

**SUMMARY OF THE PROCEEDINGS OF MEETING ON ‘ALCOHOL,
HIV RISK BEHAVIOURS AND TRANSMISSION IN AFRICA:
DEVELOPING PROGRAMMES FOR THE UNITED STATES
PRESIDENT’S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)’**

BACKGROUND

In response to growing concern among public health experts about alcohol use and HIV in Africa, several U.S. government (USG) agencies, including the Department of Health and Human Services/Centres for Disease Control and Prevention/Global AIDS Programme (HHS/CDC/GAP), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Department of Defense (DoD) and the United States Agency for International Development (USAID) hosted a meeting in Dar es Salaam, Tanzania, 30-31 August 2005, "Alcohol, HIV Risk Behaviours and Transmission in Africa: Developing Programmes for the United States President's Emergency Plan for AIDS Relief (PEPFAR)." The primary objective of the meeting was to provide scientific and programmatic updates on alcohol-related HIV risk behaviours and transmission in Africa and to inform the development of PEPFAR programming. PEPFAR is a 5-year, US\$15 billion initiative intended to support treatment for 2 million HIV positive patients with antiretroviral drugs (ARVs), to prevent 7 million new cases of HIV/AIDS and to care for 10 million patients suffering with AIDS. HIV prevention and treatment initiatives which address alcohol abuse and increase adherence to ARV treatment have the potential to contribute to PEPFAR's goals.

This article summarizes the major technical issues and key points raised in the meeting which included presentations in several key areas: epidemiology and ethnography of alcohol and alcohol-related

risk factors for HIV transmission; prevention and treatment of HIV in the context of alcohol use; and approaches to policy and partnership designed to promote the exchange of resources and knowledge related to programmes addressing alcohol use and HIV/AIDS risk behaviours. Finally, the meeting sought to strengthen partnerships between USG agencies implementing PEPFAR and multi-sectoral organizations, including faith based communities, non-governmental organizations (NGOs), community-based organizations (CBOs), uniformed services, and the alcohol industry to support HIV prevention interventions.

The meeting benefited from a diverse range of experts and participants from across the region and the United States including USG PEPFAR-implementation staff, host-country government staff, alcohol and substance abuse specialists, researchers on alcohol and on HIV/AIDS, policy experts, community-based programme managers, and communication experts. Representatives of the military and the alcohol industry from across the region also participated and expressed commitment as partners in addressing the issue of alcohol abuse. Approximately 80 participants from 13 African countries participated in the technical meeting.

**ALCOHOL AND RISK FACTORS
FOR HIV TRANSMISSION**

***HIV Risk Behaviour in Relation to
Alcohol and HIV Transmission – A
Global and Regional Overview***

The presenters in this session described the prevalence of alcohol use

globally and regionally, and reviewed scientific data on the links between alcohol use and HIV infection. The outcomes of the World Health Organization (WHO) sponsored studies on alcohol, sexual risk, and HIV transmission were reviewed.

Patterns of alcohol consumption vary throughout the world with substantial proportions of populations abstaining from the use of alcohol. It was noted that in eastern and southern Africa, 70% of females and 45% of males abstain from alcohol. However, many individuals engage in the misuse or abuse of alcohol, leading to serious public health consequences. According to WHO 2000 estimates, the eastern and southern Africa regions have the highest consumption of alcohol per drinker in the world (WHO, 2004). In addition, the prevalence of hazardous drinking patterns in the region, such as drinking a high quantity of alcohol per session, or being frequently intoxicated, is second only to Eastern Europe.

There is increasing evidence linking alcohol consumption with high-risk sexual behaviour and infection with HIV and other sexually transmitted infections (STIs). Evidence includes neurobiological studies linking alcohol consumption and sexual arousal and disinhibition; ethnographic studies linking drinking and risky sex; and cross-sectional and prospective epidemiologic studies from around the world, including many from Africa, that link alcohol consumption and HIV infection; and strong ecologic associations between alcohol consumption, alcohol taxes, and rates of STIs in the United States.

Alcohol consumption also has been shown to contribute significantly to reduced adherence to ARVs and tuberculosis (TB) treatment in studies from Africa and the developed world. For

example, studies from the United States found an association between heavy alcohol use and decreased compliance to treatment regimens as well as poor response to HIV therapy in general. In Botswana, alcohol use was associated with interruptions in TB treatment, and treatment outcomes improved significantly when patients stopped drinking (Talbot et al., 2002).

