus of this study had been to look at the impact of the antenatal Vitamin A supplementation on perinatal transmission, but the authors had also looked at feeding patterns and published the results in 1999¹. The researchers compared the cumulative rates of HIV transmission in infants exclusively or partially breastfed (to three months). The rates of infection were similar at birth, but partially breastfed infants had higher rates of postnatal transmission at three, six, and up to 15 months of age when compared with exclusively breastfed babies.

Cumulative probability of HIV infection remained similar among those children never breastfed and exclusively breastfed up to six months. No transmission of HIV (beyond perinatal acquisition) was observed if mothers did not breastfeed.

Until recently, this data had stirred controversy because of the observational nature of the study and also because for years the research was not replicated. However, the findings alerted the research community to the need for making a distinction between different patterns of breastfeeding when trying to understand better why HIV transmission through breastfeeding occurred in some mother/baby couples but not in others.

Nonetheless, by the millennium, the data was not yet there. As the world continued to grapple with the dilemma of how to advise mothers, the protection, promotion and support of breastfeeding was already dwindling. The advent of, at first long and then short, regimens of antiretroviral prophylaxis, which could cut back HIV transmission during pregnancy and delivery, became the focus of the international debate as were programme efforts on how to reduce HIV transmission once the baby was born.

Should HIV-positive women in developing countries be advised to use exclusive infant formula feeding, especially in cases when they could receive HIV prophylaxis, so that the gains in terms of reduced transmission at birth would not be lost due to subsequent transmission via breastfeeding? Or should they rather be told to breastfeed because there might be no possibility for them to make up artificial feeds safely?

POLICY DEVELOPMENT

The dilemma was reflected not only at programme level but also, understandably, at policy level. With evolving knowledge about HIV transmission from mothers to babies, the technical agencies in the UN system (mainly WHO and UNICEF), went through, in the last 15 years, policy development processes which resulted in a series of subsequent policy statements and recommendations.

The first UN Consensus statement on HIV and breastfeeding dates back to 1992². It noted the impressive nutritional, immunological, psychological and child-spacing qualities of breastfeeding. It also noted that not breastfeeding was a major contributory factor in the 1.5 million annual infant deaths from diarrhoeal and respiratory infections. But the statement also noted the need to weigh the baby's risk of HIV infection through breastfeeding against its risk of dying of other causes if denied breastfeeding.

The final recommendations were based on the epidemiological indicators of settings in which HIV-positive women might live. In settings where infectious diseases were the primary cause of death during the first year of life, HIV-positive women were to be advised to breastfeed. In settings where this was not the case, mothers were to be advised not to breastfeed.

The interpretation of this policy came under serious scrutiny once the UN system started looking through human rights lenses at the implications of such blanket rules. In 1997, applying principles derived from key human rights instruments such as the Convention on Elimination of all Forms of Discrimination Against Women (1979) and the Convention on the Rights of the Child (1989), a new Policy Statement was issued by UNICEF, UNAIDS, WHO, the lead agencies in this area.³

This policy squarely put the right to make informed choices about infant feeding methods into the hands of the mother. It stated:

"Because both parents have a responsibility for the health and welfare of their children, and because the infant feeding method chosen has health and financial implications for the entire family, mothers and fathers should be encouraged to reach a decision together on this matter. However, it is the mothers who are in the best position to decide whether to breastfeed, particularly when they alone



Breastfeeding in Tajikistan

Photo: U. Palaniappan/ACF, 2006

may know their HIV status and wish to exercise their right to keep that information confidential".

Following this statement, a set of guidelines⁴, which explained which infant feeding options might be available for the mother to choose, was developed. The options included: breastfeeding by the mother; by a wet nurse (known not to be HIV positive); modified breast milk (e.g. donated pasteurised breastmilk); complete replacement feeding (i.e. no breastmilk at all) with either commercial or home-made infant formula.

In 2000, based on additional research data, the recommendations were further refined⁵ to say:

"When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise exclusive breastfeeding is recommended during the first months."

The new recommendation on exclusive breastfeeding was not based on the South African study¹ and possible preventive effect on HIV transmission, but on the known benefits of protection against infectious diseases such as diarrhoea and pneumonia.

After all, it had been well documented that breastfed babies had a much greater chance of survival when compared with their artificially

fed counterparts. WHO analysis⁶ of data from several studies showed this with absolute clarity. The relative risk of death in the first two months of life was shown to be six times greater for artificially fed babies than for those who were breastfed. The risk continued to be elevated even in the second year of the babies' lives. In terms of effectiveness, breastfeeding has been ranked as the number one intervention for child survival with the potential of preventing 13–15% of child deaths in low-income countries⁷.

REPLACEMENT FEEDING – ONLY IF AFASS!

Acceptable, feasible, affordable, sustainable and safe replacement feeding has become known as AFASS. The UN has made it clear, that when one of these five conditions is not in place, replacement feeding is likely to carry a great risk for the baby.

At first sight the five conditions may seem easy to disentangle, yet they are quite complex:

Acceptable: The mother is under no social or cultural pressure not to use replacement feeding, she is supported by the family and community in carrying out this practice or able to cope with pressure from her family and friends to breastfeed, and she can deal with possible stigma attached to being seen with replacement food.



Dilemmas on infant feeding: is breastmilk best of infant formula from Alacta or Nestlé?

Feasible: The mother (or family) has adequate time, knowledge, skills and other resources to prepare the replacement food and feed the infant up to 12 times in 24 hours.

Affordable: The mother and family, with community or health-system support if necessary, can pay the cost of purchasing/producing, preparing and using replacement feeding, including all ingredients, fuel, clean water, soap and equipment, without compromising the health and nutrition of the family. This concept also includes access to medical care if necessary for diarrhoea and the cost of such care.

Sustainable: Availability of a continuous and uninterrupted supply and dependable system of distribution for all ingredients and products needed for safe replacement feeding, for as long as the infant needs it, up to one year of age or longer.

Safe: Replacement foods are correctly and hygienically prepared and stored, and fed in nutritionally adequate quantities, with clean hands and using clean utensils, preferably by cup.

The key to enable HIV-positive mothers to make the best possible decisions about feeding their babies is the provision of skilled counselling which includes full information on the

pros and cons of infant feeding options and is free from commercial pressures. And equally importantly, mothers must be supported to carry out their decision after it has been made.

CURRENT UN RECOMMENDATIONS

The 2000 UN recommendation have been in place for six years but meanwhile an additional body of evidence has been accumulated. In October 2006, a WHO Technical Consultation adopted the following refined and clarified recommendations⁸.

HIV-negative women or HIV status unknown: Exclusive breastfeeding for six months and continued breastfeeding for two years or beyond.

HIV-positive women: Exclusive breastfeeding for six months unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS). The most appropriate infant feeding option for an HIV-exposed infant depends on individual circumstances, including consideration of health services, counselling and support.

This recommendation now unifies the duration of exclusive breastfeeding by HIV-positive women with that for the general popula-

tion, thus helping to tackle some of the confusion caused by the previous double standard – i.e. six months which clashed with “during the first months”.

THE BASIS FOR THE RECOMMENDATIONS

A number of studies contributed to this important refinement of the recommendations of which three are presented for illustration:

An investigation by the Centre for Disease Control (CDC) in Botswana, where an outbreak of severe diarrhoea and a sharp increase in malnutrition and infectious diseases, led to a dramatic increase in deaths among children under five years⁹. Not breastfeeding and poor growth before illness were the two biggest risk factors. This country appeared to fulfil all five AFASS criteria so that all HIV-positive women were advised to artificially feed and received free infant formula. However, in late 2005, early 2006, heavy rains affected water quality. The resulting epidemic highlighted the vulnerability of infants and young children on replacement feeding.

Consequently, CDC suggested that the “safe” component of “AFASS”; should be empirically demonstrated and not assumed. Any programs contemplating the use of infant formula should verify that this could save lives in the particular context before the launch of widespread distribution.

Also from Botswana the ‘Mushi’ Study (mushi means milk)¹⁰ showed that in the context in which the study was conducted, any gains from the reduction of HIV transmission through free formula distribution were lost because of increased mortality from infections such as diarrhoea and pneumonia.

Professor Hoosen M. Coovadia and his colleagues carried out a meticulous prospective study in South Africa. This provided the long awaited evidence on the effect of exclusive breastfeeding versus mixed feeding on HIV transmission¹¹. This research confirmed the finding of the earlier study¹: that infants exclusively breastfed by their HIV positive mothers have a lower risk of HIV transmission than those who are mixed fed. Moreover, the type of mixed feeding also matters: infants exposed to a mix of breastfeeding with infant formula feeding had double the risk of HIV transmission than those breastfed exclusively; the addition of solid foods to breastfeeding raised the risk eleven fold.

WHAT DO THE NEW 2007 RECOMMENDATIONS IMPLY?

First and foremost the recommendations will be of little help unless skilled, unbiased counselling by well trained health workers, sensitive to the individual’s situation, is available to HIV-positive mothers. They may have only discovered their status through recent HIV testing which should always be voluntary and confidential. These women need support long before the birth of their baby. They need good antenatal care to facilitate their infant feeding decisions. Continued support is necessary so that mothers can practice their chosen infant feeding option. In the light of the evidence, including new programmatic data, to improve the chances of a child’s HIV free survival, HIV-positive mothers appear to have two principal infant feeding options: either six months of exclusive breastfeeding or complete replacement feeding. However, the other infant feeding options remain open for discussion if the mother is interested. For example, in places where there are properly managed human milk banks, or in situations when a mother can manage home-pasteurisation of her own breastmilk (feasible and proven to eliminate the HIV virus), women might opt for one of these choices perhaps for the early months when infant vulnerability to infection is greatest. When or if a child is found to have his or her own HIV infection (not merely the mother’s transferred antibodies) the mother may be strongly encouraged to breastfeed into the second year of her child’s life. HIV-positive children who are breastfed have better survival outcomes, later start of AIDS and lower rates of pneumonia and less chronic diarrhoea.¹²

These examples illustrate that it is crucial to emphasize that a mother’s decision is not necessarily a “once and for all” decision. The mother must be helped to re-assess her situation continuously and to adjust her feeding option if possible or necessary.

POLICY FRAMEWORK

To ensure that HIV-positive mothers do receive all the support they need for their difficult decision, there are some policy imperatives that must be fulfilled. They are encapsulated in the *HIV and Infant Feeding: Framework for policy action*.¹³ This Framework, developed by eight UN agencies plus the World Bank, was

adopted in 2004 and 2006 by the highest decision-making body in public health, the World Health Assembly (WHA). It highlights five priority areas for governments:

1. Develop or revise a *comprehensive national infant and young child feeding policy* which includes HIV and Infant Feeding.
2. Implement and enforce the *International Code of Marketing of Breastmilk Substitutes* and WHA resolutions.
3. Intensify efforts to protect, promote and support *appropriate infant and young child feeding practices in general*, while recognizing HIV as one of the exceptionally difficult circumstances.
4. Provide *adequate support to HIV-positive women* to enable them to select the best feeding option for themselves and their babies, and to successfully carry out their infant feeding decisions.
5. Support *research on HIV and infant feeding*, including operations research, learning, monitoring and evaluation at all levels, and disseminate findings.

The first and third priorities emphasise the need for strong national commitment which should result in a coordinated, comprehensive approach. HIV and infant feeding should not be singled out but be addressed within a policy that facilitates exclusive breastfeeding for six months, followed by nutritious complementary feeding with continued breastfeeding for two years and beyond, for the general population. Exclusive breastfeeding is not a common practice in many countries. Unless society as a whole embraces this practice, it will be forever difficult for HIV-positive mothers to make it happen. Scaling up of the Baby-Friendly Hospital Initiative (launched by WHO and UNICEF in 1991) is highlighted as an important opportunity to address HIV and infant feeding.

The second priority area recognizes the need for both breastfed and artificially fed babies, their parents, families and all caregivers to be protected from commercial pressures. The International Code¹⁴, adopted by WHA in 1981 aims to “contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.”

In the context of HIV the Code is often misunderstood. It neither compels women to breastfeed nor prohibits the use of breastmilk substitutes, including infant formula. It aims to take commercial pressures out of the infant feeding arena to ensure that decisions about products are based on impartial, scientific and factual information which will protect the child’s health. The Code also protects all health professionals and scientists who might be vulnerable to commercial pressures and conflicts of interest in their working lives. Moreover the Code protects company personnel whose incomes must not depend on sales of breastmilk substitutes. Over the past 26 years, WHA has clarified and amplified the Code through numerous subsequent resolutions, which have equal status to the Code.

Some of the key elements under the fourth priority have been addressed in this article. It is important to mention that this priority area calls for improved follow up, supervision and support of health workers in order to sustain their skills both in health care and quality counselling, and also to prevent burn-out.

The final, fifth, priority area reminds us that there is still much need for further research, both at basic and operational level. The world has clearly made some progress in this difficult and complex area, but the work needs to continue to improve the survival for children born to HIV-positive mothers, and to protect breastfeeding for the majority of children who would benefit from it.

The following quotation from Professor Hoosen Coovadia of the University of Natal in South Africa summarizes the challenge:

“Breastfeeding enhances motherhood as love nourishes the family. It is the key to a healthy life for infants and children. Breastfeeding has withstood many threats to its survival through its evolutionary history. It is our responsibility now to ensure that breastfeeding continues to be fostered, promoted and protected for all women through the HIV crisis. We can achieve this goal and preserve this basic right by increasing the means through which breastfeeding becomes safe for HIV-positive women through the AIDS pandemic.”

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ACCEPTABLE, FEASIBLE, AFFORDABLE, SUSTAINABLE, SAFE?



The latest WHO consensus statement regarding HIV and infant feeding suggests that, in resource-poor settings, it is more realistic successfully to promote exclusive breastfeeding for six months than to make replacement feeding AFASS (affordable, feasible, acceptable, sustainable and safe) for HIV-infected mothers. Worldwide, infant feeding patterns give a less optimistic picture, since continuous and prolonged exclusive breastfeeding is not a “natural” feeding practice, neither at present nor in the past. As a vital fluid produced by a living female body within the gendered process of reproduction, breastmilk is not believed to be a perfect and self-sufficient food through which a woman is able to guarantee a child’s development on her own.

By Saskia Walentowitz*

SINCE 2001, the World Health Organization recommends exclusive breastfeeding for six months for all infants, followed by the introduction of nutritionally adequate, safe and appropriate complementary foods with continued breastfeeding for at least two years¹. While experts agree that breastmilk is the best infant diet and protects the child against various infections, there has been debate over the optimal duration of exclusive breastfeeding. Compared to the previously recommended duration of four to six months, the main advantage of exclusive breastfeeding for six months lies in an additional reduced risk of gastrointestinal infections and of all-cause child morbidity. Hence, in the context of developing countries, infant feeding experts conclude that the benefits of exclusive breastfeeding in terms of decreased morbidity and mortality outweigh potential risks associated with exclusive breast-

feeding for 6 months. In the absence of safe replacement feeding, these risks include the mother-to-child transmission of HIV/AIDS, which is significantly reduced by exclusive breastfeeding, but can be totally avoided only by not breastfeeding.

According to the latest consensus statement based on new evidence regarding HIV and infant feeding², the WHO recommends exclusive breastfeeding for 6 months to HIV infected mothers unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS). If at six months AFASS criteria are still not met, the mother is advised to introduce suitable complementary foods and to continue breastfeeding until an adequate and safe diet without breastmilk can be provided. The overall paradigm of the global infant feeding strategy in the context of HIV/AIDS now is HIV-free survival at 18–24 months. Low maternal

CD4 counts as well as high viral load in breastmilk and plasma have been identified as important risk factors for HIV transmission and child mortality, though the recommendations regarding infant feeding do not integrate differential transmission risks.

