

# THE CIRCLE of hope NEWSLETTER



The First Nations  
and Inuits of  
Quebec HIV  
and AIDS  
Strategy



Spring 2012

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“ To work together in the spirit of honor  
and respect towards a holistic  
HIV/AIDS strategy for the First Nations and Inuits of Quebec ”

# Words from THE PROGRAM AGENT

Greetings to all,

A few months ago, I replaced Louise Tanguay and I am now working on the HIV/Aids file. Sexual health and the stakes surrounding the issue fascinate me! I am looking forward to working with you on exciting and innovative projects supporting the maintenance and adoption of healthy sexual practices in your communities.

Already, in December, you received nice red bracelets in the context of the 2011 Aboriginal Aids Awareness Week. We hope these were useful to you and we encourage you, if you haven't already done so, to distribute them during meetings focused on sexual health with the youth. They will certainly be interested in the information included on the flash drives!

The report on the sexual behaviours study will be published very soon. This report will be a great source of information for you by providing a portrait of the sexual habits, beliefs and attitudes of the youth and adults in the communities. These results must be a springboard for action. That is why we are offering our support for the implementation of the recommendations resulting from this study. Please do not hesitate to call on us!

Finally, we have developed, in collaboration with a First Nations consultant, a workshop on homosexuality. The objectives of this workshop are to demystify the terms related to

homosexuality, raise awareness regarding the prejudices being circulated to the detriment of homosexual individuals, reflect on the effects resulting from homophobia and develop new attitudes and behaviours towards homosexual people. The workshop, available both in French and English, is intended for high school-aged youth and can be provided for example at the school or youth centre. If you are interested in this workshop, please contact me! Note that there are no fees for us to provide it.

I hope that this new edition of the Circle of Hope will inspire you!

Marie-Noëlle Caron  
Public Health Advisor

**Espace ITSS,  
it's for you!**

ESPACE **ITSS**  
DES REPÈRES POUR MIEUX AGIR

This new website, which is piloted by the *Institut national de santé publique du Québec*, offers you access to:

- Practical and relevant tools
- Recent productions and emergent information on STBBI
- Fact sheets
- Training capsules
- Inspiring interviews with interveners in the field.

Visit our site at <http://www.espaceitss.ca>

## THE CIRCLE OF HOPE NEWSLETTER

This NEWSLETTER aims to provide an information and communication platform to all the people affected by HIV and AIDS among the Quebec First Nations and Inuits. It also aims to provide an update on the FNQLHSSC HIV/AIDS-related projects. If you wish to subscribe to receive your free copy of the newsletter, or if you wish to publish a text, personal account or open letter, please contact the FNQLHSSC at 418 842-1540. The opinions expressed in this NEWSLETTER are those of the authors and do not necessarily reflect the official positions of the FNQLHSSC.



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Graphic design : Siamois graphisme

# YOUTH AND SEXISM: From Inequality to Indifference

## UNRAVEL SEXISM AMONG YOUTH IN YOUR COMMUNITY!

The latest issue (#19) of *The SexEducator*, published by the *ministère de la Santé et des Services sociaux*, presents a series of articles on sexism in young people. It outlines the most recent information about sexism during adolescence as well as provides a starting point for reflection about ways to address the issue with young people.

It includes among others:

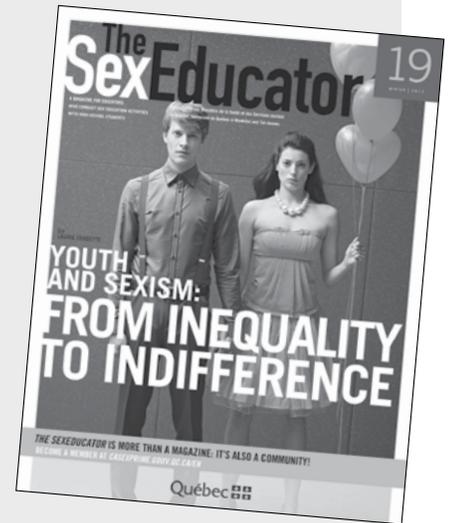
- Definitions;
- Examples of sexual stereotypes associated with boys and girls;
- Elements of context conducive to the development of stereotypes;
- Demonstrations of sexism in young people;
- Consequences of sexism and sexual stereotypes;
- Suggestions for learning activities for interveners.