A report from the April 2005 meeting of the 58th World Health Assembly highlighted the association between alcohol consumption and unsafe sex, STIs, and HIV/AIDS. The Assembly adopted a resolution requesting action from member states. These requested actions included population-based policy measures such as taxation or raising the drinking age, which are the most cost-effective public health responses to alcohol-related disease burden in countries with moderate and high levels of alcohol consumption. Alcohol consumers represent a critical target group for HIV prevention, treatment and care interventions. The role of alcohol must be addressed in order to reduce alcohol-related risk of transmission of HIV.

Heavy drinking populations should be recognized as key target groups for HIV intervention programmes. HIV prevention programmes targeting alcohol misuse should focus not only on preventing sexual risk behaviours, but also on the treatment of alcohol-related problems. Drinking venues can be ideal settings in which to implement HIV prevention programmes, particularly with support and collaboration from the owners and staff. Multi-faceted intervention strategies are required and may include education/awareness campaigns, condom negotiation and other life skills activities for clientele in drinking establishments, and HIV prevention training activities for

bar servers and owners. The presentations in this session addressed the clear and urgent need for programmes to address the impact of the use and abuse of alcoholic beverages on HIV-related sexual risk behaviours in sub-Saharan settings.

Presentations on the epidemiology of alcohol consumption in the eastern and southern regions of Africa indicated that these regions have the highest consumption of alcohol per drinker in the world. Despite high levels of knowledge about HIV risk, high alcohol consumption is associated with disinhibition and low levels of condom use. Presenters stressed that alcohol consumption is linked to social, community and cultural factors, including easy access to alcohol; widespread acceptance of heavy drinking; alcohol advertising and lack of employment or recreational opportunities. Substantial evidence links alcohol consumption with increased risk of STI and HIV infection and with non-adherence to ARV and TB treatment. Finally, experts emphasized that multi-level interventions are needed to address social and cultural norms that contribute to alcohol-related HIV risk.

Ethnography of Alcohol, Sexual Risk and HIV Transmission

Presenters in this session provided a focused description of HIV risk behaviour in the context of alcohol use, with specific reference to the socio-economic determinants that define the production and use of alcohol; the community and cultural practices that shape or provide opportunities for alcohol use and HIV risk.

Ethnographic studies on alcohol abuse and HIV prevention in Africa show how ethnographic work can inform public health interventions by providing detailed descriptions of people in their natural settings, and an understanding of the

social, cultural, economic and material contexts in which alcohol and HIV-related risk behaviours take place. As anthropologists have noted, public health is a cross-cultural exercise, in which public health professionals collaborate with a variety of partners from national and local government, NGOs, and CBOs, and local recipient communities with differing social organization, values, beliefs, and practices. Public health interventions, thus, require “translation” into local models and terms appropriate for and understood by the community (Hahn, 1999).

Alcohol production and consumption are an integral part of the local culture and economy in the eastern and southern Africa region. Locally brewed alcoholic beverages are inexpensive and readily available, making their consumption difficult to limit. Alcohol also plays an important role in rites of passage such as marriage ceremonies and funerals. Cultural restraints, including religion, have varying influence on alcohol consumption; some religions accept alcohol consumption while others that prohibit drinking are also influential. In some areas, socioeconomic factors resulting in loss of land and livelihood have contributed to the weakening of traditional cultural restraints around alcohol consumption. Therefore, for interventions to be effective, public health professionals must collaborate with local recipient communities with differing social organization, values, beliefs, and practices. Ethnography can be useful in public health planning and programming; for example, to access and document the practices of hidden and hard to reach populations; to provide detailed descriptions of the social contexts and settings for alcohol and drug use and HIV-risk behaviours; and to inform the design of interventions that are appropriate for the local context.

Alcohol, Gender-Based Violence, and Risk for HIV Transmission

Women's vulnerability to HIV is often increased when family members, husbands, and partners drink alcohol. The primary objectives of this session were to provide a framework for examining the relationship among alcohol use, gender-based violence (GBV), and HIV; to identify practices that contribute to increased HIV risk and to describe interventions that address the interplay of alcohol, GBV, and HIV, with lessons learned and implications for transfer to other settings.