PROLONGED AND CONTINUOUS EXCLUSIVE BREASTFEEDING IS NOT THE NORM

The WHO strategy suggests that, in resource-poor settings, it is more realistic successfully to promote exclusive breastfeeding for six months than to make replacement feeding AFASS for HIV-infected mothers. While the consensus statement largely encourages governments and stakeholders to promote and support exclusive breastfeeding, it only invites them to take measures to make replacement feeding safer for HIV-infected women after they chose this option. Worldwide, infant feeding patterns give a less optimistic picture. Fifteen years after the Innocenti Declaration, only one third of all infants in the developing world are exclusively breastfed for the first six months of life³. In Sub-Saharan Africa, where HIV prevalence is highest, exclusive breastfeeding rates increased from 15% to 32% between 1990 and 2004. However, the estimations of these rates are currently based on single 24h feeding recalls, an assessment method that leads to a large overestimation of exclusive breastfeeding, which is not a regular feeding pattern in practice⁴. Continuous and prolonged exclusive breastfeeding remains highly uncommon worldwide. The last WHO consensus statement declares that it is feasible to improve adherence and duration of exclusive breastfeeding if women are provided with consistent messages and frequent high-quality counselling. At the same time, it states that infant feeding counselling remains insufficient, inaccurate or non-existing due to weak and poorly organized health facilities.

Ethnographic evidence further shows that a solely technical response is not enough to ensure the sustainable improvement of exclusive breastfeeding practices. While breastfeeding is valued and practiced in most developing countries, exclusive breastfeeding for six months could and cannot be a “natural” feeding practice⁵. C. Makhoul Obermeyer and S. Castle showed that the real and/or perceived “insufficient milk syndrome” (IMS) appears to be the most important factor in early supplementation,

cited both as an a priori justification for introducing other food and as an a posteriori explanation. Women discontinue breastfeeding, which leads to a decrease of their breastmilk production and encourages in return further supplementing. Health practitioners echo the widespread perception of insufficient milk by women and thus contribute to discourage exclusive breastfeeding. At once, according to the authors, the development of breastmilk substitutes devalued the women’s role as a nurturing mother. The promotion of infant formula had been greatly facilitated by early supplementation habits and women’s doubts about their own breastmilk “product”. Various beliefs regarding the fragility of breastmilk as a bodily substance, which is thought to reflect a woman’s moral rather than her physical weakness, do nourish these doubts. At the same time, breastfeeding is strongly controlled by male authority, making continuous breastfeeding difficult, especially in regions where lactation and sexual intercourse are regarded as incompatible. Makhoul Obermeyer and Castle conclude that breastfeeding is strongly woven into the cultural fabric of society and must hence be re-thought as something more than a product. Finally, the underlying factors of insufficient milk are “poverty, sexism and powerlessness” that technical information cannot eliminate.

“BREAST IS BEST”. WHAT ABOUT WOMEN?

This powerful analysis can be further refined by making a systematic link between breastfeeding and gendered reproduction. Breastfeeding is part of the whole reproductive process set off by the conception of a new human being, and even before that moment since, in some cultures, infants are seen as returning ancestors. As anthropologist M. Godelier has demonstrated⁶, reproduction is universally regarded as a result of the sexual union between a woman and a man that requires the intervention of a third agent, namely the divine in its various manifestations. Therefore, breastmilk is understood as a bodily substance that results from the transformation of one or more other bodily substances that participate in the generation of a child⁷. Breastmilk comes most often from female blood or male semen or from both. Sometimes, it also stems, fully or partially, from the food taken by the mother. Although breastmilk is a substance produced by a female body, it is not automati-

cally regarded as a female by nature. In some Arab societies, for example, breastmilk is understood as transformed semen and, therefore, as a male substance. Where breastmilk is believed to come from female blood, milk is indeed seen as a female substance, but as such it is not a perfect substance, rather a perfectible fluid. A wide range of life-cycle rituals, traditional medicines and other prophylactic practices are performed in order to improve the quality of breast milk and to assure “good” and sufficient milk that furthers the child’s growth and health. Where breast milk is seen as a male substance, it might be perceived as more akin to a perfect fluid. Here, breast milk is produced in a female body and flows through a female body that is often seen as potentially dangerous or impure. Hence, a whole range of rituals and practices are necessitated to prevent intrinsically “good” milk from becoming “bad” milk. When breast milk comes from the food ingested by the mother, it is important to ensure the right intake of the right kind of food in right amounts in order to produce good breast milk. Not only the woman, but also the husband and father as well as the family and the community are held responsible for this. In no case is breast milk seen as a purely female and intrinsically perfect, self-sufficient substance. This combination stems exclusively from modern biomedicine, prior to the context of HIV, and it hardly exists elsewhere. It is what one might call the “modern paradox” of scientific knowledge on breastmilk, which has been made possible only through the conceptual and analytical separation of breastmilk from the living female body where it is produced. By stating that “breast is best”, the implicit message is “woman is best”. Thus, as widespread ideas of “bad” or “insufficient” milk and correlated early supplementation demonstrate, this message does not seem to be shared by most cultures, despite various cultural efforts to improve a woman’s breastmilk.

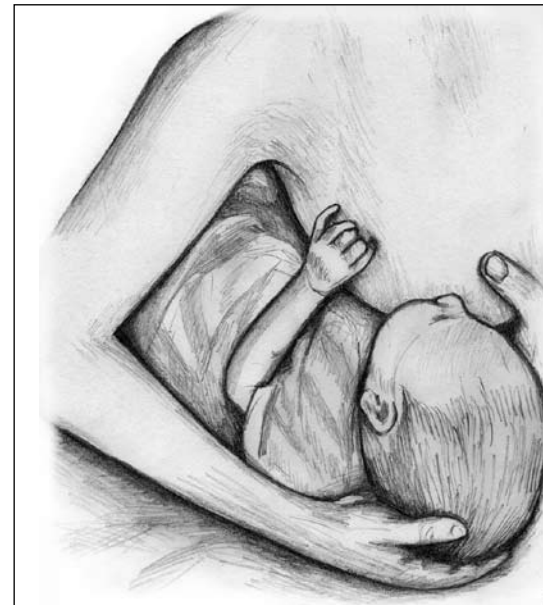
“A CHILD CANNOT SURVIVE ON BREASTMILK ALONE”

It is not only for those societies where a strong gender hierarchy obtains that breastmilk is not regarded as sufficient for the healthy development of a child. As a physical and emotional act being part of the whole reproduction process, most cultures believe that breastmilk final-

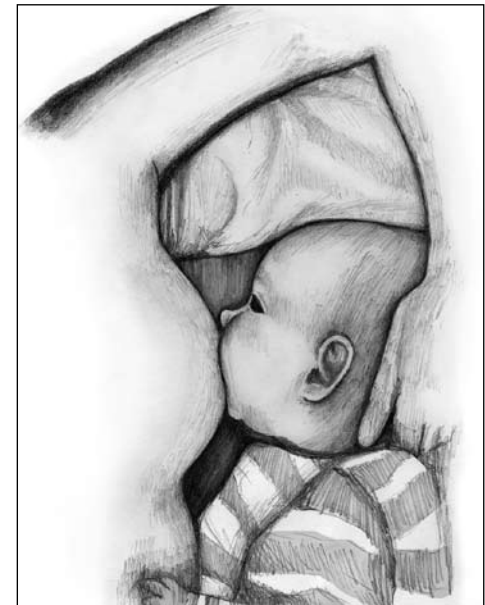


izes the construction of the child’s body and personhood. Hence, the belief that the woman makes the child on her own, by way of gestation and later breastfeeding, cannot be found in any culture. “A child cannot survive on breastmilk alone” is a statement frequently heard in Kenya and elsewhere, even from women who simultaneously complain to have painful breasts because they produce too much breastmilk. It is not only about “insufficient milk” in quantity and/or quality. It is also about breastmilk that does not suffice, because a woman does not make the child alone. But, it is precisely this message that is implicitly promoted through the fostering of exclusive breastfeeding. Here again, it is the conceptual and analytical separation between breastmilk and breastfeeding and, thus, the separation between breastfeeding and the gendered generation of a child that paved the way to the recent recommendation of exclusive breastfeeding for six months.

In short, there is strong anthropological evidence to support the fact that exclusive breastfeeding is not the norm, for the very reason that it is exclusive: it excludes the father of the child as well as the wider family and community from the reproductive process of which breastfeeding and infant feeding are constitutive elements. Hence, it provides a woman with



too much power in that it states that she is able to finish a child’s body and person by virtue of a perfect bodily fluid produced by her body alone! In this anthropological context, improving exclusive breastfeeding rates implies working against deeply rooted universal ideas and perceptions regarding the coming into being of a child, as well as undermining male power in and over this process. Here, however, we touch on something that is anything but easy to achieve. The same anthropological context might explain why prolonged exclusive breastfeeding is not the norm in Western societies either. Poverty, sexism and powerlessness as underlying factors of “insufficient milk” in developing countries are not the primary causes, but aggravating factors of a paradox where a perfect vital fluid comes out of a living female body that is most often, but not necessarily everywhere, considered as subaltern. In this regard, it is interesting to know that among the highly gender balanced Tuareg society in the Western Sahara, breastmilk is regarded as a sacred female and male substance that needs to be supplemented by... breastmilk from other women in order to nourish the child with various social links that are vital to its physical, cognitive and emotional integrity.



IS EXCLUSIVE BREASTFEEDING AFASS?

Anthropological evidence sheds a different light on the WHO recommendations of prolonged exclusive breastfeeding for all infants, including those whose HIV-infected mothers do not meet AFASS criteria in order to avoid all breastfeeding. One could say that exclusive breastfeeding does not appear to be AFASS in the cultural context of many mothers. It is not acceptable because of the strong belief that a child cannot survive nor develop correctly with breastmilk alone; not feasible for those mothers who cannot take their infants to working places and therefore are not able to breastfeed them at any time, and, more importantly, for those who live in settings where early supplementation is the norm, so that infants are likely to be fed with whatever kind of food as they are commonly believed to “belong to the community”; not affordable in the many cultures where breastmilk is thought to be (partially) made of the food taken by the mother who can hardly afford regular meals; not sustainable because of all the reasons mentioned previously, and, finally, not safe because of the risk of mother-to-child-transmission of HIV/AIDS. In addition, according to strong and widespread beliefs regarding “bad” milk, including colostrum regarded as “unfinished” milk, “poison-

ous” milk of a mother who got pregnant again, and other breastmilk that is often considered to be as dubious in its nature as the women who produce it, there are many occasions in which breastmilk is believed to be “unsafe”, because it makes the child sick or even can kill it.

But, with reference to scientific knowledge, AFASS criteria are not applied to exclusive breastfeeding because of the multiple benefits of breastmilk that have been identified as a perfect and readily available food as soon as it had been analysed outside a woman’s body. Breastmilk, however, does not exist independently of a living female body and person behind it. For this reason, improving adherence and duration of exclusive breastfeeding, be it in the general population or only among HIV-infected mothers, is not easy to achieve on a large scale simply by providing frequent high-quality counselling, even if it could be made available tomorrow. Joint public and international efforts should be undertaken in order to promote and improve exclusive breastfeeding in the general population as well as among HIV-infected mothers who want to breastfeed, by trying to make it AFASS in specific local contexts. But the same efforts should also be undertaken in order to make replacement safe for HIV-infected mothers who choose not to breastfeed or who are not able to breastfeed exclusively

for the first six months of life. Making replacement feeding safe for HIV-infected mothers, by considering it as a monitored generic drug such as antiretrovirals, would also help to prevent negative feeding outcomes associated with early infant cessation. For the moment, no expert has a convincing solution for this huge problem that cannot simply be overlooked by assuming that mothers will continue to breastfeed their infants exclusively for six months because they do not meet AFASS criteria for replacement feeding. Infant feeding choice is an ongoing process that proceeds with changing individual circumstances. Mothers might disclose their status to their husbands who tend to prefer replacement feeding. With increasing access to early infant diagnosis, more and more mothers who learn that their infant is HIV-negative will not be likely to accept to continue to expose their children to HIV, even if it seems more indicated in the absence of safe replacement feeding. Finally, more and more mothers are aware of their HIV status and knowingly lost previous children to the disease. These mothers might not want to breastfeed regardless her individual circumstances, but might be willing to do the impossible to make replacement feeding safe. Is it ethical to leave the delicate issue of safe replacement feeding to the mothers in the privacy of their homes, while promoting public efforts in favour of exclusive breastfeeding, assuming against socio-cultural and health-system related evidence that it is the more realistic feeding option? Unsafe replacement feeding is not a fatality. But unless one eventually recognizes that some of the currently tested anti-retroviral treatments have a significant impact on mother-to-child-transmission of HIV/AIDS through breastmilk, transmission rates through exclusive breastfeeding remain the same. Recommending exclusive breastfeeding for six months for HIV-infected mothers while neglecting the issue of safe replacement feeding in this context, means: encouraging mixed feeding, unsafe replacement feeding as well as inappropriate infant feeding after early breastfeeding cessation.

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Declaration of Commitment

TOWARDS A FUTURE GENERATION WITHOUT HIV AND AIDS

We, the participants of the aidsfocus.ch conference on “Positive Motherhood. Opportunities and Challenges of HIV Prevention, Treatment and Care” representing aidsfocus member organisations commit ourselves to work together with our partners towards the goal of a future generation of children born without HIV and AIDS.

GLOBALLY, 18 million women are HIV positive, and their numbers and proportions compared to men continue to increase. Every year, around half a million children under the age of 15 years become infected with HIV. More than 90% of these infections occur in developing countries, and almost all of them are associated with so-called vertical HIV transmission during pregnancy, labour and delivery, or breastfeeding.

Most infant HIV infections could be averted. In Switzerland and other high-income countries, vertical transmission of HIV from mother to child is very rare as services for its prevention are widely available.

We, the participants of the conference, commit ourselves to address and overcome this major injustice and social inequity by taking action within our own fields of activity, thereby respecting the basic principles of Human Rights and the involvement of people living with HIV and AIDS:

- 1. We promote a comprehensive strategic approach to support all women to ensure prevention of HIV infections in infants and young children and to advocate for internationally agreed standards and policies.** We support the guiding principles of the World Health Organisation (WHO), consisting of four components: Primary prevention of HIV infection, prevention of unintended pregnancy among women living with HIV, prevention of HIV transmission from mothers living with HIV to their infants, and care, (antiretroviral) treatment and support for mothers living with HIV, their children and their families.
- 2. We consider the strengthening of health systems, including the improved quality of care and better client centred services, to be an overarching priority,** within which any efforts to prevent vertical transmission and to safeguard the health of women of reproductive age, their partners and other family members need to be integrated.
- 3. The involvement of the community and civil society in health services, programmes and strategies for the prevention of vertical HIV transmission is critical** in order to make these services acceptable and more effective, and in creating a supportive environment.



The participants of the aidsfocus.ch conference committed themselves to work towards the goal of a future generation of children born without HIV and AIDS.



Photos: Ch. Engeli

9. We pay attention to the rights of infants and children to wellbeing, survival, development and to grow up in a caring environment. These are considered as guiding principles at all levels of prevention, treatment, care and support, including the right to antiretroviral treatment and care tailored to children's needs.

10. We cooperate with national health systems and authorities as well as other stakeholders such as civil society and the traditional sector, in order to integrate and scale up high quality comprehensive programmes for the prevention of vertical HIV transmission through sexual and reproductive health services for all.

11. We lobby with Governments and institutional actors to commit and take leadership in developing and supporting national health and social policies and strategies for the promotion of comprehensive programmes for the prevention of vertical HIV transmission by investing adequate financial and technical resources and developing human resource capacity.