One of the best ways to foster relations free of sexism between boys and girls is SEX EDUCATION.

**SO, IT'S UP TO YOU!**

**PARTICIPATE IN THE DEVELOPMENT OF A COMMUNITY WHERE THERE IS GENDER EQUALITY!**

See the online magazine: [casexprime.gouv.qc.ca/en](http://casexprime.gouv.qc.ca/en)



## CONFERENCES to come



### 16th Annual BC Aboriginal HIV/AIDS Conference

**“Weaving Collectively the Intricacies of HIV/AIDS through Culture and Knowledge”**

Healing Our Spirit BC Aboriginal HIV/AIDS Society  
April 16 and 17, 2012  
Kamloops, BC



### The Canadian Association for HIV Research

**21st Annual Canadian Conference on HIV/AIDS Research - CAHR 2012**

The Canadian Association for HIV Research  
April 19-22, 2012  
Montréal, Quebec



### AIDS 2012 - XIX International AIDS Conference / International AIDS Society The Canadian Association for HIV Research

July 22-27, 2012  
Washington DC USA

**International Indigenous Pre-conference on HIV & AIDS, TO SEE AND BE SEEN will precede the International AIDS Conference is to be held on July 20 and 21, 2012.**

# Beyond equity

## In the current context, the vaccination of boys would not constitute an effective strategy for fighting against HPV.

Including boys in the vaccination campaigns against the Human Papillomavirus (HPV) would only yield limited benefits in terms of public health, asserted a team of the *Unité de recherche en santé des populations* (URESP) in a recent edition of the *Journal of Infectious Diseases*.

HPV is among the most common types of sexually transmitted infections. Certain forms of the virus cause genital or anal warts and lesions among men and women. Other forms are associated with cervical, anal, penile, mouth and throat cancers. Since 2007, the Canadian provinces have implemented HPV vaccination programs targeting girls ages 9 to 13 years before any infections are present.

### SENDING A MESSAGE

Controversial on many fronts, HPV vaccination also raises eyebrows for equality reasons: why vaccinate the girls and not the boys? The critics particularly mention the protection of homosexuals and the importance of sending the message that both genders have an equal responsibility in terms of preventing infections.

Marc Brisson, Nicolas Van de Velde, Mélanie Drolet, Marie-Claude Boily from the URESP and Eduardo Franco from McGill University have evaluated the effects of various vaccination scenarios thanks to a HPV propagation model that they developed. This model takes into consideration numerous variables related to the biology of the virus (probability of contracting it, probability that a lesion will evolve into cancer...) and the dynamics of human sexuality (level of sexual activity, number of partners...). "It's the most complex model I have ever worked on", underlined Marc

Brisson. "It was necessary to use the super-computers of Université Laval and the Imperial College London in order to perform the simulations."

### A BENEFIT OF 20%

The researchers therefore calculated the additional benefits that a vaccination of an equal percentage of girls and boys would provide. And what was the result? There would only be a 20% benefit on a population-wide scale. The vaccination of the boys would therefore yield benefits, but not benefits that are in line with the efforts invested, concluded Marc Brisson. "It would be more effective to increase vaccine coverage for girls by a certain percentage." When this percentage is high, not only are more girls immunised, but many boys will also never contract the virus.

The vaccination of boys therefore does not constitute the best use of available public funding earmarked for countering HPV. "The situation could change if the price of the vaccine were to decrease", the researcher specified. "We are currently trying to establish at what price the vaccination of boys would be justifiable from a population perspective."

— JEAN HAMANN

Source: Magazine Contact, winter 2012, volume 26, edition 2, p. 7  
<http://www.contact.ulaval.ca/index.html>



Marc Brisson, of the Unité de recherche en santé des populations, developed with his team a HPV propagation model taking into consideration the biology of the virus and human sexual behaviours.

## Global health sector strategy on HIV/AIDS 2011-2015

The WHO *Global health sector strategy on HIV/AIDS, 2011-2015* promotes a long-term, sustainable HIV response through strengthening health and community systems, tackling the social determinants of health that both drive the epidemic and hinder the response, and protecting and promoting human rights and promoting gender equity as essential elements of the health sector response.