Violence is a key factor that contributes to women's vulnerability to HIV infection, particularly among younger women. The United Nations Population Fund (UNFPA) Gender Theme Group defines GBV as "violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. It includes, but is not limited to, physical, sexual and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family, or within the general community)" (UNFPA, 1998). The prevalence of GBV ranges from rates of 40% to 60% in sub-Saharan countries. Gender-based violence pertains to both sexes, but most frequently impacts young women. It includes harmful customs and behaviours perpetrated against women, including intimate partner violence, domestic violence, assault, child sexual abuse, rape, and the growing problems of forced prostitution and trafficking of women.

There are physical, behavioural and social effects of the link between GBV and HIV. Violence is associated with higher numbers of sex partners, unprotected sexual intercourse, earlier sexual debut, and excessive drug and

alcohol use. Gender based violence is consistently linked with heavy drinking patterns and women who experience sexual or physical violence are at increased risk for HIV. One study found that women who were physically or sexually abused were 50% more likely to be HIV positive than women who had not been abused (Dunkle et al., 2004). A key explanation for the link was that women's ability to successfully negotiate condom use becomes compromised when women are in relationships involving violence. Substance abuse and sexual risk taking were described as among the main behavioural effects of having experienced GBV, while the main social effects were stigma, blame and alienation.

In some cultures, gender roles and cultural, familial and religious constructions of masculinity and femininity dictate that women are submissive and male partners control the sexual relationship. Among the implications for policy and programme is a need to challenge norms regarding violence, to empower girls and women, and to include screening for GBV in health facilities. Post-violence interventions that are much needed include the provision of HIV post-exposure prophylaxis with ARVs, adequate referral, and the need for perpetrators to be punished. Interventions to reduce the prevalence of GBV include normative changes, empowerment of females, screening and provision of services, and behavioural interventions with men.

Alcohol Use and HIV Risk among Military/Uniformed Services

The objectives of the session were to describe the prevalence rates, risk factors, and issues regarding alcohol use, risk behaviours, and HIV prevention for persons in military and uniformed services; and to share potential strategies

for addressing the unique challenges for this at-risk population.

Military personnel are vulnerable to abusive alcohol consumption due to isolated postings, boredom, separation from family, camaraderie or “esprit de corps,” high tension and danger, regular salary, easy access (the cost of alcohol is subsidized for personnel), availability (it is considered necessary for morale to have alcohol in the mess halls), and peer pressure. Young recruits may be particularly vulnerable to alcohol and HIV-related behavioural risk because they are susceptible to peer pressure; have feelings of invulnerability; are away from their home environment; and may be more likely to patronize commercial sex workers (CSWs).

HIV-positive military personnel may suffer poor outcomes due to environmental, psychological or emotional stress related to military duty, stigma and discrimination, compromised access to care, inadequate nutrition and the potential for re-infection. The potential impact of HIV on the military is enormous and includes: the inability to sustain external deployments; the inability to sustain a technologically advanced force; increased expenses; loss of productivity; loss in continuity of command; and compromised morale and security. Interventions should draw on the unique structured environment of the military with its values of camaraderie, mutual protection, and peer influence to encourage and strengthen HIV/AIDS prevention.

PREVENTION AND TREATMENT OF HIV

Prevention of Alcohol Risk Behaviour and HIV Transmission – An Overview of Policies and Interventions

While no causal link exists between alcohol and HIV/AIDS, there is a clear

association between the abuse of alcohol, especially when associated with intoxication, and engagement in risky behaviours, substantially increasing the risk of STIs including HIV/AIDS. If the HIV pandemic is to be effectively addressed, reducing rates of alcohol misuse and associated risk taking is a key step.

The key components of risk reduction in relation to alcohol use include coalition building, community empowerment, professional capacity building and access to effective and evidence-based treatment. Integrated policies and interventions are needed to address population-level (such as alcohol availability) and individual-level (more specifically targeted to special alcohol contexts and behaviours) problems. Sensible and comprehensive national alcohol policies are a prerequisite to reducing the risk of alcohol abuse and impact on the rates of HIV/AIDS in the community. Increased use of screening, brief interventions, properly targeted social marketing, and the regulation and enforcement of culturally-appropriate laws governing access to alcohol are all beneficial in reducing alcohol-related risk behaviours. It is also important to work in partnership with the alcohol industry as it has more resources and access to the market. The societal response to HIV/AIDS, in which governments, civil society and the alcohol beverage industry work together to promote sensible and sustainable alcohol policies encouraging risk reduction and moderation is essential. Research and evaluation should be carried out to identify the most effective policies and interventions.