12. We advocate with Swiss Government authorities and other stakeholders at the national, international and multilateral level so that the 2001 UN Declaration of Commitment on HIV/AIDS, signed also by Switzerland, is respected and that the relevant Millennium Development Goals are achieved. We lobby with these actors to respect and implement the principles and approaches lined out in this "Declaration of Commitment: Towards a future generation without HIV and AIDS".

Berne, 26 April 2007

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4. We encourage the active involvement of the partner, family and community in the programmes and strategies. Particularly men need to be involved into reproductive health, family planning, childcare, voluntary, confidential, quality counselling and testing and the prevention of vertical transmission of HIV as well as decisions around infant feeding.

5. We fully acknowledge the need for scaling up HIV testing amongst women and men of reproductive age, for which antenatal care provides an ideal entry point and emphasize that public health considerations and collective rights need to be balanced with the individual rights of women. We aim for the respect of the 3C's (counselling, confidentiality and consent) in strategies to scale up HIV testing.

6. In order to avoid HIV transmission to infants during breastfeeding as well as morbidity and mortality of infants due to infectious diseases, the advantages and risks of breastfeeding for HIV infected mothers need to be balanced. In line with the current scientific evidence for resource poor countries, we promote exclusive breastfeeding for six months in the general population and at the same time, we promote

making replacement feeding AFASS (acceptable, feasible, affordable, sustainable and safe). The most appropriate infant feeding option for an HIV infected mother depends on her individual circumstances and socio-cultural environment. Continued counselling and support is needed to help women make an appropriate, safe and informed choice.

7. We need to take into account the prevailing cultural environment and adapt strategies for the prevention of vertical HIV transmission to local circumstances and the culturally constructed context of human reproduction. We emphasize the importance of overcoming stigma, discrimination and violence that people living with, or affected by, HIV and AIDS are faced with. We thereby build on existing resources and chose a solution-oriented approach.

8. We promote Human Rights of women of childbearing age, especially the rights of HIV positive women, including the right of all women to have satisfying and safe sexual lives and the ability to make informed choices about their reproductive health and fertility.

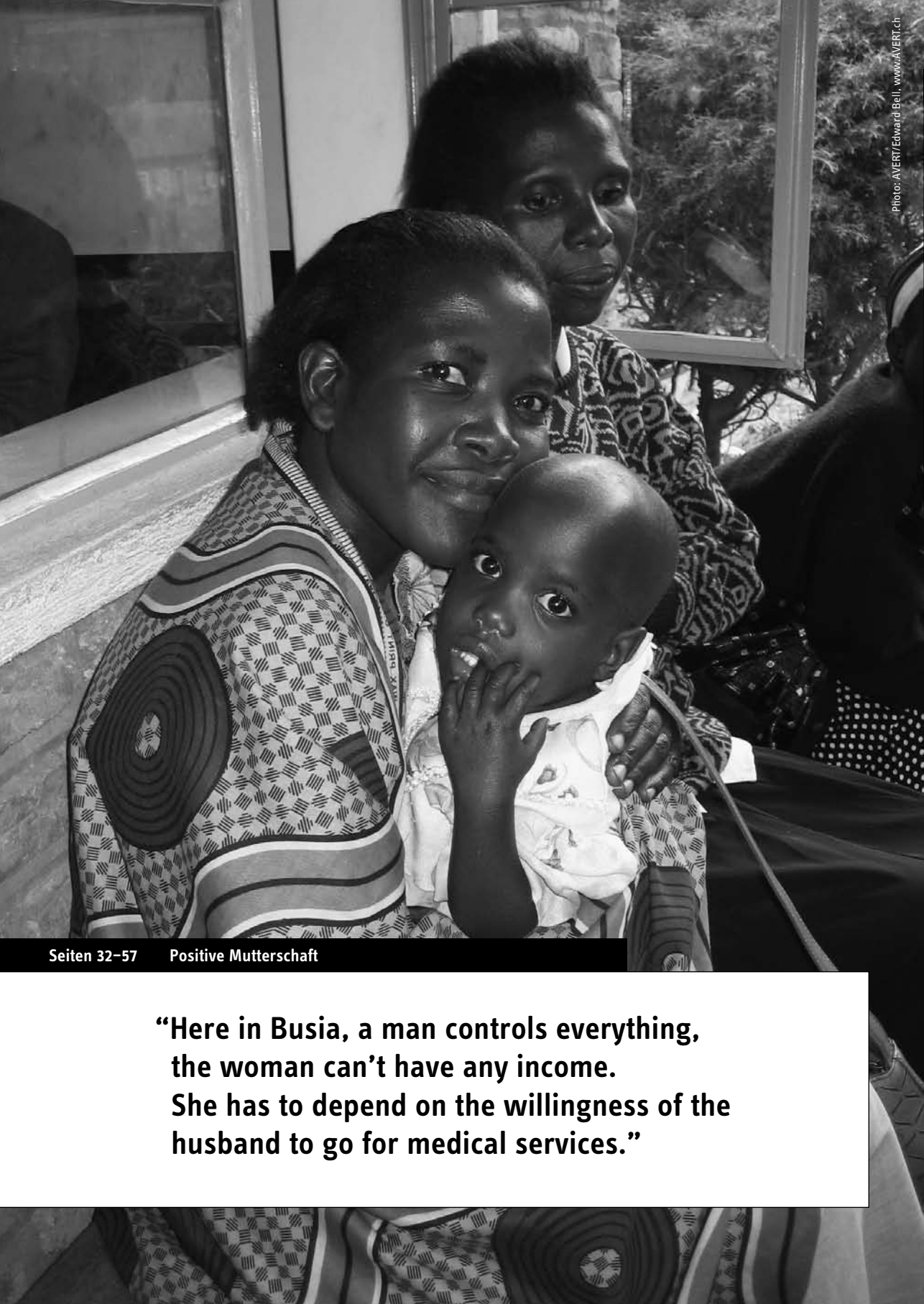


Photo: AVERT/Edward Bell, www.AVERT.ch

EIN AUGENSCHWEIN IN SÜDAFRIKA

Die Themen HIV/Aids und geschlechtsbezogene Gewalt standen im Zentrum einer Studienreise, die drei schweizerische Parlamentarierinnen im Mai nach Südafrika führte. Die Situation in Südafrika ist nicht nur bezüglich sexueller Gewalt gegen Frauen alarmierend. Die HIV-Ansteckungsrate ist heute bei jungen Frauen besonders hoch. Von der Tragödie ist damit auch die kommende Generation betroffen.

Von Susanne Rohner*

HIV/AIDS und sexuelle Gewalt sind eng miteinander verstrickt: Das höchste Risiko, mit HIV angesteckt zu werden, tragen heute in Südafrika junge Frauen, die gleichzeitig in erschreckendem Ausmass von geschlechtsbezogener Gewalt betroffen sind. Da Gewalt in manchen Familien, Gemeinschaften und der Gesellschaft eine alltägliche Realität darstellt, sind viele Frauen und junge Mädchen nicht nur in ihren Rechten und ihrer persönlichen Freiheit eingeschränkt, sondern auch in der Möglichkeit, sich vor HIV/Aids zu schützen.

Im Mai haben sich die drei Schweizer Parlamentarierinnen Ruth Genner (Grüne/ZH), Francine John-Calame (Grüne/NE) und Ruth-Gaby Vermot-Mangold (SP/BE) während einer einwöchigen Studienreise nach Südafrika vor Ort über die Situation im Zusammenhang mit HIV/Aids und Gewalt gegen Frauen informiert. Die Studienreise erfolgte auf Einladung von UNFPA (Bevölkerungsfonds der Vereinten Nationen) und PLANeS (Schweizerische Stiftung für sexuelle und reproduktive Gesundheit). Alle drei Nationalrätinnen engagieren sich in der Schweiz in der parlamentarischen Gruppe Kairo+ für die Umsetzung des UNO-Aktionsprogramms von Kairo. In diesem 1994 von 179 Staaten, darunter die Schweiz, verabschiedeten Programm wurde die Bedeutung und das Recht auf sexuelle und reproduktive

Gesundheit verankert und in Zusammenhang mit Forderungen wie der nach der Gleichstellung der Geschlechter, der Bekämpfung der Armut und Zugang zu Bildung gestellt. «Der Aufenthalt in Südafrika hat den Politikerinnen die Möglichkeit geboten, sich über Treffen mit VertreterInnen der Regierung, des Parlaments, von internationalen Organisationen und Nichtregierungsorganisationen darüber zu informieren, wie Südafrika auf die grossen Herausforderungen im Zusammenhang mit HIV/Aids und Gewalt gegen Frauen reagiert, wie die Entwicklungsgelder eingesetzt werden und wo Handlungsbedarf besteht», erklärt Anita Cotting, die als Geschäftsführerin von PLANeS die Politikerinnen nach Südafrika begleitet hat.

ARMUT, UNGLEICHHEIT, GEWALT

Um die Ausbreitung von HIV/Aids zu stoppen, müssen Armut und Ungleichheit der Geschlechter überwunden werden, lautet eine Forderung des UNFPA. In Südafrika bieten Verfassung und Gesetzgebung eigentlich gute Voraussetzungen, ist doch die Gleichstellung der Geschlechter in der Verfassung verankert. «Es besteht breiter Konsens über diese Verfassung, welche die Grundlage legt für einen nicht-rassistischen, nicht-sexistischen und demokratischen Staat», stellt Ruth Genner fest. Auch auf politischer Ebene wurden seit dem Ende der

“Here in Busia, a man controls everything, the woman can’t have any income. She has to depend on the willingness of the husband to go for medical services.”

Apartheid markante Fortschritte erzielt, bekleiden doch heute zahlreiche Frauen Schlüsselpositionen in der Regierung. Auch ein Drittel der Sitze im nationalen Parlament sind von Frauen besetzt, und bis ins Jahr 2009 sollen dank einer entsprechenden Quote sogar die Hälfte der Parlamentsmitglieder Frauen sein. Spezifische Gesetze wie zum Beispiel dasjenige über häusliche Gewalt aus dem Jahr 1999 (domestic violence act) würden den Frauen eigentlich auch Schutz vor Gewalt bieten. Wie die Realität zeigt, hapert es jedoch an der Umsetzung. Nach offiziellen Zahlen werden in Südafrika jährlich 60 000 Vergewaltigungen registriert und täglich 8000 Fälle von häuslicher Gewalt – sicher ist das aber nur die Spitze des Eisbergs.

Als Ursachen der Gewalt gelten Armut, ökonomische Abhängigkeit der Frauen, mangelnde Bildung, Traditionen und Bräuche, die ungleiche Geschlechterrollen aufrechterhalten, schwierige Familienstrukturen aufgrund der gesellschaftlichen Veränderungen und die Bevölkerungskonzentration in den Townships. Südafrika teilt damit zwar das Problem der geschlechtsbezogenen Gewalt mit zahlreichen anderen Ländern, jedoch mit dem Unterschied, dass sich in Südafrika die Erblasten des Apartheidsystems in der Form von ökonomischer Ungleichheit weiterhin manifestieren und die Situation verschärfen.

Die Regierung Südafrikas hat Massnahmen ergriffen und führt zum Beispiel bereits seit 16 Jahren 16-tägige Aktionen «Keine Gewalt gegen Frauen und Kinder» durch, die in diesem Jahr in Zusammenarbeit mit Nichtregierungsorganisationen zu einer ganzjährigen nationalen Sensibilisierungskampagne auf allen Ebenen ausgeweitet wurden.

Konkrete Hilfe für Opfer sexueller Gewalt bieten die Thuthuzela Care Centres. Thuthuzela bedeutet in der Xhosa-Sprache «Trost». Die bisher zehn Zentren haben bis über Afrika hinaus Vorzeigefunktion. Die Schweizer Delegation hat dasjenige in Kapstadt besucht und war beeindruckt von dessen Pioniercharakter: «Die Schweiz könnte sich vom Modell dieser Zentren inspirieren lassen, bei dem ÄrztInnen, PolizistInnen, JuristInnen, SozialarbeiterInnen und PsychologInnen unter dem gleichen Dach eng zusammenarbeiten», erklärt Ruth-Gaby Vermot-Mangold. Damit soll verhindert werden, dass die Opfer erneut traumatisiert werden, indem sie durch separate Ver-

fahren von den verschiedenen Behörden gleich mehrmals wieder mit dem Erlebten konfrontiert werden. Die Zentren, die von internationalen Organisationen unterstützt werden, sind in Quartieren eingerichtet, die speziell von sexueller Gewalt und HIV/Aids betroffen sind. Sie verfolgen vor allem zweierlei Ziele: eine gute medizinische und psychosoziale Betreuung der Opfer einer Vergewaltigung und die Strafverfolgung der Täter. Die gute Betreuung soll bei den Opfern ein Posttrauma verhindern und die gute medizinische Behandlung unter anderem die Gefahren in Zusammenhang mit HIV/Aids mindern. Alarmierend ist allerdings die Feststellung der Mitarbeiterinnen, dass zunehmend auch Kinder als Opfer sexueller Gewalt die Thuthuzela Care Centres aufsuchen.

HIV/AIDS: HOHES ANSTECKUNGSRISIKO FÜR JUNGE FRAUEN

Geschlechtsspezifische Gewalt und die Ungleichheit der Geschlechter haben nach Angaben von UNFPA gravierende Auswirkungen auf das HIV-Risiko einer Frau. Südafrika weist zwar im Vergleich zu anderen afrikanischen Ländern relativ gute Gesundheitsindikatoren auf. Bezüglich HIV/Aids ist die Situation jedoch alarmierend. In Südafrika waren nach UNO-Angaben von 2006 5,5 Millionen Menschen HIV-positiv. Schätzungen zufolge sind rund 20 Prozent der Bevölkerung mit dem Virus infiziert. Junge Frauen sind heute deutlich stärker gefährdet als Männer, mit dem HI-Virus angesteckt zu werden. So liegt nach UNO-Angaben das Ansteckungsrisiko für junge Frauen bis zu viermal höher als bei Männern. Zwischen 1997 und 2004 hat sich die Mortalität bei Frauen im Alter von 20–39 Jahre mehr als verdreifacht. Die Ausbreitung von HIV/Aids hat verheerende Auswirkungen auf die gesamte Bevölkerung: Die durchschnittliche Lebenserwartung ist von 62 Jahren im Jahr 1990 auf 47 Jahre im Jahr 2005 gesunken ist.

Das hohe Ansteckungsrisiko junger Frauen hat auch für die folgende Generation Konsequenzen: Kinder leiden nicht nur als Aids-waisen besonders an den Folgen der Epidemie, sondern sie sind zunehmend auch selber von der Krankheit betroffen. Nach UNO-Angaben waren im Jahr 2000 24,5 Prozent der Frauen, welche ein vorgeburtliches Gesundheitszentrum aufsuchten, HIV-positiv. Die Zahlen variieren regional stark, wobei KwaZulu Natal mit



Foto: Michel Bühner

Empfang im «Thuthuzela» Care Centre, dem Zentrum für Opfer sexueller Gewalt in Township Manenberg bei Cape Town

36,2 Prozent besonders hohe Raten aufweist. Nach jüngsten Zahlen der WHO war im Jahr 2000 in 57 Prozent aller Todesfälle bei Kindern HIV/Aids die Ursache.

Im Rahmen eines Strategieplans zu HIV/Aids hat die Regierung von Südafrika im Jahr 2001 in neun Provinzen ein Präventionsprogramm zur Verhinderung einer Übertragung von HIV von der Mutter aufs Kind eingeführt. Dieses stützt sich auf die Pfeiler Prävention und Behandlung. Letztere beinhaltet Diagnose, Beratung, Behandlung, Ernährungsberatung sowie Behandlung mit antiretroviralen Medikamenten. Nach Angaben der WHO werden in Südafrika knapp ein Drittel der durch HIV infizierten schwangeren Frauen mit antiretroviralen Medikamenten behandelt, um eine Übertragung des Virus von der Mutter auf das Kind zu verhindern. Bezüglich Stillen ist es schwierig, allgemeine Empfehlungen abzugeben, da das Stillen einerseits ein Übertragungsrisiko birgt, ungestillte Kinder andererseits einem grösseren Risiko für andere Krankheiten ausgesetzt sind.

