Health
Briefing Papers

The Issue of Ending the Stigma around HIV and AIDS

One dictionary definition of **stigma** is "the shame or disgrace attached to something regarded as socially unacceptable", but to most people stigma is often attached to things which evoke fear. Since the first case of AIDS was diagnosed in the early 1980s, those living with HIV have been socially outcast and stigmatised. Today there is a growing international effort within health circles to attempt to break down this stigma.

Around the world, reactions towards HIV and AIDS epidemics have raged from hostility and outright violence to silence and denial. The social stigma is particularly damaging towards those who fear being branded and therefore keep their diagnosis silent, preventing them from being tested for the virus, consequently not seeking treatment. Since the 1980s, it has been proven that those thought to have the virus may be abused, shunned, denied jobs and housing or even refused care in many parts of the world, further hindering efforts for treating and possibly eradicating the disease.

Traditionally, the stigma around AIDS has been coupled with a homophobic stigma against the LGBT community, especially against gay and bisexal men. This is because you are 18 times more likely to contract HIV through unprotected anal sex than unprotected vaginal sex. Perhaps there is a deeper homophobic issue which needs to be tackled along with the ending of stigma surrounding the virus itself.

As of June 2016, 18.2 million people living with HIV were having treatment via AVT (Antiretroviral Therapy) - this figure an increase from 15.8 million in 2015, 7.5 million in 2010 and less than one million at the turn of the century. Although this is a promising increase in the number of infected patients accessing treatment, it resembles less than half the world's population of people living with HIV/AIDS. It is believed that up to 40% of these people live in countries where they do not feel comfortable and even safe from revealing their health status, preventing them from much needed treatment.

African government officials attending HIV/AIDS discussions in 2001 began a research agenda into the disease recommending action in these four areas:

- **The Family** - responding with home based care and similar programs, bearing in mind that children face unique challenges and should be active partners rather than passive recipients in any intervention.
- **Health Care Settings** - developing discharge and referral systems that are sensitive to people's needful privacy, developing codes for ethics and

professional conduct for health care services and offering for of redress when violations occur.

- **The Religious Sector** - identifying language and doctrines that may be stigmatising and promoting caring and non-judgmental alternatives
- **The Mass Media** - developing media standards for journalists who report on HIV/AIDS, holding communicators accountable for reporting the epidemic accurately and sensitively.

It is evident that schemes such as these are a step in the right direction. However, although proposed, they often fail to take off and require a global push when implementing them. More is required to prevent the stigma surrounding HIV/AIDS, and it urgently requires an international response.

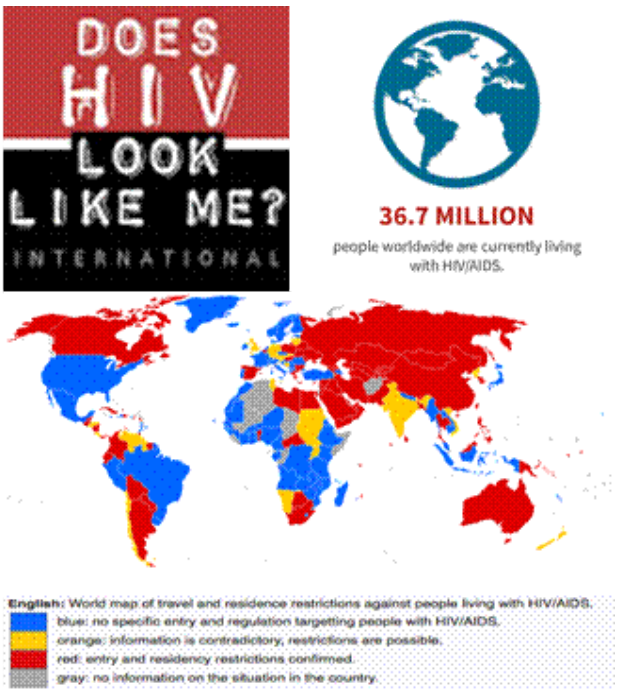
Points to Consider:

- Is there a way of encouraging countries to end discrimination, callous actions and bigotry against those with HIV and AIDS?
- How can the UN help those with HIV and AIDS to disclose their status without fearing exclusion in their community?
- How can the UN promote equality for those with HIV and AIDS and end punitive laws?

Useful Links:

https://www.nzaf.org.nz/getting-tested/testing-month/hiv-risk-for-gay-men/

https://aidsinfo.nih.gov/



The Issue of the Illicit Organ Trade

Improvements in the success of transplant surgery in recent decades have created a surge in demand for organs. However, as this demand has outstripped the supply, a black market for organs and transplant surgery has emerged.

Illicit organs come from two main sources, either voluntarily sold by individuals or involuntarily taken, often from victims of human trafficking. The majority of organs come from Asia and North Africa, but it is also becoming an issue in more developed countries, with reports of organ harvesting emerging from the UK and across Europe.

Most illicit organs are sold for transplants in the Middle East, Europe and America, where a heart can cost up to £1 million. A small market also exists for illegal medical experimentation and religious rituals. The people involved in the illicit organ trade varies widely, from doctors and patients looking for an alternative to long waiting lists, to organised criminals and terrorist groups such as the Islamic State trying to generate income.