Alcohol abuse and misuse should be addressed as part of a comprehensive approach to health. Drinking alcohol is a major social activity in many parts of Africa, especially for men; however, HIV prevention programmes have been slow

to intervene. Interventions to reduce alcohol-related high risk sexual behaviour may need to specifically target men and address their interests, concerns, and needs.

Opportunities exist to incorporate alcohol screening and brief interventions into existing services such as primary care, STI treatment, and voluntary counselling and testing (VCT). Lack of referral systems between HIV and alcohol programmes and services must be addressed.

As part of a comprehensive approach to reduce alcohol-related risk, the following interventions can be implemented: media campaigns to increase awareness of alcohol-related health risks; school-based interventions for high-risk youth; brief interventions for high-risk drinking (prevention and treatment); brief interventions for alcohol and HIV/ AIDS risks and modified alcohol treatment to improve adherence to ARV and TB medication. Key components of a comprehensive programme to reduce alcohol-related risk behaviours include community mobilization, collaboration between public and private partners, training and capacity building for health care workers and public health professionals, and access to effective, evidence-based treatment.

Impact of Alcohol Abuse on HIV Treatment and Options for Treatment of Alcohol Addiction – A Global and Regional Overview

Alcohol treatment is disease prevention and provides opportunities for HIV risk-reduction interventions as well as promoting adherence to HIV treatment. The presenters of this session emphasized that addiction is a brain disease and that a major challenge in the identification and treatment of these patients is that alcohol

and drug dependent individuals are stigmatized by society due to the destructive behavioural consequences of addiction. Consequently, treatment of alcohol addiction requires a bio-psychosocial approach that includes treatment for both physical and psychological dependence. It is also important to understand the diagnostic spectrum of alcohol use disorders focusing on the distinctions and characteristics of heavy drinking, alcohol abuse and alcohol dependence.

Profound neurobiological changes accompany the transition from use to abuse to dependence. Treatment interventions are based on accurate diagnostic assessments. It has been demonstrated internationally (including in Africa) that brief interventions to reduce alcohol use in patients who are heavy drinkers can be effective. Brief interventions are time-limited patient centred counselling strategies that focus on changing behaviour and increasing compliance with treatment medications. They are often used in outreach and primary care settings to change at-risk alcohol use patterns. These interventions can be delivered in primary health care facilities, VCT and HIV care settings by health care providers already assigned to those delivery systems. Patients suffering from more severe alcohol abuse or dependence disorders need more specialized treatment. Treatment for addictive disorders can be provided in a variety of setting including outpatient, intensive outpatient, day care and inpatient settings, depending on availability of these services and the intensity of the disorder.

Psychosocial counselling delivered in individual and group sessions with involvement of family members or significant others is the central component of treatment. The major counselling approaches that have been

shown to be effective internationally are cognitive behavioural treatment, 12-step oriented treatments, and relapse prevention. In addition to counselling, various medications are available that can reduce or prevent feelings of discomfort associated with withdrawal and help restore the chemical balance in the brain, or reduce the desire for alcohol, or produce a highly unpleasant reaction when the patient ingests alcohol.

There are significant challenges and opportunities associated with providing treatment for alcohol disorders in developing countries and in diverse cultural settings. Significant challenges include training and employing addiction counsellors and the viability of outpatient models where transportation may be difficult. An important opportunity exists to cross-train VCT counsellors and HIV care providers to identify alcohol disorders and provide brief behavioural interventions to reduce alcohol misuse and HIV risk in heavy drinkers, and to refer patients with more severe addictive disorders to specialized treatment programmes. While the value of peer-led and free 12-step programmes in any population of alcohol and drug dependent persons has been demonstrated, their applicability varies significantly across cultures and this must be taken into consideration.

A successful approach for delivering services for alcohol treatment and HIV could be to integrate primary health care, HIV prevention, care and treatment, and alcohol treatment services. These health care services should be supported by CBOs, churches, mosques and self-help groups. In this model providers at all sites are cross-trained in HIV and addiction, and VCT, primary health care and HIV treatment sites screen for substance abuse disorders and provide assessment and referrals for alcohol dependence and brief

interventions for at risk drinking. Primary health care and HIV sites can address ongoing medical complications of substance abuse and monitor medications such as naltrexone or disulfiram in conjunction with directly observed anti-retroviral therapy (DART).