STRATEGIEWECHSEL DER SÜDAFRIKANISCHEN REGIERUNG

In Südafrika sind von Seiten der Regierung zahlreiche Massnahmen im Kampf gegen HIV/Aids eingeleitet worden. Ein Strategiewechsel habe stattgefunden, stellt Ruth Genner fest. Bisher waren HIV/Aids im Rahmen der allgemeinen Gesundheitspolitik behandelt worden. «Aus der Erkenntnis heraus, welche gravierenden Auswirkungen HIV/Aids nicht nur auf die Bevölkerung hat, sondern auch auf die Wirtschaft, hat die Regierung in diesem Frühling ihre bisher passive Haltung geändert und HIV/Aids zu einem übergeordneten, dringlichen Thema gemacht, das quer durch alle Sektoren und Departemente behandelt werden muss, so Ruth Genner.

Nach UNO-Angaben flossen Investitionen in der Höhe von 927 Millionen US-Dollar ins Nationale HIV/Aidsprogramm für 2006–2007. Über gemeinsame Präventionskampagnen verstärkten die Behörden die Zusammenarbeit mit nicht-staatlichen Organisationen, förderten den Zugang zu freiwilliger Beratung und HIV-



Foto: Michel Bühler

«Mama Rita», eine ehrenamtliche Sozialarbeiterin, kümmert sich in ihrem Township Waterloo (bei Durban) um HIV-positive und aidsranke Frauen und Männer.

Tests, verstärkten die Prävention von Mutter zu Kind Übertragungen und dehnten die Behandlung mit antiretroviralen Medikamenten aus. Im Jahr 2006 haben mehr als 300 000 an Aids erkrankten Personen mit einer antiretroviralen Behandlung begonnen. Wie die Realität zeigt, genügen diese Massnahmen aber bei weitem nicht, um die Entwicklung zu stoppen. Ein Hindernis besteht darin, dass Südafrika un-

ter einem chronischen Mangel an qualifizierten Arbeitskräften leidet. Und die grosse Herausforderung bleibt bestehen, mit besseren Rahmenbedingungen langfristige Verhaltensänderungen herbeizuführen.

Der UNFPA fordert deshalb im Kampf gegen HIV/Aids und geschlechtsbezogene Gewalt umfassende Massnahmen auf verschiedenen Ebenen, darunter die Bekämpfung der Armut, Investitionen in die Bildung, die Verbesserung der reproduktiven Gesundheit und Respektierung der reproduktiven Rechte sowie die Verbesserung der Gleichstellung der Geschlechter. Angesichts der besonderen Betroffenheit von jungen Menschen müssen sich die Programme in Prävention und Behandlung ganz besonders auch auf diese Bevölkerungsgruppen ausrichten.

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DIE GESCHICHTE VON DENSILE

Die 26jährige Swasiländerin Densile ist HIV-positiv. Ihr Neugeborenes kam dank der Prophylaxe in der Rotkreuzklinik in Sigombeni gesund zur Welt. Chronologie einer Ermutigung.

Von Maria Katulu*

JANUAR 2006. Wir begegnen Densile zum ersten Mal, als sie zur Schwangerschaftskontrolle in die Rotkreuzklinik nach Sigombeni kommt. Sie ist zu diesem Zeitpunkt 25 Jahre alt und im vierten Monat schwanger. Sie ist bereits Mutter eines sechsjährigen Mädchens und eines dreijährigen Jungen.

Densile erzählt, ihr Mann sei sehr sehr krank, und sie pflege ihn. Sie vermute, er habe Aids, doch wolle er sich trotz schwerster Erkrankung keinem HIV Test unterziehen.

Während dieser ersten Schwangerschaftskontrolle wird Densile von unserer Hebamme, die eine Spezialausbildung in PMTCT hat, intensiv beraten. Mit den üblichen Untersuchungen wurde auch Blut für einen HIV-Test abgenommen.

Viele Frauen wollen das Resultat eines HIV-Test erst in der nächsten Kontrolle erfahren; Densile will es aber gleich wissen. Eine Viertelstunde nach der Blutentnahme muss ihr die Hebamme die schwierige Nachricht übermitteln: Densile ist HIV-positiv.

Die Hebamme nimmt sich viel Zeit, mit ihr die schwierige Situation zu reflektieren. Densile fürchtet sich vor der Zukunft: Würde ihr kranker Mann überleben? Würde ihr Kind gesund sein? Würde sie selbst nun auch krank werden? Am Ende des Gesprächs ist für Densile klar, dass sie ihren Mann überzeugen muss, zur Klinik zu kommen. Die Hebamme und sie vereinbaren, dass unser Pfleger, der auch eine Ausbildung in HIV-Beratung hat, mit ihrem Mann über das Thema Aids sprechen und ihn zu einem HIV-Test bewegen würde.

FEBRUAR 2006. Densile Ehemann wird in unsere Klinik gebracht – er hat Aids im letzten Stadium. Zwei Woche später stirbt er. Densile verbringt einen Trauermonat, wie es in der Tradition der Swazi üblich ist, von der Umwelt isoliert bei sich zu Hause. Sie ist eine stille Frau mit einer elementaren Schulbildung, doch kann sie sich gut ausdrücken.

Nach dem Tod ihres Manns muss sie nun allein für ihre sechsjährige Tochter und ihren dreijährigen Sohn sorgen. Nur gelegentlich bekommt sie etwas von ihren Eltern oder von ihrer Schwiegermutter, die ebenfalls arm sind. Umso wichtiger ist das Lebensmittelpaket, das sie nun regelmässig vom Roten Kreuz erhält.

Densile fühlt sich müde, sie hat viel Kraft gebraucht, um ihren Mann zu pflegen. Sie ist tapfer – als afrikanische Frau hat sie gar keine andere Wahl. Zudem teilt sie dieses Schicksal mit unendlich vielen anderen Frauen. Der Tod ist hier in jeder Familie präsent, das ist die Realität des Lebens im südlichen Afrika.

APRIL 2006. Als Densile zur nächsten Schwangerschaftskontrolle kommt, erfährt sie, dass die Menge ihrer CD-4 Zellen noch über 300/mm³ beträgt.

Anmerkung: Zu diesem Zeitpunkt begannen wir mit der antiretroviralen Therapie auch bei schwangeren Frauen erst, wenn die Menge der CD-4 Zellen bei 200/mm³ oder darunter lag. Laut neuen Richtlinien beginnen wir die Therapie bei schwangern Frauen bereits bei einem CD 4 count von unter 350, falls die Schwangerschaft über das erste Schwangerschaftsdrittel hinaus ist.



Rotkreuzmitarbeiter bei der Gesundheitsarbeit im Feld



Densile mit ihren beiden Kindern unterwegs

In der 32. Schwangerschaftswoche erhält Densile eine Präventionsdosis Nevirapin mit der Instruktion, diese einzunehmen, wenn die Wehen beginnen. Die Hebamme legt ihr nahe, wenn immer möglich zur Geburt rechtzeitig ins Spital zu gehen, und erklärt ihr die Wichtigkeit der Präventionsdosis für das Neugeborene in den ersten 72 Stunden seines Lebens.

JUNI 2006. Eines Morgens steht Densile in Begleitung ihrer Schwester mit ihrem neugeborenen Mädchen in der Klinik. Sie hat in der Nacht zuvor zu Hause geboren und bringt nun das Neugeborene, damit es rechtzeitig die HIV-Prävention erhält.

Densile und das Baby bekommen Cotrimoxazol zum Schutz vor Infektionen. Densile wird instruiert, dass sie während sechs Monaten voll stillen soll und danach abstillen und dem Kind feste Nahrung geben muss. Die Richtlinien des Landes zur Prävention der Mutter-Kind-Übertragung des HI-Virus (PMTCT) schreiben dies gestützt auf Studien in ruralen Gebieten Afrikas vor.

JULI 2006. Densile kommt einen Monat nach der Geburt wieder zur Kontrolle, sie fühlt sich schwach, sie ist nach der WHO-Norm im drit-

ten Stadium von HIV/Aids. Ihr CD 4 count beträgt nur noch 119. Unsere Pflegenden bereiten sie intensiv auf die exakte und lebenslange Einnahme der ARV-Medikamente vor. Ihre Schwester, die selbst bereits seit einiger Zeit mit der Therapie begonnen hat, begleitet sie zu den Beratungsgesprächen zur Vorbereitung des Therapiebeginns.

Densile kann nun mit der antiretroviralen Therapie beginnen. Eine unserer Assistenten besucht sie zu Hause und unterstützt sie in der korrekten Einnahme der Medikamente. Pünktlich nach zwei Wochen kommt die junge Mutter wieder zur Kontrolle. Sie hat die Einnahme der Medikamente gut verstanden und spürt glücklicherweise keine Nebenwirkungen.

Densile ist sehr zuverlässig, sie kommt immer pünktlich zu den vereinbarten Terminen und nimmt jeden Morgen und jeden Abend ihre Tabletten ein.

OKTOBER 2006. Drei Monate nach Beginn der Therapie erkrankt Densile und hat Durchfall und Bauchschmerzen. Nach einigen Tagen hat sie sich erholt.

APRIL 2007. Nachdem Densile positiv auf unsere Anfrage reagiert hatte, einen Film mit ihr zu drehen, besuchen wir sie zu Hause, und auch während den Dreharbeiten verbringen wir einige Zeit mit ihr. Densile wohnt auf dem Grundstück ihrer Schwiegereltern in einem der in den Hügeln rund um Sigombeni verstreuten Homesteads. Vor dem Haus mit nur einem Zimmer und einer Küche wächst Mais, welcher dieses Jahr ziemlich vertrocknet ist, da der Regen erst sehr spät einsetzte. Einige Kürbisse und etwas Gemüse sehen gesünder aus.

Später am Tag führt uns Densiles Schwiegermutter zu ihrem Sohn, dem einzigen, der noch lebt, und den sie momentan pflegt. Er liegt schwer krank im Bett und mag nicht sprechen. Er hat Aids und erst kürzlich mit der Therapie unserer Klinik begonnen.

Anmerkung: Ich habe mich sehr gefreut, als ich ihn vorgestern – drei Wochen nach diesem Besuch – in der Klinik antraf und es ihm sichtlich sehr viel besser ging; er hat gut und schnell auf die Therapie angesprochen.

MAI 2007. Densile geht täglich auf eine Plantage Tomaten pflücken. Zu Hause füllt sie diese zusammen mit ihren Kindern in kleine Plastiksäcklein ab und geht dann von Haus zu Haus, um diese zu verkaufen.

Densile weiss, dass sie einen langen und harten Weg vor sich hat.

Die 6-jährige Tochter Jabulile ist höchst wahrscheinlich mit dem Aids-Virus angesteckt. Sie sieht kränklich aus und hat überhaupt nicht auf die Therapie gegen Ringwürmer auf ihrem Kopf angesprochen. Es wird die Aufgabe unserer Mitarbeiter in Sigombeni sein, die Mutter beim nächsten Klinikbesuch sorgfältig darauf vorzubereiten, dass das Mädchen getestet werden muss. Wir haben sehr gute Erfahrungen mit Kindern in diesem Alter, sie sprechen meist gut auf die Therapie an. Gerade am Vortag habe ich Wuisile angetroffen, sie war unser erstes Kind welches vor zwei Jahren mit der Therapie begonnen hat. Die jetzt Zehnjährige ist voller Energie.

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COPING WITH THE STIGMA OF POSITIVE MOTHERHOOD

The National Community of Women Living with HIV/AIDS (NACWOLA) was founded in the year 1992 in Uganda. It started with a low profile as a support group for HIV positive women to share their problems and experiences and to support one another. Today it is a country-wide membership organization working to promote positive living for women living with HIV and AIDS through psychosocial support and economic empowerment. This also counts for “positive mothers”.

By Annet Biryetega*

IN EAST AFRICA, Uganda took the lead in responding to the HIV epidemic early on and managed to achieve reductions in prevalence already during the 1990s with the epidemic now stabilized overall. The 2006 UNAIDS statistics for Uganda revealed that Uganda’s prevalence marginally increased to 6.7 percent in 2005, and that it was significantly higher among women (nearly 8%) than among men (5%). Factors such as poverty, gender inequality and social marginalization of specific population groups are contributing factors that put women and children at great risk of HIV infection.

CHALLENGES OF POSITIVE MOTHERHOOD

Many HIV-positive women are not formally employed. Therefore they do not have a reliable source of income. This means that they have to depend on their husbands for all their essential needs. Such a situation makes pregnant positive mothers very vulnerable because they often cannot afford the healthy diet required for women infected with HIV during pregnancy. Many African men in the rural communities would prefer spending their income on alcohol than prioritizing the needs of their wives.

Women have little access to medical treatment as they depend on the man’s permission and money to be able to attend a health facility. A Ugandan woman elaborates: *“Here in Busia, a man controls everything, the woman can’t have any income. She has to depend on the willingness of the husband to go for medical services”*.

The woman’s position in a home is that of a dependent – submissive to her husband. This violates her rights to make informed decisions, to economic empowerment and self-determination, as well as to access treatment, care and protection, especially in the instance of women living with HIV and AIDS. A pregnant woman can develop health conditions which require immediate, emergency medical attention, but she may not have transport to go to hospital, and even if she had the money she would have to wait for her husband to give her the permission to travel there.

The cultural setting in many African societies is predominantly patriarchal. The practice of polygamy is also still widely practiced. In various societies a man is entitled to marry many wives as long as he is in position to pay the bride price. Under Islamic law, also recognized by the Marriage Act, a Moslem man has a legal right to marry four wives. Other conditions that encourage polygamy include statis-



NACWOLA aims to strengthen HIV-positive mother’s self confidence and self esteem.

tics that indicate an irregular ratio of women to men. This has resulted in a wide spread belief that polygamy is necessary; which concurrently provides a ripe environment for the spreading of sexually transmitted infections (STIs) as a number of people co-exist in “one” sexual relationship.

Most women in Uganda live in rural areas and have very little access to information about the existing health services. For instance most women suffering from an STI may be unaware of the fact – which is very dangerous to an HIV-positive pregnant mother. There is limited support within the community to avert the situation due to lack of access to treatments for STIs and regular sexual health screening. Challenges

also surround access to support for safe conception as well as services for the Prevention of Mother to Child Transmission (PMTCT).

NACWOLA works with HIV-positive women and has experience of their fear of stigma as well as their social exclusion. Irine is one of them. She lost her husband a few years back. Shortly after his death, members of the community asked the Local Commissioner to tell Irine that women in the area are worried because she was a potential danger. When she asked for support, first the Local Commissioner and then her brother-in-law who knew what his brother died of demanded sex before they would intervene on her behalf.

In the early years of the AIDS epidemic, there was a tendency to discourage HIV-positive mothers from getting pregnant, due to the fear that their bodies would be further weakened and concerns that the newborn will soon be left an orphan. Such a concept has been challenged by scientific findings, the life-lengthening effects of antiretroviral therapy and recent efforts to establish PMTCT programmes. Unfortunately some people in the communities still lack information or simply do not trust such programmes. So it comes to be that stigma of positive mothers and their new born babies continue.

All mothers are expected to breastfeed their babies, therefore family members in most cases traumatize a mother who keeps her baby on infant formula. It is also expensive to buy infant formula so some mothers start on the formula feeding method but they get defeated along the way.