You will find more information about this new strategy on the World Health Organization website at <http://www.who.int>



# Did you know that...?

Researchers from the University of Western Ontario have announced that a preventive vaccine against HIV/Aids created in Ontario will soon be tested on humans.

The FDA (the American agency responsible for drug administration) has given its endorsement so that phase 1 clinical trials can take place on 40 HIV-positive individuals as of January 2012.

Since 2005, the team of Dr. Chil-Yong Kang has been working on this vaccine which could eventually help to contain the propagation of the virus.

“FDA approval for human clinical trials is an extremely significant milestone for our vaccine, which has the potential to save the lives of millions of people around the world by preventing HIV infection.”— Dr. Chil-Yong Kang.

The researchers have explained that the results of the SAV001 vaccine obtained on animals demonstrate a positive reaction from the immune system without any side effects or health risks.

No other vaccine against HIV/Aids is currently being developed in Canada. The SAV001 vaccine will be one of approximately thirty vaccines being tested on an international scale. To date, despite significant scientific resources, no vaccine has been commercialised yet.

The steps:

- **Phase 1 trials:** The data collected will serve to ensure that the vaccine is safe for humans. It will be administered among 40 HIV-positive individuals.
- **Phase 2 trials:** This step will allow for measuring the immune response among humans. Approximately 600 HIV-negative individuals who are at a high risk of infection will receive the vaccine.
- **Phase 3 trials:** This is the stage in which the actual effectiveness of the vaccine is tested. Approximately 6000 HIV-negative individuals will participate in the trials.

Source: <http://www.radio-canada.ca>

## Reducing mother-to-child HIV transmission in Canada

3 February 2012

In high-income countries such as Canada, the United States and in Western Europe, great strides have been made in reducing mother-to-child transmission (also called vertical transmission) of HIV. This has come about because the following steps have been instituted:

- offering HIV testing to pregnant women
- offering prenatal care for HIV-positive pregnant women
- the use of potent combination HIV therapy (commonly called ART or HAART) during pregnancy
- intravenous AZT (zidovudine, Retrovir) for the mother during delivery
- six weeks of oral anti-HIV therapy for the infant after birth
- use of formula rather than breast milk for feeding (breast milk can contain HIV)
- HIV-positive parents not pre-chewing food for infants (this can sometimes transmit HIV)

By implementing all of these steps, HIV-positive mothers can give birth to a healthy HIV-negative infant and maintain their child's health as it develops.

As part of the Canadian Perinatal HIV Surveillance Program (CPHSP), researchers have been studying vertical transmission and ways to minimize it for the past 20 years. In their latest report they document profound reductions in vertical transmission that have occurred in Canada during the study. Their report, published in the journal *AIDS*, points to future directions for research and support so that the rate of vertical transmission can be further reduced.

### STUDY DETAILS

Researchers collected health-related information about pregnant HIV-positive women and their infants between 1990 and 2010, from 22 health departments in all Canadian provinces and territories. ▶

The HIV status of the infants in the study was confirmed in one or more ways, as follows:

- testing two separate blood samples for HIV's genetic material by PCR (polymerase chain reaction)
- culturing HIV from blood samples
- the presence of HIV antibodies in the infant's blood 18 months after birth

The researchers divided their study into the following two time periods:

- before 1997
- 1997 and later

This division was necessary because the availability of HAART in 1997 greatly changed most doctors' approaches to managing pregnancy in HIV-positive women.

The study team focused on 2,692 mothers and their infants.

The CPHSP's data was analysed by the Canadian HIV Trials Network (CTN), which is funded by the Canadian Institutes of Health Research (CIHR). CPHSP's work is supported by the Public Health Agency of Canada.

## RESULTS—FACTORS AFFECTING TRANSMISSION OF HIV

Researchers noticed a decline in vertical transmission after 1994, when clinical trial results found that the drug AZT greatly reduced mother-to-child transmission. An even greater reduction in HIV transmission occurred after HAART became widely available in 1997.