The World Health Organisation (WHO) estimates that that as many as 20% of all organ transplants are illegal, and that this generates more than $1.2 billion. However, the nature of the trade means that it is incredibly difficult to accurately determine the true scale of the problem.

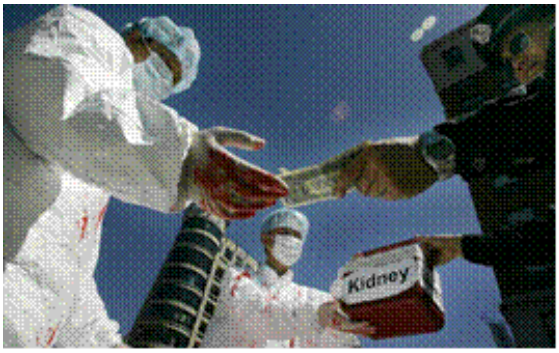
For patients, participation in the illicit organ trade can have disastrous consequences. Those receiving illegal transplants are at risk, particularly as they often lack the crucial long-term care that accompanies legitimate transplant surgery. In addition, donors are regularly exploited, enduring procedures that conform to few medical standards and leave them with long-term health problems.

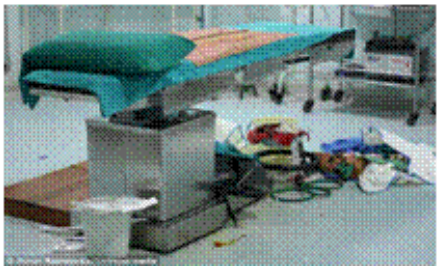
The illicit organ trade also has repercussions for legitimate transplant surgery. Stories of botched transplants have been found to deter patients from choosing a transplant when they need it. Furthermore, reports of organ harvesting have done little to encourage the public to sign up to organ donation schemes. This creates downward pressure on the supply of organs, making the illicit market more attractive for patients in need of a transplant.

<u>Points to Consider:</u>

- How can we gain better information about the illicit organ trade?

- How can the harvesting, smuggling and use of illegal organs in transplant surgery be stopped?
- What can be done to increase the supply of legal organs?





The Issue of Ensuring Access to Healthcare Among Refugee Populations

The human tragedies experienced in recent years when 2 million refugees fled ethnic and political violence in Rwanda are a dreadful illustration of how 'refugee emergencies kill'. The mass exodus overwhelmed the world's response capacity. One million Rwandan refugees fled to Zaire (now the Democratic Republic of the Congo, since 1997) over a period of days in mid-1994, where some 50,000 refugee lives were lost in a few weeks, primarily to cholera. At the same time, nearly one quarter of the children in the camps hastily established for these refugees were found to have acute malnutrition.

The challenges of ensuring access to healthcare among refugee populations can be divided into three areas:

1. **Mortality -** A mass influx of refugees always creates the immediate danger of major loss of life. Mortality rates that are catastrophic have been documented during large refugee emergencies such as in Rwanda, listed above. The main concern often comes in the first few days or weeks of an influx, and it is in this period that refugees are often most vulnerable, so it is imperative that all vital sectors are prepared accordingly.

2. **Cause specific mortality** - The major causes of morbidity or mortality amongst refugees are diarrhoea diseases, measles, respiratory infections, and malaria. These diseases consistently account for between 60-80% of all reported causes of death. Most of these leases are easily curable and require limited but essential attention from a healthcare professional.

3. **Malnutrition -** The various forms of PEM (Protein Energy Malnutrition) remain the most common problems. However, in recent years more micronutrient deficiency diseases have been reported among refugee populations entirely dependent on external food aid. Most notable outbreaks include Mozambique in 1988 and around the Horn of Africa.

The United Nations High Commissioner for Refugees (UNHCR) has developed basic standards for the most vital sectors including:

- **Water** - minimum survival 7 litres/person/day, target 15-20 litres/person/day
- **Food** - daily caloric requirements 2100 Kcals/person/day

- **Sanitation** - excreta disposal 1 latrine/20 person
- **Shelter** - minimum shelter area 3.5 sqm/person

These basic guidelines help to reduce fatalities by an estimated 67% which ensures that during the host Governments mobilisation period, refugees can remain as healthy as possible. The UNHCR emphasises the requirement of a Primary Health Care (PHC) approach, focusing on preventative programmes which offer one term advantages for the refugee population but also for the host country. The PHC strategy is sustainable and also helps strengthen the national health development programme.

Achieving the main goal of sustainability and integration into the host country's national health system is often the most difficult step to take. Parity requires that the services provided to refugees should be at a level equivalent to that appropriate in the host country however this often far from the case. The best way of achieving this parity is to support and strengthen local health services so that vital medicines and vaccines can be administered to the refugee population.

<u>Points to Consider:</u>

- How the UN supply medicine such as vaccines to Refugees in order to help reduce the pressure they have on the healthcare systems of host countries, including the spread of tropical diseases.
- How to best to employ an appropriate health and nutrition information system to those affected?
- How best to achieve sustainability involves reaching broad parity and integration of refugee and national health services?