A RIGHTS BASED APPROACH

NACWOLA's specific ways of supporting HIV-positive mothers to cope with stigma is to encourage them to be open and share their experience with other positive women while keeping the spirit of optimism. NACWOLA also promotes psychosocial support through initiatives such as "Memory Work" and the "Hope Project". In order to make positive women more independent, NACWOLA encourages income generating activities for the women and their family. It is important to keep the family relationship peaceful. Women are taught that living with HIV requires a holistic approach. This includes good nutrition, counselling, information about drugs and their side effects and an understanding of the context of women's lives. NACWOLA promotes access to prevention, care and treatment services by providing counselling and referrals to other service providers.

The challenge of some people in the communities who reject babies born to HIV-positive mothers arises from ignorance. Prevention of Mother to Child Transmission (PMTCT) programmes are fairly new and not everybody has all the necessary information about their efficacy and safety. In Uganda, the PMTCT programme was started by the Ministry of Health as a pilot project in 1998 in five sites and then expanded to cover the entire country. PMTCT is now offered by service providers like The Aids Support Organization (TASO). At the TASO PMTCT site supported by the US Centre for Disease Control and Prevention (CDC) and WHO, HIV-positive pregnant women are screened for ART eligibility and provided with the necessary treatment as appropriate. But the overall reach of such services is still limited. According to the Uganda AIDS Commission, in 2005 just 12 percent of HIV-positive pregnant women received antiretroviral treatment to prevent transmission of the virus to their unborn children.

NACWOLA supports women who have tested HIV positive to access such programmes. This returns hope to HIV-positive mothers by assuring them that, if the programme is adhered to, there is a high probability to save the unborn baby from becoming infected. This revives the wish of women that they can still practice their reproductive health rights and have healthy children.

The rights based approach of NACWOLA aims to strengthen HIV-positive women's self confidence and self esteem, and support them in setting up self help groups. Furthermore, NACWOLA plays a significant role by bringing their experiences into the process of developing national priorities and policies, and by actively participating in the provision of services targeted at such women. NACWOLA promotes the rights of HIV-positive women, and focuses attention on their needs through high level advocacy. NACWOLA is recognized as playing an important role and being uniquely situated with regard to gender inequality and HIV in Uganda by virtue of its composition as a membership organization run for and by HIV positive women.

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DEM KIND GEHT ES (NOCH) GUT ...

Obwohl weitgehend vermeidbar werden in Tansania jährlich 72 000 Kinder neu mit dem HI-Virus angesteckt, die grosse Mehrheit durch die vertikale HIV-Übertragung von der Mutter aufs Kind. Das Spital von Dareda im Norden Tansanias ist eines der wenigen Spitäler in Tansania, welches einen speziellen Fokus auf die in Afrika am meisten vernachlässigte Patientenpopulation von HIV-Infizierten setzt, nämlich die Kinder.

Von Reto Villiger*

ETWAS VERLEGEN

betritt Veronica (26) den dunklen, karg eingerichteten Nebenraum der Wöchnerinnenabteilung. Die beiden schnittförmigen Narben auf ihren Wangen weisen sie als Iraq aus, als dem in der Region von Dareda verbreitetsten Volkstamm zugehörig. In den Armen trägt sie ihr neugeborenes Kind, welches fest eingehüllt in einem bunt grünen Kanga schläft. Die junge Mutter setzt sich auf den Holzhocker, ihr Blick zum Fussboden gesenkt, eine Geste des Respekts gegenüber dem Arzt und der Krankenschwester, welche mit ihr reden möchten. Sie weiss, warum sie hier ist, auch wenn ihr niemand den Grund des Gesprächs nannte. Im Rahmen der Schwangerschaftsvorsorgeuntersuchung wurde sie positiv auf HIV getestet. Wie so manche HIV-positive Schwangere ist sie nach der Mitteilung des Resultats nie wieder in unserer Klinik erschienen. Anhand ihrer Vorsorgekarte konnte sie aber bei der Geburt als HIV-positiv identifiziert werden.

Ihrem Kind geht es gut. Immer noch blickt Veronica zur Erde nieder, doch angesichts dieser Mitteilung verziehen sich die Mundwinkel der verunsicherten Mutter zu einem feinen Lächeln. Es ist ein Balanceakt zwischen der Stärkung des mütterlichen Glaubens an eine Zukunft des Kindes und der Mahnung vor einer möglichen Ansteckung desselben.

Medizinisch gesehen handelt es sich um ein HIV-exponiertes Kind. Es ist bekannt, dass die Kinder von HIV-positiven Müttern ohne präventive Massnahmen ein etwa 40 Prozent hohes Risiko einer Ansteckung haben. So werden in Tansania jährlich 72 000 Kinder neu angesteckt, die grosse Mehrheit durch ihre eigene Mutter. Von diesen infizierten Kindern stirbt die Hälfte innert der ersten beiden Lebensjahre.

Angesichts dieser brutalen Realität war es für mich als Kinderarzt eine absolute Priorität, im Aufbau eines Programms für HIV-positive Kinder vorerst präventive Massnahmen zur Verhinderung der kindlichen Ansteckung in die Wege zu leiten. Seit Ende Oktober 2006 hat das Spital von Dareda, welches vier Autostunden südwestlich der Grossstadt Arusha liegt und zur katholischen Diözese von Mbulu gehört, ein PMTCT-Programm (Prevention of mother to child transmission). Dieses umfasst einerseits ein Counselling und Testing aller schwangeren Mütter bezüglich HIV in den Vorsorgekassen des Spitals sowie der beteiligten Aussenstationen. Die positiv getesteten Mütter werden am selben Tage in unsere HIV/Aidsklinik gebracht, um von fachspezifisch geschulten Krankenschwestern eine erste Beratung zu erhalten. Ziel ist die Einbindung der Mütter in regelmässige einmonatliche Kontroll-



Fotos: SolidarMed

Das Spital von Dareda ist eines der wenigen, das HIV-exponierte Kinder wirklich ernst nimmt.



Bisher kommt nur eine Minderheit der positiv getesteten Mütter nach der Geburt mit ihrem Kind zur Nachkontrolle.

len mit kontinuierlicher Schulung im Umgang mit der eigenen Krankheit sowie der möglichen Präventionsmassnahmen zur Verhinderung der kindlichen Ansteckung.

NICHT AUS DEN AUGEN VERLIEREN...

Neben der mütterlichen Ebene gibt es eine kindliche. Nur zu häufig kommt es hier in Tansania vor, dass diese ignoriert wird und mit der Geburt als Abschluss der Schwangerschaft die Arbeit als erledigt betrachtet wird respektive die Mutter anlässlich der normalen Kontrollen ohne Kind in der HIV-Klinik gesehen wird. Und so stirbt denn die Hälfte der effektiv infizierten Kinder oft unbemerkt am ersten schweren Infekt. Es war deshalb eine unumgängliche Pflicht, die engmaschigen Nachkontrollen der HIV-exponierten Kinder in das Programm aufzunehmen, gerade auch, weil in unserem Spital keine direkten HIV-Nachweismethoden vorhanden sind und somit auf

die Bestätigung mittels Antikörpertest im Alter von 18 Monaten gewartet werden muss (tatsächlich zeigen neuere Untersuchungen, dass die Aussagekraft von positiven Tests bereits ab einem Alter von 9 bis 12 Monaten gut ist).

Es mag gewisse Schwierigkeiten bergen, Patienten, ohne ihren definitiven HIV-Status zu kennen, rein klinisch nachzukontrollieren und bei Auftreten gewisser Symptome entsprechende therapeutische Massnahmen einzuleiten. Da die Mortalität gerade in der Altersgruppe der Säuglinge am höchsten ist, ist es aber umso wichtiger, diese Patienten nicht aus den Augen zu verlieren.

Das PMTCT-Programm von Dareda steht noch am Anfang, und die Zahl der nachzukontrollierenden exponierten Kinder ist wegen der entsprechenden Latenzzeit bis zur Geburt klein. Doch gewisse Tendenzen können klar erkannt werden: Eine Stärke des Programms ist die Tatsache, dass fast 100 Prozent der Schwan-

geren in unserer Antenatal Clinic (ANC) getestet werden können, was in etwa 250 Tests pro Monat entspricht. Anders als in anderen Bereichen unseres HIV/Aidsprogramms haben wir für Schwangere bewusst eine Counselling-Strategie gewählt, welche der opt-out-Strategie nahe liegt, und so wird der HIV-Test als ein fester Bestandteil der Routineuntersuchungen von Schwangeren durchgeführt. Meist werden vor dem Testen Gruppen-Counselings durchgeführt, die Testresultate werden aber immer individuell besprochen.

HERAUSFORDERUNG STIGMA

Interessanterweise führte dieses Vorgehen nicht wie in anderen tansanischen Spitälern zu einem Rückgang der Patientenzahlen in der Klinik. Seit Beginn des Programms Ende Oktober 2006 konnten total 1500 Schwangere einem HIV-Test unterzogen werden. Die Rate der HIV-positiven Schwangeren liegt zwi-

schen 1 und 2 Prozent und würde (auch wenn nicht unbedingt repräsentativ für die ganze Bevölkerung) der staatlich erörterten HIV-Prävalenz von 2 Prozent für die Region Manyara entsprechen. Diese tiefe Prävalenz ist einerseits erfreulich (landesweit knapp 10 Prozent), andererseits hat sie eine deutlich grössere Stigmatisierung der HIV Positiven in der Bevölkerung zur Folge. Wir nehmen an, dass dies einer der Hauptgründe ist, weshalb die Mehrheit der positiv getesteten Schwangeren bisher weder zu Nachkontrollen noch zur Geburt in Dareda erschienen ist. Parallel dazu erweist es sich als extrem schwierig, die Ehemänner zu involvieren. Diese weigern sich, selbst einen Test durchzuführen und das Problem als ein partnerschaftliches oder sogar familiäres anzusehen. Stattdessen wird die Schuld an der Erkrankung einseitig der Ehefrau zugeordnet, was in Tansania bis zur Verstossung der Frau aus Familie und Gemeinschaft führen kann.



Foto: SolidarMed

Auch HIV-positive Kinder brauchen eine Chance.

Angesichts dieser Tatsachen kann der Fokus in einer zweiten Phase des Programms auf eine andere Aktivität gerichtet werden, die Entstigmatisierung. Eine Sensibilisierungskampagne in den benachbarten Dörfern ist im Gange. Im Gedankenaustausch mit anderen Spitälern der Region haben wir erkannt, dass ähnliche Probleme bestehen. Und neue Strategien zur effizienteren Einbindung der HIV-positiven Schwangeren und deren Familien sind im Gespräch.

Dank der Ausweitung des PMTCT-Programms in die Gebär- und Wöchnerinnenabteilung des Dareda Hospitals (Überprüfung des HIV-Status anhand bestimmter Codes in den Vorsorgekarten) konnte unsere Patien-

tin Veronica wieder ins Programm aufgenommen werden. Ihr Kind wurde als erstes Kind hier in Dareda gemäss den neuen, erst provisorisch vorliegenden tansanischen PMTCT-Richtlinien behandelt, nämlich mit einer Nevirapin (NVP)-Einzeldosis und zusätzlich mit einer vierwöchigen Zidovudin (AZT)-Gabe. Die Richtlinien werden angelehnt an die neusten WHO-Empfehlungen, die auch eine AZT-Behandlung der Mutter ab der 28. Schwangerschaftswoche vorsehen sowie eine einwöchige Gabe von AZT und Lamivudin (3TC) zusätzlich zur NVP-Einzeldosis bei der Geburt. Solange die staatliche Belieferung der Spitäler mit antiretroviralen Medikamenten kein Problem darstellt, scheint die Abkehr von der NVP-Einzeldosis aus mütterlicher wie kindlicher Sicht sinnvoll. Allenfalls ermöglicht die Medikation in der Schwangerschaft gar eine bessere Kontrollierbarkeit des Patienten-Follow-ups.

Veronica wird in ein paar Tagen aus dem Spital entlassen. Wir hoffen, ihr die Gewissheit mitgeben zu können, dass sie selber die Gesundheit ihres Kindes auf entscheidende Weise beeinflussen kann.

* Der Schweizer Kinderarzt **DR. RETO VILLIGER** arbeitet seit September 2006 im Auftrag von SolidarMed als pädiatrischer Berater in Dareda, Tansania. Zu seinem Tätigkeitsfeld gehört neben der allgemeinen medizinischen Versorgung der Kinder der Aufbau eines Behandlungs- und Betreuungsprogramms für HIV-positive Kinder. Kontakt: solidarmed@solidarmed.ch

DER POSITIVE TEST IST NICHT DAS ENDE

In Afrika südlich der Sahara werden jedes Jahr mehr als 500 000 mit dem HI-Virus infizierte Frauen schwanger und gebären. 20 bis 25 Prozent der Kinder sterben innerhalb der ersten zwei Lebensjahre, 60 bis 70 Prozent vor dem sechsten Lebensjahr. Der Schweizer Kinderarzt Nicolas Regamay berichtet über sein Engagement für Mutter und Kind in Kamerun.

Von Nicolas Regamay*

IN AFRIKA stellt die Übertragung des HI-Virus von der Mutter auf ihr Kind während der Schwangerschaft, Geburt und während der Stillperiode die bei weitem häufigste Form der HIV-Infektion bei Kindern dar.

Im April 2000 startete ich als Schweizer Kinderarzt im Krankenhaus Ngaoubela in Kamerun ein Pilotprojekt zur Verhinderung der HIV-Übertragung von Mutter auf Kind. Kamerun zählt zu den Ländern, die eine hohe HIV-Prävalenz aufweisen, und innerhalb des Landes steht wiederum die Region Adamaoua, wo sich das Krankenhaus Ngaoubela befindet, laut nationaler Statistik bezüglich HIV-Prävalenz an der Spitze.

Im Krankenhaus Ngaoubela werden seit April 2000 Frauen, die zur Schwangerschaftsvorsorge kommen, ausführlich über HIV/Aids informiert und erhalten die Möglichkeit, einen HIV-Test gratis durchführen zu lassen. Falls der HIV-Test positiv ausfällt werden sie medizinisch betreut und während der Schwangerschaft von einem Projektmitarbeiter zu Hause besucht. Die HIV-positiven Schwangeren erhalten während der Geburt das Medikament Nevirapine, das das Übertragungsrisiko des HI-Virus auf das Kind vermindert, und werden anschliessend mit ihren Neugeborenen medizinisch und psychologisch weiter betreut.

BETREUUNG VON 200 MUTTER-KIND-PAAREN

Über die fünf Jahre des Projektes liessen sich mehr als 5000 Frauen auf HIV testen. Davon waren sieben Prozent HIV-positiv. Über 200 Mutter-Kind Paare konnten medizinisch betreut und mit dem Medikament Nevirapine behandelt werden.

Besondere Bedeutung wurde der Information der Schwangeren über HIV/Aids vor und nach dem HIV-Test gegeben. Zwei Pfleger wurden dazu speziell geschult. Ohne ein einfühlsames Beratungsgespräch neigen nämlich viele Menschen, die plötzlich vor der Diagnose «HIV-positiv» stehen, dazu, den Mut zu verlieren und sich fallen zu lassen. Das «pre-test counseling» konnte durch die Anschaffung eines Fernsehers mit Video-Gerät verbessert werden: Während den Wartezeiten vor der Schwangerschafts-Vorsorgekonsultation werden den Schwangeren Informations-Kurzfilme über HIV/Aids gezeigt. Zudem konnte das Krankenhaus ein neues Kopiergerät anschaffen, um Informationsblätter über HIV/Aids, welche den Schwangeren verteilt werden, in den verschiedenen lokalen Sprachen zu kopieren.

