

Technical Working Group 5: HIV/AIDS and other diseases (MDG #6)

Co-Chair: Deputy Minister of Public Health

Co-Chair: Minister of Martyrs and Disabled.

Minister of Martyrs and Disabled: Thanks this is a very important meeting. Our friends in the international community are seeing that we have made some advances. But there are still lots of diseases, which target the poorest sectors of society, such as children and the disabled. We need preventative strategies to counter diseases such as malaria. We look forward to achieving these goals in the next 10-15 yrs, but this means a lot of hard work. We rely on our good international friends and god to revive our lives.

We continue to need the support of the international community. We cannot wait - we have to accelerate the work and we should take steps to address these deadly diseases. What can we do about the sanitation system of Kabul for example, which causes a lot of water-borne diseases? Children and the disabled don't have access to clean water. MMR is high in the rural areas. It is a shame that there is no data available.

We have tried to do this work within our limited resources. But if we shy away from concrete steps we will not succeed in our work. I believe that malaria and other diseases have been taking the lives of our children who are the future of Afghanistan. As a minister, I thank the MOPH and UNICEF for their good work, but I ask them to take concrete steps.

Dr Pinney: Target 6: halt and reverse the spread of HIV/AIDS. The indicator is the prevalence amongst 15-24 age range of pregnant women. We have no data on this, and are not likely to have any time soon.

WHO: we discussed in the UN, and said that because of cultural constraints, it is not possible. But if the Govt decides to screen all blood donations, we could develop a statistic for the general population based on blood donors for this. If the group agrees, this might be our recommendation.

Dr Pinney: Indicator 19 - of the population using contraception, what proportion of them are using condoms? Very difficult to get this information – sensitive issue. 19a) last high risk sex, b) HIV/AIDS knowledge. We are asking this to household heads rather than just the 15-24 age group. 19c) contraceptive prevalence rate. MICS also provides info on contraceptive knowledge. National average = 72%. Regional variations are not linked to Pastun conservatism, as might have been expected. North has very high levels of ignorance. Overall only 10% of the population are using contraception. Quite low.

Of the population using contraceptives, how many are using condoms? This is for HIV transmission. Pill is the most popular form of contraception. Condom use rate is just 0.4% in rural and 1.3% in urban. Injected contraceptives are more popular in rural areas and sterilization in the urban areas.

We can also look at the ratio of school attendance by orphans. A child is least likely to go to school if his father is dead. If the child's mother dies, a little less likely, and if both parents die, as likely to attend school as other kids.

Chair (MoPH): The question of culture is not just Afghan, it is Islamic and Islamic culture cares for the orphans. WHO were convinced that HIV was very low in Pakistan. Their consultant said that whatever it was, should be strengthened. This is also true here.

Dr Sinha: how reliable is the data on knowledge of contraception? We are asking married women. But my experience in India is that married women don't like to admit to knowledge of contraception because it implies promiscuity. Might be same here?

Dr Pinney: trying to collect again in 2005. Big sample, nationally representative etc. We are using women to talk to women, a safer environment.

Chair: Do our partners have a guesstimate?

UNICEF (Linda): I think I read a 1% estimate? At UNICEF, we have 3 surveys going out this year, 1 for TB patients and the other amongst IV drug users, and the last will be a behavioural survey. We have discussed the possibility of testing pregnant women, but since most are outside health care system it is not possible, so the blood donors are most important for this.

USAID: UNAIDS says HIV rate is 0.01% in 2000. Based on the refugees in Pakistan? Modeled.

Chair: The University of Minnesota is working on a large-scale mathematical model to estimate HIV and then suggest prevention methods. Why are we looking at young pregnant women? Would be easier in the general population.

Dr Sinha: Because we are trying to halt the spread which is usual during pregnancy.

Dr Pinney: Also because pregnant women are usually in health care and drugs can be administered.

WHO: Is this even feasible? Should we be trying to collect this info, just for the sake of the indicator?

SDC: There is a huge problem with identifying people with HIV AIDS - when people find out they are stigmatized by society, then they don't come forward for treatment. Important to give information and de-stigmatize them. It's also key to educate the health professionals who have unacceptably low levels of knowledge.

Dr Pinney: University of Minnesota must have to collect some data. Can we look at their plans for empirical data collection and influence them.

Chair: we have received a proposal. Can we involve them in the MDGs? But they don't have the funds.

HNI: If women are concerned about being tested in ante-natal clinics, this might further decrease their attendance.

Linda, UNICEF: this is a target for countries that are really over-burdened by AIDS. Can we not focus on the prevention education type stuff?