Overall, there was a transmission rate of 5% in the study. However, this figure masks changes in transmission that occurred over time. For instance, transmissions were distributed as follows:

- before 1997 – 20% of infants were infected
- 1997 and later – 3% of infants were infected
- But the figures for 1997 and later can be broken down, revealing further differences in transmission rates as follows:
- among mothers who used HAART – 1% of infants were infected
- among mothers who were prescribed only one or two anti-HIV drugs – 1.6% of infants were infected
- among mothers who did not receive any anti-HIV treatment – 16% of infants were infected

## TIMING OF HAART MAKES A DIFFERENCE

The researchers investigated the timing of initiating HAART among pregnant women and found that there were differences in infection rates of their infants as follows:

- among women who started HAART more than four weeks before they gave birth – 0.4% of their infants were infected
- among women who used HAART for less than four weeks while pregnant – 9% of their infants were infected

The research team did not provide details as to why some women did not receive HAART.

## DELIVERY METHODS

Starting in 1999, the researchers' database consistently collected information about how babies were delivered. Between 1999 and 2010, about 60% of births were vaginal and 40% were Caesarian (C-section). The overall rates of HIV transmission between these two modes of delivery were as follows:

- vaginal delivery – 2.8% of infants were infected
- C-section – 1.9% of infants were infected

These differences in infection rates between the two modes of delivery were not statistically significant.

However, the mode of delivery appeared to have a significant impact on HIV transmission depending on whether or not the woman used anti-HIV therapy. Among women who used HAART, having a vaginal delivery or C-section did **not** result in statistically significant differences in the rates of infection as indicated below:

- mothers who used HAART and who had a vaginal delivery – 0.6% of infants were infected
- mothers who used HAART and had a C-section – 1.4% of infants were infected
- Among women who did **not** use HAART, differences in infection rates emerged when analysed by delivery method:
- mothers who used no, one or two anti-HIV drugs during pregnancy and had a vaginal delivery – 10.3% of infants were infected
- mothers who used no, one or two anti-HIV drugs during pregnancy and had a C-section – 3.8% of infants were infected

## ACROSS CANADA

Mother-infant pairs were distributed across Canada as follows:

- Ontario - 33%
- Quebec - 28%
- British Columbia - 15%
- Alberta - 14%
- Saskatchewan and Manitoba - 9%
- Atlantic provinces - 1%

During the study period, *one* HIV-positive mother gave birth in northern Canada (North West Territories, Nunavut, Yukon).

## CHANGES IN ETHNO-RACIAL GROUPS

Women in the study self-reported their race/ethnicity. Based on these self-reports, the ethno-racial distribution of women was as follows:

- Black - 46%
- White - 28%
- Aboriginal - 19%
- Asian - 3%
- Latin American - 1%
- unknown - 3%

Over the course of the study, the overall proportion of White women fell from 47% before 1997 to 25% after 1997. In contrast, in the same time periods, the proportion of Black women increased from 35% to 48% and that of Aboriginal women from 14% to 20%.

### Risk factors

Unprotected sex with a man was the most common HIV transmission risk factor for women in the study (65%). This was followed by injecting street drugs (25%) and receipt of contaminated blood or blood products (1%).

## IN PERSPECTIVE

The present study demonstrates the profoundly beneficial protective effect of HAART on the fetus. The overall vertical transmission rate among women who used HAART in Canada is about 1%. Among women who initiated HAART well before the final four weeks of pregnancy, the transmission rate fell to 0.4%. These figures are similar to those reported from other high-income countries such as the UK, Ireland and France. However, much work remains to be done so that the figure in Canada can fall to zero.

## NOT IN CARE

According to the research team, since 1997 very few infants—about one or two per year—were born in Canada to HIV-positive mothers who did not receive HIV care during pregnancy. Among such infants, about 50% were HIV positive by the time health care workers could conduct HIV testing three to nine months after they were born.

The study team did not provide details about why these women apparently were not tested for HIV while pregnant. However, the researchers suggest that some of these women are “likely from marginalized populations who do not access [medical and social services during pregnancy].”

## NOT GETTING HAART

Another problem that researchers found is that since 2006 each year between 2% and 6% of HIV-positive mothers did not receive prenatal care or were not prescribed HAART. According to the researchers, one reason that may explain some of these cases is that HIV infection was not diagnosed until delivery or after delivery.

## IMPROVING CARE

To help prevent further cases of vertical transmission, the researchers call for more study and resources to be directed at “more vulnerable populations, including immigrant and Aboriginal women as well as women who use injection drugs.”