Für viele HIV/Aidsbetroffene Mütter und Kinder konnte auch eine antiretrovirale Kombinationstherapie eingeleitet werden. Dank der Anschaffung eines FACS-Gerätes zur CD4-Lymphozytenmessung ist jetzt eine dem Stadium der Erkrankung angepasste Therapie vor

Ort möglich. Somit ist die Prognose der Krankheit auch nicht mehr so katastrophal wie noch vor wenigen Jahren. Ein Monat HIV-Therapie mit einer Dreifachmedikation ist aktuell für 40 bis 50 Franken erhältlich, was diese Medikamente in zunehmender Masse für die Bevölkerung zugänglich macht.

GEZIELTE INFORMATION UND PRÄVENTION

Die im Projekt erhobenen epidemiologischen Daten zeigen unter anderem, dass es erhebliche Unterschiede in der HIV-Prävalenz zwischen verschiedenen Ethnien und Dörfern gibt.



Fotos: N. Regamey



Im ländlichen Kamerun erhalten Kinder dank des Programms zur Prävention der vertikalen HIV-Übertragung eine Zukunft.

Dies erlaubt, eine auf Risikogruppen gezielte HIV-Präventionsstrategie zu betreiben. So wurde zum Beispiel im Dorf Malarba eine HIV-Informationsstelle eröffnet. Das Dorf liegt an der Hauptstrasse und ist ein beliebter Übernachtungsort für Lastwagenfahrer. Die hohe Prostitutionsaktivität im Dorf macht sich durch die hohe HIV-Prävalenz bei den Frauen des Dorfes bemerkbar.

Besonders erwähnenswert und erfreulich ist noch, dass uns im Zuge der Bemühungen, das Thema HIV/Aids von Tabu und Scham zu befreien, gelungen ist, eine Selbsthilfegruppe HIV-Infizierter und Betroffener zu gründen, die einstweilen schon über 50 Mitglieder zählt und ganz wesentlich dazu beiträgt, wieder Mut und Selbstvertrauen zu gewinnen.

Dank der Pilotdaten, die durch dieses Projekt gewonnen werden konnten, wurden ähnliche Projekte in zwei weiteren Krankenhäusern in der Region Adamaoua gestartet. Ein grösseres Mutter-Kind HIV-Präventionsprogramm, das alle Krankenhäuser der Region einbezieht, konnte im Verlauf realisiert werden. Dieses Programm wird nun von weiteren Geldgebern aus den USA und aus Norwegen unterstützt und weitergeführt. Der Staat hat in den letzten Jahren ebenfalls die Wichtigkeit des Problems erkannt und liefert nun zum Teil kostenlos HIV-Tests und Medikamente zur Prävention der vertikalen HIV-Übertragung. Somit können infizierte Schwangere bereits während der Schwangerschaft mit einer antiretroviralen Therapie behandelt werden. Es vergehen jedoch manchmal Monate, ohne dass die bestellten Medikamente vom Staat geliefert werden. Somit beruht die Kontinuität des HIV-Präventionsprojektes weiterhin zum grossen Teil auf Spendengeldern.

*** DR. MED. NICOLAS REGAMEY**, Facharzt für Kinderheilkunde und Oberarzt an der Medizinischen Universitäts-Kinderklinik am Inselspital in Bern, weilt gegenwärtig im Rahmen eines Followships in London. Das von ihm beschriebene Projekt wurde zu Beginn von privaten Spenden aus dem Erlös vom Verkauf von Kinderzeichnungen finanziert. Im Jahr 2002 konnte die Hilfe der Stiftung Aids & Kind gewonnen werden. Weitere Spenden werden mit Freude entgegengenommen. Kontakt: N.Regamey@imperial.ac.uk.

mothers2mothers

“Our vision is a world without HIV infected babies, where mothers with HIV/AIDS live long and healthy lives, raising their children and caring for their families. Our mission is to create an effective, sustainable model of care that provides education and support for pregnant women and new mothers living with HIV/AIDS: To prevent babies from contracting HIV through mother-to-child transmission; to keep mothers and babies living with HIV/AIDS alive and healthy by increasing their ability to access health-sustaining medical care; and to empower mothers to battle the stigma associated with HIV/AIDS in their families and their communities.”

By mothers2mothers*

NOSIPHO, at seven months pregnant, visits her local clinic to access antenatal care and chooses to test for HIV. When she finds out that she is HIV-positive, Nosipho realizes she will have to cope with the struggles she has been warned about on billboards and has watched her neighbors endure. When she considers telling those close to her about her HIV-positive status, she becomes despondent and afraid: She worries about her family rejecting her and even more so, about her boyfriend's potentially violent response. A nurse at the clinic explains to Nosipho that she can pass the virus on to her baby, and she becomes even more afraid imagining giving birth to a sick baby: How would she take care of him, and how will she even take care of herself? At this time when she needs support most severely, she feels most alone.

Although Nosipho is not aware of it, about one third of the other women in the clinic waiting room are in a similar situation. Most will only get a few minutes of education and support from the overworked clinical staff as part of government prevention of mother-to-child (PMTCT) programmes: When they leave, they will know very little about what it means to be HIV-positive or how to best cope with the news.

Silent in her confusion and uncertainty, Nosipho looks to the nurse for reassurance. The nurse tells her about mothers2mothers (m2m), a group of HIV-positive mothers who are available to educate and counsel her. Down the hall in the m2m meeting room, she finds ten women sitting in a circle; they offer her a chair and welcome her to join the conversation. Over lunch, a Mentor Mother named Thandi pulls Nosipho aside and asks her how she is feeling and if she has any questions about the news. Thandi explains that there are medications she can take and behaviours she can adopt to reduce the likelihood that she will infect her child and to improve her own health. Rejoining the group, Nosipho listens to the other women's stories, some of whom have recently delivered healthy babies. She realizes many of them – and their children – are living healthy lives despite their HIV status.

WHAT MAKES m2m DIFFERENT?

Nosipho is one of the mothers who was supported by and is now working with mothers2mothers (m2m). This innovative project was founded in Cape Town, South Africa, in 2001 by Mitch Besser. An American doctor working in the provincial hospital system, he witnessed wom-

en coming into clinics and hospitals for pregnancy tests and HIV testing. If testing positive, they were given a short consultation and then advised to return near the end of their pregnancy for single dose or short course anti-retroviral medicine, to prevent transmission to their baby. The patients received minimal counselling upon discovering their status, and little follow up care could be offered by overwhelmed medical staff. After delivery many of these women did not return to the clinics and hospitals for care, they simply fell through cracks in the system. As a result the number of babies born HIV positive was not diminishing, as the number of mothers getting sick and dying from AIDS was increasing.

mothers2mothers does not do testing or distribute medication. It is an education, psychosocial mentoring and support organization. This is critical to their success since the greatest problem with testing and anti-retroviral drug distribution today is a lack of uptake – through fear, stigma, lack of education, and language and culture barriers.

mothers2mothers identifies and trains HIV positive mothers from the communities who have recently given birth to healthy babies. They place them through a rigorous curriculum, and return them to maternity wards and clinics as Mentor Mothers. Mentor Mothers educate new mothers, supporting them as they confront decisions that mean the difference between illness and health. It is critical to the success of the program that Mentor Mothers are employed and paid as integral, valuable and professional members of the health care team. They operate in antenatal clinics, hospitals, maternity wards and post-delivery clinics alongside established PMTCT treatment programs. All of these services are provided within the state system and alongside other NGOs with whom m2m partner. m2m thus complements already existing PMTCT programs.

When a woman arrives for her first antenatal visit, she is paired with a Mentor Mother. This Mentor Mother performs an assessment to determine what the client understands about HIV and its ramifications for her health, her child's health, and her life, and all the factors that influence her living. If the client desires, her Mentor Mother will accompany her to her medical appointments and aid the woman in completing referral appointments. Addi-

tionally, the Mentor Mothers lead group meetings and discussions with all the participating women in the program so that the women benefit from the support of others. The Mentor Mother also acts as an advocate on the labor wards, ensuring that treatment is provided during the birth process to prevent transmission.

mothers2mothers was developed in response to perceived medical and social needs to keep mothers in care after delivery. To address these factors, m2m also speaks to the postpartum woman's questions and needs with regard to feeding, accessing family health care, and adjusting to life in the community as a woman and mother living with HIV. mothers2mothers acknowledges the physical and emotional challenges of the postpartum period.

Recognizing the importance of extending the program into the community, townships, and villages, mothers2mothers also utilizes the seasoned skills and talents of Mentor Mothers to provide community education and outreach on topics related to reproductive health, especially HIV/AIDS. Site Coordinators and Mentor Mothers regularly travel to clients' homes and/or invite family members to a mothers2mothers location in order to provide education and support to women who are disclosing their HIV status. In addition, m2m adapts to rural health care settings where women cannot travel to the nearest health care facility for Antenatal Clinic visits and/or delivery, playing an integral role in promoting ARV therapy adherence.

Since its inception the programme has grown to include programmes for mothers and babies after delivery, to support women and families taking anti-retroviral drugs and to provide skills training and opportunities to earn a living. Mothers Creations, an m2m income generation project, provides economic opportunity to more than 100 women who have collectively earned more than four million rand in the last four years. Products from Mothers Creations are sold around the world. Each month m2m sites in South Africa see more than 20'000 women. More than 95% of the mothers in the programme are tested for HIV, versus a national average of 10%. Nearly all of them give birth to HIV negative children. The operating cost is \$35'000 per clinic or hospital site, and less than \$15 per client. m2m trains and employs many otherwise unemployed wom-

en, creating a cadre of healthcare professionals which the government cannot otherwise afford to deploy. Presently, m2m has more than 300 employees at 89 sites in South Africa, 10 sites in Lesotho, and partners with local organizations to promote similar programs in Ethiopia and Botswana. With new funding for 2007, m2m has plans to begin expansion into Kenya, Rwanda and Zambia.

VITAL IMPACT ON PMTCT PROGRAMS

mothers2mothers has a substantial positive impact on efforts to prevent the transmission of HIV from pregnant women and new mothers to their babies (PMTCT), according to an important public health study focusing on key indicators for the PMTCT programs. The study was conducted by Horizons/Population Council and Health Systems Trust (HST), an independent South African research organization. The study shows that PMTCT care substantially improved at sites after m2m services were introduced.

The study found that m2m's programs have a considerable impact on key factors involved in preventing mother-to-child transmission of HIV:

- Increasing the number of women who received the drugs to prevent transmission to infants
- Increasing the number of infants receiving the drug to prevent transmission of HIV
- Helping women to disclose their HIV status to their partners and families
- Improving women's knowledge about how HIV can be transmitted from mothers to infants during pregnancy and breastfeeding

- Increasing the number of women who chose an exclusive infant feeding method which reduces transmission risk Helping women feel that they were better able to help themselves, care for their infants and live positively
- Increasing the number of women who received a CD4 test during pregnancy to make sure that the appropriate PMTCT drugs were given
- Improving the use of family planning after pregnancy
- Encouraging more women to discuss the importance of faithfulness and safer sex with their partners

The independent research took place at three healthcare facilities in Pietermaritzburg, in South Africa's KwaZulu-Natal Province, from 2005 to 2006. The study looked at the impact of m2m's peer education and psychosocial support programs on the attitudes and behaviours of pregnant women and new mothers living with HIV/AIDS. Overall, the Horizons/Population Council study is an important study which demonstrates through empirical evidence, the value of the education and psychosocial support that mothers2mothers offers mothers living with HIV/AIDS.**

... AND WOMEN'S EMPOWERMENT

Mothers living with HIV should be empowered to become active members of their community, rather than to live only as victims, is the basic understanding of m2m. In the words of Site Coordinator and mother speaking about her m2m experience: "I didn't want anything to do with HIV-positive people or women, but when I saw these healthy-looking women and listened to their stories, I immediately became part of that family. We actually created a bond, which will last forever. I was empowered and prepared for disclosure..."

* **mothers2mothers (m2m)** is an NGO based in Cape Town, South Africa, that offers an effective, sustainable model of care that provides education and support for pregnant women and new mothers living with HIV/AIDS. Contact: Linda Codron, Communications Manager, mothers2mothers, linda@m2m.org, www.m2m.org

** Results from the study were released in May 2007. The final is expected late 2007, see www.popcouncil.org/horizons/projects/SouthAfrica_Mothers2Mothers.htm

EINE SMARTE SACHE...

Welche Rolle kann eine kleine Nichtregierungsorganisation bei der nationalen Einführung antiretroviraler Behandlungsprogramme spielen? Mit seinem Projekt SMART ist SolidarMed der Balanceakt zwischen der Einbettung in die nationale Politik und komplementären Aktivitäten erfolgreich gelungen.

Von Esther B. Oester*

DAS SOLIDARMED ART-Projekt (SMART) beinhaltet die Einführung von antiretroviraler Therapie (ART) in sieben ausgewählten ländlichen Distrikten in Tansania, Mombambique, Lesotho und Zimbabwe. In all diesen Gebieten konnte SolidarMed an längere Spitalpartnerschaften anknüpfen. Das Projekt ist von der Direktion für Entwicklung und Zusammenarbeit (DEZA) finanziert und dauert von Juli 2004 bis Dezember 2007.

Der Beginn von SMART fiel in den Partnerländern mit der Einführung multisektoreller Initiativen zur flächendeckenden Einführung der Aidstherapie zusammen. Das SMART-Projekt läuft somit ergänzend zu den nationalen Programmen. Eine kürzlich im Auftrag der DEZA durchgeführte Evaluation zeigt, dass es sich um eine fruchtbare Ergänzung handelt: Die Projektergebnisse haben dazu beigetragen, die nationalen Programme zu verbreitern; umgekehrt haben die nationalen Programme Ideen von SMART aufgenommen und das Projekt geradezu absorbiert. So wurde etwa zur Zeit der Projektplanung in keinem der beiden evaluierten Länder Tansania und Zimbabwe Antiretroviralthherapie auf Distriktebene angeboten. Heute ist sie in den nationalen Gesundheitsstrukturen eingeführt und in den SolidarMed-Partnerdistrikten durch zusätzliche, in der Regel kirchliche Spitäler gestärkt.

Alle acht Standorte des SMART-Projekts sind ländlich, abgelegen und in vieler Hinsicht marginalisiert. Die Einführung von antiretroviraler Behandlung wurde dem jeweiligen na-

tionalen Rahmen angepasst, und im Laufe der Projektdurchführung zeigte sich zudem, dass jedes Programm oder Projekt individuell eingebettet und entwickelt werden musste. Das ART-Programm umfasste alle Komponenten im Kontinuum von Behandlung und Pflege: VCT (voluntary counselling and testing), ART (Antiretroviralthherapie), PMTCT (Prävention der Mutter-Kind-Übertragung von HIV) und Home Based Care. Diese Komponenten wurden je nach dem Kontext der jeweiligen Partnerspitäler unterschiedlich ausgestaltet. Derzeit sind an den Partnerspitälern von SMART insgesamt 1500 Patienten unter antiretroviraler Therapie und weitere 4000 unter medizinischer Prophylaxe von opportunistischen Infektionen.

TANSANIA: DAS WARTEN BEFLÜGELT DIE PHANTASIE

In Tansania zeigte sich nach der ersten Planung, dass die zwei SolidarMed-Partnerspitäler Aussicht auf Gratismedikamente im Rahmen der nationalen Einführung des ART-Programms hatten, sich dazu aber dem nationalen Tempo anpassen mussten. Das führte insbesondere im ersten Projektjahr zu Verzögerungen, setzte aber auch Kräfte frei, die sich im Endeffekt positiv auf die Projektentwicklung auswirkten.

Als erster Schritt wurde im Umfeld beider Partnerspitäler das VCT (voluntary counselling and testing) distriktweit eingeführt. Die Ausbildung für die Gesundheitsfachleute ebnete bei der Gesundheitsverwaltung und in der Be-



völkerung viele Wege für spätere Information und Sensibilisierung. Weitere Anstrengungen flossen in die Ausbildung von Spitalpersonal für die Therapie und die Vorbereitung der Spitäler auf die Einführung des neuen Dienstes (Labor, Datenmanagement, Infrastruktur etc.).