CSO: I also share the view that we should Afghanise this indicator. Some refugees who have come back from the Gulf countries and have been infected by HIV and now are here. Therefore preventive measures must be taken. But still not like other countries. Data collection is a problem - socially and culturally, it is hard for people to speak about this. I do not agree with the figure on contraception prevalence. We are making a lot of campaigns, so it might be that they are very reluctant to admit this knowledge of contraceptive measures. It is better if we select an indicator on which we have data. Others are not relevant to Afghanistan.

MOWA: One other issue is addiction to drugs. We don't have data on HIV. We don't have good health facilities to test so we just can't judge the prevalence.

Chair: we must not delude ourselves. We are low prevalence, but high risk. We must not sit back and take no action. It will rapidly increase. What should be our target on the knowledge of the HIV/AIDS?

Farhadi: The problem here is not just sexual, it is about IV drug use. We need to reflect the drug use issues in the MDGR.

SDC: That's a good point. But let's not exclude the high risk behaviour group. There is a survey amongst this group in kabul about to be released. To focus on the knowledge, we first need the baseline, and we should not get away from the surveillance of the general population.

WHO: There is a national task force. What is their strategy? Off the record, ICRC collected data on the Hep B in a small area 5 yrs ago, and found that high levels of blood for transfusions were infected. In Quetta camp - 8.3% had Hep B in 2003. Others are coming to clinics with other STDs as a result of high risk behaviour so might assume that HIV is more of a problem than we can see at present. Let's focus on 15-49. This is the full reproductive group, plus captures the wealthy and ultra-mobile who are especially at risk of bringing this disease into the country.

Chair: Let's consider it.

MOWA: I have a question. Do you see a link between malaria and HIV AIDS transmission. Does the mosquito transmit from one infected person to the next?

USAID: there is no relationship.

Chair: There is a relationship between HIV and TB as HIV reduces the immunity and makes people more susceptible to TB and other diseases. No data. The mosquitoes do not transmit.

Linda, UNICEF: I support the expansion to 15 - 49 (the reproductive age group).

WHO: the key is comprehensive and correct knowledge. 100% is a challenge. We don't have a baseline.

Actionaid: What do we mean by comprehensive?

Chair: Of course some questions are culturally inappropriate, and we will change them.

Actionaid: 100% is too high. Assumes everyone has access to media and education.

USAID: MoPH has a lot of competing priorities and can't get funding because it is the low prevalence. Risks sidetracking the Ministry. The targets should be set according to the scale of the problem.

Dr Pinney: 55% of rural population has a radio. We assume it works and they can get reception.

Chair: I don't know if we need to aim for 100%. There is a concept called herd immunity - don't need 100% vaccination. If 80% have knowledge it is reasonable.

USAID: are we focusing more on rural or urban. Is there a priority?

Chair: that is a question for the ANDS.

Linda: 50-60 % is more realistic in a semi-literate country

HNI: challenge to maintain levels. That has slipped in Europe and is now manifested in higher risk behaviour and higher prevalence rate.

Chair: By 2015, at least 50% of population aged 15-49.

Andrew: Orphans indicator only applies to countries where there is a prevalence of 1%, but we are probably not at this level. So we probably don't have to report against this, although we do have the data.

Chair: we can expect the rate to increase. By 2015 the language might be relevant.

SDC: Planning to set up 5 centres so we can keep track, also through blood donations. This is practical.

Chair: should we have something for safe blood.

WHO: It tends to be high risk (i.e. IV users) who give blood for cash incentives. The Govt must screen 100% blood screening for HIV and other STDs.

Chair: I like that suggestion but the private sector might make it difficult for the Govt to control screening practice.

HNI: Education should lead to high demand for the screened blood.

Chair: Let's go for 100% of blood to be screened. This could prevent a lot of diseases. This is a very important for the investment.

WHO: Make it a requirement. Legislation is easy but implementation tougher.

Chair: By 2015, 100% of blood will be screened.

Chair: Percentage of 15-49 yr olds with correct comprehensive knowledge of HIV = at least 50%
Screening of blood donations = 100%. Prevalence - Should we try to keep it at less than 1%?

Actionaid: This is still a high figure in the overall population?

WHO: Keep it at 0.01%, which with pop growth = 30,000 people.

HNI: Still have to work out how to measure the prevalence.

Chair: this can be done through screening blood. Formula can then be used to estimate the national rate.

Dr Pinney: Are we getting rid of the contraception indicators? We have these data for the rural pop. The condom use is a frontline tool in the battle against HIV.

IMF: It is very risky to be setting targets and benchmarks when we know so little of the current situation, and so much about the transmission mechanisms. To think we can contain it to these arbitrary numbers is very risky.

Linda, UNICEF: Support measuring contraceptive prevalence as it is important for maternal mortality also.

HNI: 0.5% is as good as we can get for the HIV prevalence target. Given that we don't know the real current situation.

WHO: This gives the impression that we are still expecting Afghanistan to have HIV in 2015. So why don't we have an annual reduction of 10%, so that by 2015 leads to 100% reduction.