One of the most daunting challenges for HIV-positive persons who are addicted to drugs and alcohol is the level of sustained adherence to ART that is required to ensure viral suppression. Studies have shown that increased alcohol consumption may interfere with adherence to treatment regimens. A recent paper by Braithwait et al (2005) describes self-reported alcohol consumption among 2,702 veterans in care and demonstrates a temporal and dose response relationship to poor ARV adherence. The lack of adherence was particularly striking in the currently binge-drinking group. Another study using an intense individual-focused patient intervention to improve adherence in a group shown to be at high risk for non-adherence due to alcoholism was not associated with changes in medication adherence (Samet et al., 2005).

In conclusion, for individuals undergoing treatment with ARVs, alcohol abuse may be a significant negative factor affecting co-morbidity and drug interactions as well as treatment adherence. Targeted screening can identify those with hazardous use, abuse, and dependence, and brief interventions and brief treatment can help patients reduce hazardous use and motivate and assist more severely alcohol dependent patients to seek further treatment. Substance use treatment must be linked to primary care, mental health, AIDS-specific care and related services, such as counselling, testing, partner notification and social services. Important opportunities exist to cross train VCT counsellors and HIV care providers to identify alcohol disorders in

their patients and to provide brief interventions and referral to alcohol treatment programmes.

POLICY AND PARTNERSHIP

Significant challenges exist if the goal of sustainable and sensible alcohol policies at the national level is to be achieved. Alcohol policies must operate in the best interests of the community as a whole. Open debate is essential on the appropriate balance between personal freedom and the role of the state in providing appropriate protection for those at risk. Some of the key factors fuelling the desire for comprehensive alcohol policies include alcohol-related violence, access to alcohol by young people, binge drinking, and social dislocation. A major concern of governments is the increasing cost for police, health and local government in managing the consequences of alcohol misuse. Alcohol policy in the future should be based on creative partnerships, in which all sectors of society contribute to reducing alcohol-related morbidity and mortality.

In many countries, government is the largest financial stakeholder in the alcohol industry and these financial interests must be balanced with the costs of alcohol misuse. Local NGOs have an important role in providing counselling services, referrals, and training, and in advocating for sensible alcohol policies. Integrated policies and interventions are needed to address population- and individual-level problems. Research and evaluation should be carried out to identify those policies and interventions that are most effective in preventing alcohol and drug-related morbidity and mortality.

CONCLUSION

In order to meet the goals for HIV

treatment, prevention and care set by international initiatives such as PEPFAR, the relationship between alcohol misuse and the transmission of HIV must be addressed programmatically. The technical meeting held in Dar es Salaam August 30 – 31, 2005 was a critical step in providing representatives from 13 African nations that receive PEPFAR funding the technical and practical information necessary to develop programming in this area. At the end of the meeting, all of the countries attending developed action plans for possible future activities devoted to reducing alcohol and HIV/AIDS risk. As a result of the dissemination of information presented at the Tanzania meeting, some African PEPFAR countries are incorporating alcohol and HIV programming into their portfolio of services and projects for 2007. In addition, a special USG Technical Working Group (TWG) subcommittee on alcohol and HIV has been created by the U.S. Global AIDS Coordinator to provide assistance to PEPFAR countries in developing alcohol and HIV prevention and treatment initiatives.

This TWG subcommittee has already been tasked with developing two major initiatives: one initiative will address prevention of alcohol-related HIV risk in high-risk venues and another will develop brief interventions to be used in settings where HIV positive patients are receiving ARVs and in selected VCT sites and STI clinics.

Another key outcome of this meeting was the technical and programmatic resolutions made at the 42nd Annual Regional Health Ministers' Conference held in Mombasa, Kenya in February 2006. The Health Ministers, drawn from countries in the east, central and southern Africa regions resolved to incorporate issues related to alcohol in the national HIV/AIDS strategy and ensure that appropriate alcohol and HIV/AIDS

policies, guidelines and programmes are in place. They also resolved to establish a regional and national technical working group to spearhead the implementation of alcohol and HIV/AIDS programmes. At the time of this writing, USG and country technical experts in the region are working to identify critical needs and gaps with respect to national programmes in alcohol prevention and treatment. The data gathered and collected will be presented to Ministers of Health in these regions to help inform national HIV/AIDS programme and policy development.

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Report by:

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AFRICAN JOURNAL OF DRUG AND ALCOHOL STUDIES

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