In einem Partnerspital wurden anfänglich klinisch diagnostizierte PatientInnen auf ihre opportunistischen Infektionen behandelt, mit der Idee, sie später ins ART-Programm aufzunehmen. Viele hielten sich nach der Behandlung aber für geheilt und kamen nicht zu den vorgesehenen regelmässigen Folgeuntersuchungen. Erst mit der Einführung der freiwilligen Tests, verbunden mit der Ausbildung für das Spitalpersonal und der Information der Bevölkerung, waren die Voraussetzungen geschaffen, dass die PatientInnen regelmässig zur Kontrolle ins Spital kamen. Diese Erfahrung zeigte allen Beteiligten, dass Therapie erst nach dem Testen sinnvoll umgesetzt werden kann.

Ab März 2006 wurden die antiretroviralen Medikamente an die Spitäler ausgeliefert, und Ende 2006 hatten das Daredasptal im Norden Tansanias 31 und das Lugalasptal im Süden Tansanias 46 ART-PatientInnen. In beiden Spitalern wurden in dieser Zeit etwa dreimal so viele PatientInnen auf opportunistische Infektionen behandelt.

Das Evaluationsteam bezeichnete SMART als einen Balanceakt in verschiedener Hinsicht. Das Projekt hat durch seine komplementäre Rolle und dank der richtigen Gewichtung mitbewirkt, dass das Gesundheitssystem heute für das Kontinuum von Beratung, Therapie und Pflege für HIV/Aidspatienten angepasst ausgerüstet ist. Dazu gehörten Investitionen in die Anschaffung von Labormaschinen oder kleinere Renovationen und Neubauten. Spezielle Errungenschaften des Projektes waren das schnelle Einführen der neuen Therapie und die hohe Motivation des Gesundheitspersonals.



Foto: SolidarMed

Das Daredaspital hat eine offene Tür für PatientInnen, die einer Behandlung mit antiretroviralen Medikamenten bedürfen.

Im Gegensatz dazu ist die Evaluation kritisch gegenüber den Errungenschaften von SMART auf der sogenannten Nachfrageseite, der Seite der PatientInnen also. Es gelingt den Partnerspitälern von SMART wie auch allen anderen Spitälern in Afrika nicht, alle PatientInnen im Therapiesystem zu behalten. Die Ausfallquote von etwa 15 Prozent sollte laut Evaluation durch ein verbessertes follow-up der PatientInnen in ihren Dörfern vermindert werden.

MULTISEKTORIELLER ANSATZ

In Ifakara im Süden Tansanias unterhält SolidarMed seit dem Jahr 2000 ein Projektleitungsbüro. Schon vor SMART wurden von hier aus Aktionen zur HIV- und Aidsprävention und zur Eindämmung der sozialen Auswirkungen von Aids unterstützt. SMART ermöglichte, die Behandlungskomponente in diese Projekte aufzunehmen. Zu diesem Zweck entwickelten wir ein Projekt zur Dezentralisierung der Behandlung von HIV/Aids.

Wir konnten dabei an eine alte Projektpartnerschaft mit einer Gruppe von Kapuzinern anknüpfen. Diese hatten schon Ende der Neunzigerjahre damit angefangen, Aidsweisen aufzunehmen und hatten gemeindeorientierte Ansätze entwickelt. Zudem hatten sie mit äusserst bescheidenen Mitteln ein umfassendes Home Based Care Programm aufgebaut. Diese Projekte wurden ergänzt um Einkommensschaffung für Frauen und kombiniert mit Präventionsanstrengungen. Im Moment, als das ART-Projekt geplant wurde, konnten wir auf eine mehrjährige Pilotzusammenarbeit zurückblicken.

Bei der Einführung der freiwilligen HIV-Tests und der Dezentralisierung der Therapieangebote wurden derartige Partnerschaften wichtig und fruchtbar. Die Komponente Dezentralisierung wurde gemeinsam mit den Gesundheitsbehörden des Distrikts entwickelt. Zudem wurde ein Monitoringsystem für Angebote und für die Nachfrage nach VCT aufge-

baut. Diese Komponenten war aus einem zweiten Projektfonds finanziert, aber gleichzeitig mit dem ART-Projekt entwickelt und durchgeführt worden. Damit wurden Synergien erzielt und die Wirkung der Zusammenarbeit vergrössert.

Eine der allgemeinen Herausforderungen bei der Aidsarbeit ist die Angst von Stigma und Diskriminierung. Anfänglich war die Beziehung der Spitalangestellten zu den PatientInnen eher distanziert. Die Angestellten waren sich nur „theoretisch bewusst“, dass sie nicht diskriminierend auftreten sollten. Eine spürbare Verbesserung trat erst von dem Moment an ein, als mehrere Spitalangestellte selber antiretrovirale Therapie in Anspruch nahmen und begannen, aus eigener Erfahrung zu sprechen. Dieser Effekt soll auch in Zukunft bei der Ausweitung von ART auf die peripheren Gesundheitseinrichtungen wie Dispensarien weiter genutzt werden. Es werden Post-Test Clubs ins Leben gerufen, aus denen Personen ungeachtet des Testresultates in Sensibilisierungskampagnen auftreten. Mit der steigenden Nachfrage nach Therapie wird Tansania eine Erfahrung aus Zimbabwe replizieren, nämlich die Ausbildung von lay counsellors.

In Zukunft soll zudem eine gemeindeorientierte Präventionskampagne aufgebaut werden, die auf MultiplikatorInnen aus den Gemeinschaften basiert. Sie werden von den Dorfversammlungen ausgewählt werden nach unterscheidbaren ethnischen Gruppen und innerhalb dieser nach Altersklasse und nach Gender. Der Ansatz wurde im Nachbardistrikt schon getestet und soll thematisch stärker auf HIV/Aids fokussiert und im Einzugsbereich der HIV/Aidsprojekte repliziert werden.

Andere Herausforderungen für die Prävention und Informationsarbeit sind die moralischen Autoritäten wie religiöse Führer verschiedenster Glaubensrichtungen und Konfessionen, die sich beispielsweise gegen die Verwendung von Kondomen einsetzen. Im Moment scheint im

Projektalltag die einzige Reaktionsmöglichkeit, all jene Kräfte diskret zu stärken, die hier ein unterstützendes Verhalten an den Tag legen. SolidarMed hat an verschiedenen Orten PartnerInnen, die selbstbewusst eigene Wege gehen; Ordensleute zum Beispiel, die betonen, Gesundheit und Moral sollten nicht vermischt werden, oder die Formen finden, den PatientInnen den Zugang zu Kondomen zu ermöglichen.

FLEXIBLE ARBEITSWEISE UND KOMPARATIVE ROLLE

Eine spezielle Stärke des SolidarMed-Ansatzes ist, dass die Projektentwicklungen partizipativ und mit einer grossen Breite an Beteiligten durchgeführt werden. Das Team in Ifakara zum Beispiel besteht aus tansanischen Fachleuten, geleitet von einer Koordinatorin aus der Schweiz. Im ART-Projekt ist es gelungen, die Brücke zu schlagen von der internationalen Fach- und Begleitgruppe zu den KollegInnen in den Partnerländern Mocambique, Zimbabwe und Lesotho bis zu den Fachleuten und AktivistInnen in und um die peripheren Gesundheitseinrichtungen in Tansania und Mocambique.

Diese Arbeitsweise und eine besondere Flexibilität in der Projektausgestaltung haben es SolidarMed ermöglicht, im ART-Projekt eine komplementäre Rolle zu spielen und dieses in Tansania zudem um multisektorielle Aktivitäten zu ergänzen.

Die Arbeit einer kleinen NGO rechtfertigt sich in ihrer Flexibilität, wenn es ihr gelingt, innovativ zu bleiben und ihre komplementäre Rolle immer wieder neu zu definieren. Der Evaluationsbericht hat dies SolidarMed bestätigt. Auch wenn die DEZA-Finanzierung für das ART-Projekt aufhören wird, stehen heute Möglichkeiten mit lokalen Finanzierern offen, und die Programme werden sich dynamisch weiterentwickeln.

* ESTHER B. OESTER war von August 2004 bis September 2006 Landeskoordinatorin von SolidarMed in Tansania. Kontakt und Informationen zu SMART: www.solidarmed.ch

THE CRISIS FOR HIV-POSITIVE WOMEN

Offering counseling and testing for HIV to pregnant women who come for antenatal care services provides an opportunity to identify HIV-positive women and invite them to take part in a PMTCT program. It is often at this occasion that women first learn about their HIV-positive status. Alice Welbourn sets out the reality for pregnant HIV positive women and explains what the International Community of Women living with HIV/AIDS (ICW) is calling for.

By Alice Welbourn*

HIV POSITIVE women often learn for the first time about their status when they attend an antenatal clinic when they are expecting a baby. Suddenly you are told that you have a life-threatening condition, which may also affect your baby. Even worse than this, a woman's husband or in-laws are often told first, in complete violation of her rights. Staff may treat her roughly, as if it is her "fault" that she is HIV positive. She may be threatened with abortion or sterilisation, whether she wants to have her baby or not, by the very people who should be supporting her in deciding for herself what is best to do next. This is especially devastating for the many among you who have told us about being married to older men by your parents and who, prior to your marriage, have had no other sexual relations. In the vast majority of cases, it turns out that a woman's husband is also HIV positive. Yet it is assumed – quite illogically and unjustly – that because you were tested first, you must have been the one to bring HIV to the relationship.

TO ACCESS TREATMENT SUCCESSFULLY, WE ALSO NEED CARE AND SUPPORT

The International Community of Women living with HIV/AIDS (ICW) has recently taken on the new role as co-convenor of the UNAIDS

Global Coalition of Women and AIDS access to treatment arm. In that role, one of our concerns is to ensure that we are not just thinking about access to treatment for positive women, but also for the on-going care and support we need. And of course a crucial part of this for many of us is how to avoid HIV transmission to our babies. At present, the main point of entry for women to be tested and start treatment has been identified by the World Health Organization as antenatal care, because this is the time when any woman is most likely to come into contact with government health services. Sadly, worldwide health service provision is so desperately under resourced that for the foreseeable future it is unlikely women will be offered prepregnancy testing routinely, or that most women of any age who are not pregnant will be offered these services at all. Even though pregnant women want to protect their unborn child from HIV, since antenatal clinic health staff are not treating women with compassion and respect, many women are not returning for test results or treatments.

As a part of ICW's new role as co-convenor, we are calling for health service providers around the world to consider women's mental as well as physical health, and to promote:

- testing facilities for prospective mothers before they conceive, so that they can then decide whether or not they want to have a baby
- testing facilities for prospective fathers as well as prospective mothers, to ensure that they realise their joint responsibilities in relation to HIV
- testing facilities both for expectant mothers and for their partners so that responsibility for a positive diagnosis can be jointly shared
- full, non-judgmental information, support and care for all pregnant positive women, so that they can decide for themselves whether or not to proceed with the pregnancy.

Columbia University's *Mother-to-Child Transmission Plus* programme in Southern Africa and elsewhere promotes care and support not only for the expectant mother and her unborn child, but also care and treatment, as needed, for her partner and other children in the family. Until pre-pregnancy testing becomes a realisable option, such an approach may mean that positive women will be less blamed for supposedly bringing HIV into the family, and will not have to face the dilemma of receiving treatment while their partners or children are not. ICW is also very aware that many of the front-line health staff around the world are themselves

women, who often anticipate what is happening in their own marriage beds, but fear losing their jobs if they get tested. Is it possible that some of these staff are projecting onto their clients their own anxiety of how they might be treated were they HIV positive themselves?

With these ideas in mind, ICW is also calling for health services around the world to develop supportive HIV workplace policies, to ensure that HIV positive health staff are fully respected, supported and retained in their posts. We believe that once health staff feel valued and respected, whatever of their status, they will feel more ready to respond positively to the immense stresses and strains of supporting and respecting their HIV positive clients.

*ALICE WELBOURN is chair of the International Community of Women Living with HIV/AIDS (ICW) and co-chair and founder member of SOFIA, a new UK-based women's forum which aims to change policies, so that there is effective prevention and better access to treatment for women living with HIV and AIDS. Contact: info@icw.org, www.icw.org. article published in: *ICW News*, Issue 28, January/February 2005, www.icw.org/tiki-download_file.php?fileId=125, reproduced as fair use.



Testing facilities for both the expectant mothers and for their partners are needed so that responsibility can be shared jointly.

ATELIER MMS

ATELIER MMS DU 28 AOÛT 2007 À GENÈVE

COMMENT JUGER DE L'EFFICACITÉ DE NOTRE TRAVAIL?

Évaluation: assurer la qualité dans
la coopération en matière de santé

L'efficacité de la coopération en matière de santé suscite de vifs débats non seulement dans les instances politiques. Les donatrices, donateurs individuels ainsi que les financeurs institutionnels veulent eux aussi savoir si leur argent est utilisé de manière judicieuse, efficiente et efficace. La question de l'efficacité de notre engagement se pose au sein même de nos organisations, déterminés que nous sommes à accomplir avec nos partenaires sur place le meilleur travail possible au vu des ressources limitées dont nous disposons.

Evaluer c'est juger, analyser, apprécier – pour assurer et améliorer la qualité du travail effectué. Lors de cet atelier de Medici Mundi Suisse, nous chercherons à identifier les possibilités et les limites de l'évaluation et à apprendre les uns des autres par un échange d'expériences. La méthode d'autoévaluation ouvre des possibilités d'apprentissage mutuel en vue de nous rapprocher de notre objectif qui consiste à travailler le plus efficacement possible, et elle est la base pour la planification et le monitoring d'une prochaine phase. Cet atelier s'adresse principalement aux collaboratrices, collaborateurs et membres des comités des petites et moyennes organisations de coopération internationale en matière de santé.

Renseignements complémentaires:

www.medicusmundi.ch

Contact: Helena Zweifel, hzweifel@medicumundi.ch,
tél. 061 383 18 10

MMS MEETING POINT

18. SEPTEMBER 2007 IN BERN

IHRE REALITÄTEN – UNSERE ANSPRÜCHE

Wachsende Kluft zwischen der Basis,
dem Projektmanagement und den
Geldgebern

Begonnen haben sie als kleine Basisgruppen, doch heute werden die «Care Groups» in Südafrika mit neuen Herausforderungen konfrontiert. Eine ist HIV und Aids und deren Auswirkungen. Damit einher kommt nicht nur mehr Geld in Projekt, sondern es werden auch neue Ansprüche und hohe Erwartungen geschaffen...

Wie können wir mit der wachsenden Kluft zwischen den freiwilligen und für diese Arbeit ausgebildeten MitarbeiterInnen an der Basis, zu meist Frauen, und den hochgebildeten bezahlten ProjektmanagerInnen umgehen? Wie können wir diesen «Generationenkonflikt» in Projekten lösen? Wie reagieren wir auf neue Ansprüche auch von unserer Organisation und von externen Geldgebern? Von den Projekterfahrungen von DM-échange et mission in Südafrika ausgehend, werden die TeilnehmerInnen die aufgeworfenen Fragen diskutieren, ihre eigenen Erfahrungen einbringen und sich gegenseitig beraten.

Ausschreibung: www.medicusmundi.ch.