Chair: But there is no cure, so yes we have to expect that there will be many more cases.

HNI: There is a very long latency period and so the cases registered in 2015 will be the result of infection from years before. The cases are coming in from abroad and less than 0.5% is unrealistic.

Chair: can we agree to this? Please record this. It is of the sexually active population – 15-49 yrs.

Linda, UNICEF: contraceptive prevalence rate and the unmet need for family planning are good indicators for the maternal morbidity. Can we set some goals and targets? We could say 90% of wants met.

Chair: Much more appropriate.

Linda, UNICEF: suggested language: "Proportion of desire for FP satisfied". We should aim for 50% in ten years. We should also measure contraceptive prevalence but there is no need to set a goal for it.

SDC: As we educate the population, we will increase the desire for FP, and therefore the demand will go up and unmet needs may also increase until FP services can catch up.

Dr Pinney: define this as desire of women, rather than the household as it might be difficult to assess it on a household level.

HNI: Do women have the decision making power?

Chair: Are we assessing the household need or the woman's desire.

WHO: Decision making powers rest with the man and the mother in law. But we want to measure the desire of the women. Bring the married coupled together to ask them?

Dr Sinha: Well, we hope for some other social change. How will we collect the data on this. Household surveys talk to the wrong people.

WHO: If we have a network of MCH facilities that can be a source of data.

Linda: we get it from MICS. We should definitely collect amongst women alone. We can also do it at the household level - this might show the disconnect between the women and the family needs/wants. That could then feed into a public info campaign.

SDC: But we want to focus on the condoms use. And this is the male's decision.

Chair: lets go with 50%

Dr Sinha: something on IV drug users as a proportion of HIV patients.

Actionaid: IV community is a key spread in FSU and Tajikistan. People in treatment as an indicator. Is this issue being addressed?

Suggested language: a measure of preventing spread in the IV community is the fact that they are in treatment. Say 60% of known IV drug users should be in treatment.

Chair: feasibility of measuring this. Likely to be truck drivers who spread it.

WHO: these IV drug users can be reached through the NGOs.

MALARIA:

Dr Pinney: case load captured by official mechanisms. But up to 80% might be being treated in the private sector, so massive under reporting is likely. Low malarial rate compared with SSA. Determining malaria as a cause of death is very hard so no data. We have seen a big reduction. Vivax does not have resistance yet. Expansion of treatment availability. More bed nets. Length of winter in the north means a shorter malaria season.

Estimated high risk pop = 11.6m

700k bed nets have been distributed - 18% coverage assuming covering 3%.

Nets need regular treatment and therefore probably not that good.

HNI: 2003 figures were not lab confirmed and 2004 were. So, difficult to compare and the significant drop is for different reasons. Drought has had a big impact but this year was very wet so higher prevalence.

Chair: The fact that malaria is due to so many different factors, can we put this in?

WHO: It is relevant.

Chair: indicators?

WHO: long-lasting treated bed nets. The other one is prevalence. In 2006 national strategy will start the study for the baseline.

HNI: these are sufficient. Want to cover 60% of the at risk population with bed nets in 2010. This is the herd immunity threshold.

Chair: for 2015?

HNI and WHO: 80%. To reach the 2010, we need 1.2m bednets. And if we reach this, then 80% is not so far off. Suppliers tend to be the weak link in the chain.

WHO: there is a target to reduce by 50% by 2010. But we'll get the baseline in 2006.

TB

Dr Pinney: Total active caseload = 333/100,000. Infection rate has fallen from 3% to 2.5%. Proportion of TB cases identified and treated under DOTS. 2004 - 18,402 and 85% treated. 21% of new cases successfully identified and treated in 2004.

HNI: 3% infection rate is from 1978 and studies conducted amongst refugees in Pakistan have always been lower. Kabul study in 2000 - 0.6%. Infection likely to be much lower than we think. The HIV study by the global fund will also look at this.

Chair: so we have a process and outcome indicator

HNI: death rate not really a good place to focus. 70% of estimated cases, of which 85% must be successfully treated.

Chair: how can you get to the 70% of cases detected. How do we detect the undetected - i.e. the overall prevalence rate.

HNI : Prevalence is very challenging.

Chair: 2015 target - 70% of cases detected and 85% treated successfully.

Chair: Source of data:HMIES, global fund survey.

Farhadi: Hygiene awareness is very important.

Dr Sinha: as a means of preventing disease.

Chair: interesting. Should we add it?

WHO: under environment and wat san.

Linda: Suggested indicators from the MDG website. Child mortality: neonatal mortality - most U5 and infant deaths are neonatal. Prevalence of underweight children. Maternal Health: percentage of the population covered by emergency obstetrics care. Also: Adolescent fertility rate ?

Chair: we'll capture the reasoning and the other suggestions.

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