— SEAN R. HOSEIN

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Source : CATIE-News: Bite-sized HIV/AIDS news bulletins  
<http://www.catie.ca>

# On the trail of the origins of the epidemic

By: André-Constantin Passiour

Dr. Jacques Pepin is a distinguished infectious diseases specialist at the department of microbiology and infectious disease at the *Université de Sherbrooke*. He has recently published a surprising and captivating book entitled “The Origins of AIDS”. Having actually worked for many years in Africa, he was in contact with the populations that are affected by this disease. His experience in “bush medicine”, the advances of the time and mass vaccinations led to his pursuing research on the HIV virus. He examined documents closely and went back in time in order to discover that the virus has existed for much longer that we had believed. When it spread into North America and Europe, gay men were essentially the victims. Why and how? Dr. Jacques Pépin provides explanations in an interview that was conducted following the publishing of “The Origins of AIDS”.

## WHAT ENCOURAGED YOU TO WRITE THIS BOOK AT THIS POINT IN YOUR PROFESSIONAL LIFE?

I was first of all interested in the role of the medical interventions in the emergence of HIV. I worked for four years in Zaire during the 1980s and while I was there, I treated, among other things, approximately a thousand patients struggling with sleeping sickness by using old medications administered intravenously. Later on, I worked for two years in Gambia on HIV-2 infection. One day, I understood that much of the HIV-2 transmission in West Africa was due to contaminated injections rather than sexual transmission. I conducted a first study in Guinea-Bissau confirming this intuition. Then, I decided to conduct similar studies in the Central African Republic and Cameroon - regions from which HIV-1 potentially originated from. Little by little, I came to the realisation that I had enough material to write a book. I devoted a few years to getting the other parts of the story in order to finally put it all together. I therefore used, in part, research reports that are available through the scientific literature, but I especially relied on many historical elements that I dug up among libraries and archives in Europe.

## IN YOUR WORK, YOU MAINTAIN THAT LEOPOLDVILLE (TODAY KINSHASA) IS THE LOCATION WHERE THE MUTATION OF THE DISEASE FROM MONKEY TO MAN BEGAN. HOW DID YOU ARRIVE AT THIS IMPORTANT DISCOVERY?

Leopoldville is the location where the virus spread out and became diversified, but the first human-being to be afflicted with the virus came from another location in Central Africa. It is now certain that the source of HIV is the Central Chimpanzee (*Pan troglodytes troglodytes*), which is found



*Dr Jacques Pépin*

in South Cameroon, Gabon, Congo-Brazzaville, Central African Republic, Equatorial Guinea and small portions of the Democratic Republic of Congo and the Enclave of Cabinda. However, it's in the large agglomeration of Leopoldville and its twin city of Brazzaville that the virus found conditions that were conducive to its multiplication and diversification. At the time, Leopoldville was already the commercial centre of the entire region and attracting thousands of migrants. In the book, in Leopoldville itself, you can see how medical interventions (at the STD clinic in which an incredible amount of intravenous injections were performed while simply rinsing the syringes between patients) and social factors (the male-female imbalance and the resulting prostitution) resulted in allowing the virus to attain a critical mass before spreading successfully, first through Central Africa, and then towards the United States via Haiti.

**HOW DO YOU EXPLAIN THAT, DESPITE THE FACT THAT THIS DISEASE HAS BEEN PRESENT IN AFRICA SINCE THE 1930S, IT WAS ONLY DURING THE 1980S THAT SCIENTISTS GENUINELY “DISCOVERED” IT AND NAMED IT HIV? IN YOUR OPINION, COULD WE HAVE IDENTIFIED IT EARLIER ON?**

The diagnostic capacities of the African hospitals were very limited: there was very little in the way of laboratory examinations, little or no radiology, and no autopsies. There were hundreds of diseases that these hospitals were unable to diagnose. Within this context, it was impossible to recognise the emergence of a new disease causing fever with weight loss. Furthermore, in Africa, the most common opportunistic infection with Aids is tuberculosis, which was already very common before the arrival of Aids. The number of tuberculosis cases in Africa started to increase as of the 1950s, but physicians associated this change with the increase in diagnostic and therapeutic capacity as well as greater screening efforts.