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Tel. 061 383 18 10

AIDSFOCUS.CH

FORUM VON AIDSFOCUS.CH UND KWA WAZEE
23. OKTOBER 2007 IN BERN

DIE ZUKUNFT IST GRAU

Alte Menschen als Opfer und
Hoffnungsträger in der HIV/Aidskrise

red. Alten Menschen im Süden machen keine Schlagzeilen, sie gelten als wenig produktiv und passiv, sind grau und unbekannt, verborgen und vergessen. In der Entwicklungszusammenarbeit tauchen sie allenfalls am Rande auf. Alte Menschen bekommen aber die Auswirkungen der Aids-epidemie besonders stark zu spüren. Als Folge von Aids brechen traditionell vorhandene soziale Sicherungssysteme auseinander, die Restfamilien verarmen. In Afrika südlich der Sahara werden bis zu 30 Prozent der Haushalte von Grossmüttern geführt, die ihre Enkel allein aufziehen. Alte Menschen sind somit in der HIV/Aidskrise zu einem sehr wichtigen sozialen Faktor geworden.

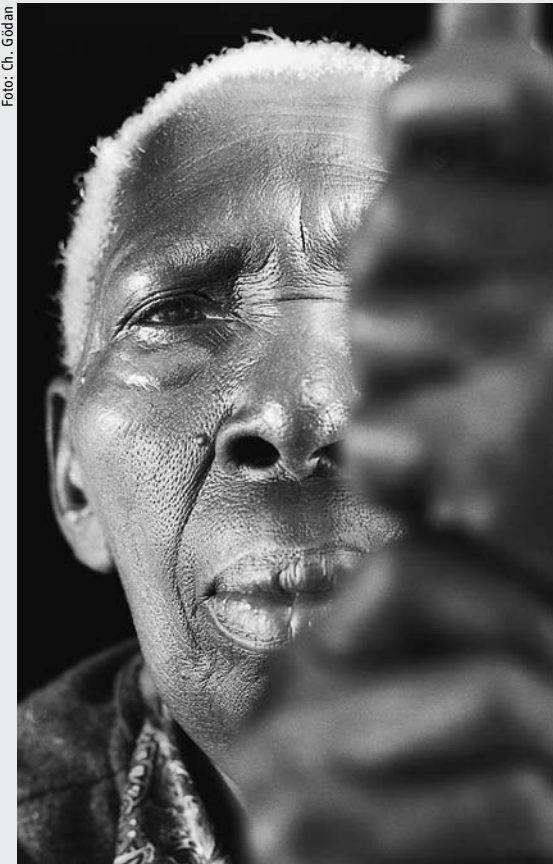
Welches sind die Auswirkungen der Aids-epidemie auf alte Menschen im Süden? Wie können Grossmütter in ihrer neuen Rolle als «careers» unterstützt werden? Ist Social Cash Transfer ein geeignetes Mittel zur wirksamen Armutsbekämpfung?

Das Forum «Die Zukunft ist grau» im Rahmen der Ausstellung «Afrikas Grossmütter im Kampf gegen HIV/AIDS» im Kornhausforum in Bern will diese Fragen genauer beleuchten, sie zur Diskussion stellen und Ansätze und Strategien zur Unterstützung vom alten Menschen im Rahmen der Entwicklungszusammenarbeit diskutieren.

Ausschreibung: www.aidsfocus.ch.

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Foto: Ch. Gödian



6. SYMPOSIUM DER SCHWEIZERISCHEN
GESUNDHEITZUSAMMENARBEIT
BASEL, 6. NOVEMBER 2007

IM ÖFFENTLICHEN INTERESSE ...

Nichtstaatliche Gesundheitseinrichtungen
und nationales Gesundheitssystem



Foto: P. Virot/WHO

Wie definieren gemeinnützige nichtstaatliche Gesundheitseinrichtungen ihre Rolle in der nationalen Gesundheitsversorgung? Wie orientieren sie sich zwischen eigener «Mission» und veränderten nationalen und internationalen Rahmenbedingungen? Diese Frage beleuchtet das 6. Symposium der schweizerischen Gesundheitszusammenarbeit.

DAS THEMA

DER STAAT MELDET SICH ZURÜCK.

Ein schwacher, funktionsunfähiger Staat gilt zu Recht als Entwicklungshindernis. Im Rahmen des Versuches einer Harmonisierung der Entwicklungszusammenarbeit (Erklärung von Paris) werden deshalb heute mehr denn früher Hoffnungen – und Gelder – in die Unterstützung nationaler Entwicklungsstrategien investiert, verknüpft mit der Stärkung der Institutionen und Kapazitäten der Staaten. Der Staat meldet sich also zurück, und zwar in einer Zeit in der er – angesichts immer mehr Herausforderungen und Gesundheitskrisen – mehr und mehr auf die Zivilgesellschaft angewiesen ist.

MEHR STEUERN – WENIGER RUDERN.

«New Public Management» oder «Stewardship» sind Kurzformeln für die Politik vieler Staaten, im Gesundheitswesen und in anderen Versorgungsektoren ihre Aufgabe und Verantwortung neu zu definieren: Der Staat konzentriert sich darauf, die nationale Gesundheitspolitik und den verbindlichen Rahmen vorzugeben, in welchem dann sowohl staatliche als auch private Akteure ihre Leistungen anbieten können.

MIT DIESEM STAAT ZUSAMMENARBEITEN?!

In der Praxis zeichnen sich aber auch heute noch viele Entwicklungsländer durch eine schwache

und vielfach auch unfähige staatliche Verwaltung aus. Für die nichtstaatlichen Gesundheitseinrichtungen und ihre Trägerschaften, die in der Vergangenheit allzu oft für den schwachen Staat die Lücken der Gesundheitsversorgung stopfen mussten, ist der Weg von der Substitution des Staates zur Einbindung in ein nationales Gesundheitssystem nicht einfach und nicht selbstverständlich. Sie formulieren Voraussetzungen, die erfüllt sein müssen – und müssen sich ihrerseits die Frage nach der Legitimation und Nachhaltigkeit ihres Abseitsstehens gefallen lassen.

POSITIONIERUNG, STÄRKUNG, ZUSAMMENARBEIT.

Auch wenn sich die Rahmenbedingungen von Land zu Land stark unterscheiden, sind die gemeinnützigen nichtstaatlichen Gesundheitseinrichtungen und ihre Trägerschaften und internationalen Partner heute überall gezwungen, die eigene Identität zu reflektieren, sich mit ihrem Angebot klar zu positionieren – und gleichzeitig ihre Strukturen und Kapazitäten zu stärken. Damit sie sich gegenüber neuen Leistungsanbietern im Gesundheitsmarkt und im politischen Dialog und den Verhandlungen mit dem Staat behaupten können, stellt sich auch die Frage nach Synergien und verstärkter Kooperation zwischen den nichtprofitorientierten Gesundheitseinrichtungen eines Landes oder Gesundheitsdistrikts.

Das Symposium der schweizerischen Gesundheitszusammenarbeit richtet sich an ein breites Spektrum von TeilnehmerInnen, die auf nationalem oder internationalem Gebiet tätig sind. Veranstalterin des Symposiums ist Medicus Mundi Schweiz, das Netzwerk Gesundheit für alle. Das Symposium wird von der DEZA mit einem Beitrag unterstützt und inhaltlich begleitet.

Programm und Anmeldung: www.medicusmundi.ch

RÜCKBLICK AUF DEN WORKSHOP VON MEDICUS MUNDI SCHWEIZ VOM 31. MAI 2007

WER SAGT DENN, DASS WIR ES RICHTIG TUN?

«Konkrete Instrumente kennen lernen»
«Selbstevaluation in der Praxis unserer kleinen Organisation umsetzen können»
«Austausch, neue Ideen, kritische Diskussion» – Dies sind einige der von den zehn TeilnehmerInnen des Workshops zu Selbstevaluation im Projektmanagement eingangs formulierten Erwartungen.

Von Helena Zweifel

Durch den Tag führten die sieben Fragen zur Evaluation, welche bei jedem Unterfangen zur Überprüfung der Qualität der eigenen Arbeit gestellt und beantwortet werden sollten: Wem soll die Evaluation dienen? Wofür? Was soll evaluiert werden? Bezüglich was soll evaluiert werden? Wer evaluiert wen? Wann? Wie? Theoretische Inputs regten zum Austausch an, und gewürzt mit den eigenen Erfahrungen und Geschichten aus der Selbstevaluations-Praxis von IAMANEH Schweiz zum gemeinsamen Lernen. In diesem Prozess lernten die TeilnehmerInnen nicht nur Konzepte und Instrumente der Selbstevaluation kennen, sie erfuhren, auch dass die Selbstevaluation ein sehr motivierender Prozess sein kann. Sie baut auf dem Wissen, den Erfahrungen, den Erfolgen und Potentialen der Beteiligten auf, schafft in einem Prozess das Gefühl, EignerIn des Projektes und Prozesses zu sein. Wie aber steht es mit der Objektivität? Was ist, wenn wir uns vor der Realität scheuen, sie verschönern oder sonst wie verzerrt wahrnehmen, wie etwas das kleine Kätzchen, das sich im Spiegel als Löwen sieht? Der Moderator Dominique Steiner griff solche Fragen gekonnt auf, regte die Reflektion an und stellte aus seinem grossen Er-

fahrungs- und Methodenkoffer mögliche Strategien und Instrumente zur Auswahl.

Der Tag war geprägt von intensiven Diskussionen in einer sehr arbeitsamen und doch lockeren Atmosphäre. In der abschliessenden Selbstevaluation mit dem SEPO, einem bekannten und hilfreichen Arbeitsinstrument zur Selbstevaluation und Projektsteuerung, werteten die TeilnehmerInnen den Tag als Erfolg. Sie hatten die interaktiven Inputs, die persönlichen Austauschmöglichkeiten, die Praxisnähe, Einstiegshilfen und verteilten Unterlagen geschätzt. Ein kleiner Wermutstropfen war das nicht ganz perfekte Zeitmanagement. Die TeilnehmerInnen sahen gute Möglichkeiten, mit dem erlernten Wissen, den bereitgestellten und am Workshop erarbeiteten Unterlagen und Orientierungshilfen und trotz möglicher Herausforderungen der Alltagsrealität das Erlernte auch umzusetzen. Viele gingen mit dem Bewusstsein nach Hause: «Evaluation ist machbar!»

Foto: MMS



Gemeinsam werden Möglichkeiten der Selbstevaluation ausgelotet.

LE NOUVEAU PRÉSIDENT DE MEDICUS MUNDI SUISSE, THOMAS VOGEL:

«ENSEMBLE, NOUS SAURONS TROUVER L'ÉNERGIE ET LES RESSOURCES ... »



Très chères lectrices et très chers lecteurs du Bulletin de Medicus Mundi Suisse,

Depuis le début du mois de juin, les membres présents à notre assemblée générale m'ont accordé leur confiance pour prendre la relève de Nick Lorenz dans la fonction de président de Medicus Mundi Suisse, le Réseau Santé pour tous. Pour moi, c'est bien sûr un très grand honneur, mais aussi une lourde responsabilité. Medicus Mundi Suisse a beaucoup progressé sous la présidence de Nick Lorenz. En treize ans, le développement de Medicus Mundi a été spectaculaire, le nombre d'organisations suisses qui se sont reconnues dans la vision «d'établir sur toute la planète des conditions qui permettent aux gens d'atteindre et de maintenir un état de santé le meilleur possible» a augmenté de 18 à 46 aujourd'hui. La reconnaissance par nos partenaires de l'expertise cumulée par les membres du réseau permet à Medicus Mundi d'être aujourd'hui un interlocuteur incontournable dans ce pays lorsqu'il est question de santé internationale. Enfin, la situation financière de Medicus Mundi, bien que toujours précaire, n'est pas préoccupante pour autant et je l'envisage sans appréhension, avec confiance même. C'est pour toutes ces raisons que je considère que c'est un immense honneur d'être le nouveau président d'une organisation aussi illustre qui peut regarder avec fierté son évolution récente.

En conséquence, je mesure aujourd'hui l'importance de poursuivre le mouvement enclenché. Ensemble, avec l'enthousiasme propre à notre réseau, il nous faudra

- poursuivre une représentativité nationale complète en offrant des prestations attractives à l'ensemble des régions linguistiques et géographiques de notre pays
- poursuivre le développement du réseau pour être la plateforme d'échange et de savoirs en santé internationale pour toutes les organisations et les personnes de ce pays qui partagent nos objectifs;
- maintenir les excellentes relations avec les partenaires qui nous soutiennent financièrement et répondre à leurs attentes quant à l'animation d'une communauté de pratique autour de la santé internationale en Suisse;
- maintenir l'attractivité du Réseau pour les membres actuels en poursuivant le dialogue permanent et en restant à l'écoute de leurs besoins;
- maintenir nos prestations et les développer en considérant l'évolution des pratiques et des moyens de partage d'expériences de savoir;
- explorer les moyens de garantir le maintien d'une situation financière saine à long terme;
- étudier la pertinence de collaborations nationales et internationales avec d'autres ONG actives dans la santé publique et dans la coopération au développement;
- rester une organisation agile capable de répondre à l'évolution de son environnement, de ses moyens et des attentes de ses membres.

Quand je regarde tout cela, je me dis que c'est effectivement une lourde responsabilité que de maintenir le cap. Mais je suis confiant. Je sais

que je peux compter sur une direction de Medicus Mundi extrêmement compétente et dévouée, sur un comité expérimenté et motivé et sur des membres engagés, actifs et parfois militants. Ensemble, nous saurons trouver l'énergie et les ressources pour poursuivre le progrès vers la Santé pour tous.

Au final, j'aimerais encore une fois vous remercier pour la confiance qui m'a été témoignée. J'aimerais aussi vous encourager, chacun de vous, à voir dans le développement de Medicus Mundi Suisse une opportunité unique de faire progresser les questions qui nous sont chères et qui sont résumées dans le concept de Santé pour tous. Ici et là-bas et dès maintenant!

Thomas Vogel, Institut Tropical Suisse
Président du Réseau Medicus Mundi Suisse

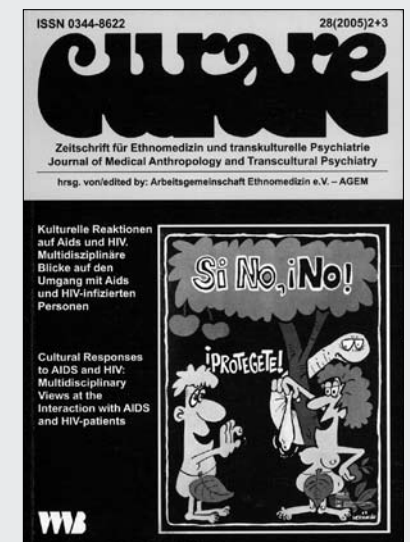
KULTURELLE REAKTIONEN AUF AIDS UND HIV:

MULTIDISZIPLINÄRE BLICKE AUF DEN UMGANG MIT AIDS UND HIV-INFIZIERTEN PERSONEN ?

«Aids beschäftigt unsere Vorstellungswelt, wobei allerdings zahlreiche Bilder über Aids und HIV bestehen, die keineswegs der Wirklichkeit entsprechen.» Eine Doppelnummer von curare, der Zeitschrift für Ethnomedizin und transkulturelle Psychiatrie, fragt nach kulturellen Antworten auf HIV und Aids. Ein Schwerpunkt ist dabei der Blick von innen, das heisst, die Art und Weise, wie in verschiedenen Gesellschaften und Kulturen auf die Präsenz von Menschen, die mit HIV und Aids leben, reagiert wird. Die Beiträge von EthnologInnen, GesundheitsforscherInnen, MedizinerInnen, Epidemiologen, EntwicklungshelferInnen und AidsaktivistInnen zeigen die disziplinäre Vielfalt im Umgang mit Aids und HIV.

Curare – Zeitschrift für Ethnomedizin und transkulturelle Psychiatrie., Vol. 28(2005)2+3

Hg: Arbeitsgemeinschaft Ethnomedizin,
www.vwb-verlag.com/Katalog/m692.html





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