**IF THIS DISEASE DEVELOPED IN EQUATORIAL AND CENTRAL AFRICA, THEN HOW CAN YOU EXPLAIN THE WAY IN WHICH IT SPREAD SO RAPIDLY ACROSS EUROPE AND NORTH AMERICA AND PARTICULARLY HOW IT ESSENTIALLY AFFECTED GAY MEN?**

The atmosphere of liberation that ensued after the Stonewall Riots had the effect that, during the 1970s and the beginning of the 1980s, certain gay men had a large number of different sex partners over the course of a year. The high prevalence of other STDs among this population also fostered HIV transmission. Finally, transmission probability per act is higher for homosexual relations than for heterosexual relations. Note that the virus spread among gay men in the United States during the 1970s, a good half-century following its beginnings in Africa.

**REGARDING THE “HOMOSEXUAL” TRANSMISSION OF THE VIRUS, THERE ARE SEVERAL THEORIES RELATED TO PATIENT ZERO. IN YOUR OPINION, IS THERE A VALID TRAIL REGARDING THE FIRST CARRIER OF THE VIRUS TO HAVE TRAVELED IN AFRICA BEFORE SPREADING THE DISEASE AMONG GAY COMMUNITIES IN THE UNITED STATES AND EUROPE?**

The exporting of the virus towards the Americas took place through Haiti. After the independence of Congo (in 1960), approximately 4500 Haitians went to Congo for work purposes. One of these workers brought the HIV-1 to Haiti in 1967 where local transmission took place in various ways. It is very likely that transmission towards the gay community of the United States occurred through sex tourism, which was substantial in Haiti during the 1970s.

**IN SOME WAY, DID THE MOBILISATION OF THE GAY COMMUNITIES THAT WERE AFFLICTED WITH THIS DISEASE CONTRIBUTE TO IDENTIFYING THE VIRUS WITH CERTAINTY AND DEVELOPING MEDICATION FOR THE ENTIRE POPULATION OF THE WORLD?**

Certainly! This mobilisation first of all forced the governments to invest in research and prevention, and then better finance the care services, which then led the pharmacy industry to become interested. There is no question that if the infection had remained limited to Africa, today we would not have dozens of highly effective antiretroviral drugs.

**HAVE OUR MODERN METHODS OF RAPID TRANSPORTATION (SUCH AS THE AIRPLANE) CONTRIBUTED TO THE SPREADING OF THE DISEASE BY PUSHING PEOPLE TO TRAVEL MORE STARTING FROM THE 1960S AND 70S?**

Absolutely. In the book, the transcontinental dissemination of the virus, which was greatly facilitated by the development of civil aviation, can be followed. For example, the virus was exported from South Africa to India through the travels of the South African population of Indian ancestry. In South Africa, the black heterosexuals were infected by subtype C (a type of virus), which came from the Congo, while the white homosexuals were infected with subtype B, which they were clearly introduced to through the United States.

**WHAT ARE YOUR FEARS FOR THE FUTURE? THIS TIME AROUND, IS HIV/AIDS AT RISK OF VICTIMISING MILLIONS OF ADDITIONAL PEOPLE IN ASIA, RUSSIA AND ELSEWHERE IN THE WORLD?**

It will not be possible for the current level of funding to continue, particularly in light of the financial crisis. It will be necessary for the national governments to take over and we must also find ways to reduce the costs besides those related to medications. In addition, instead of waiting for a miracle vaccine, it is essential to deploy methods that have proven effective such as circumcision. I believe that in Russia and Asia the situation has stabilised and improved, even in countries such as Thailand.

**IN YOUR VAST EXPERIENCE AS A PHYSICIAN - INFECTIOUS DISEASES SPECIALIST, DO YOU BELIEVE THAT WE COULD SOON ERADICATE HIV EVERYWHERE ON EARTH AS WE HAVE MANAGED TO DO WITH OTHER DISEASES?**

Certainly not in my lifetime.

Source: <http://www.fugues.com>

# Research update I :

## HIV STIGMA

In 2008, an innovative campaign aimed at gay and bisexual men was launched to stop HIV stigma. This campaign moved beyond more static messages (often the trademark of social marketing campaigns), to spark discussion at the community level about stigma and sexual decision-making—to ultimately enhance the sexual health of gay and bisexual men.

More recently, a report was published on how the HIV Stigma Campaign was created, rolled out and evaluated. Did this campaign succeed in mobilizing the gay community and in changing people's attitudes and, eventually, behaviours? This campaign model shows significant promise—take a look at the rationale below for why it worked.

### WHAT WAS THE CAMPAIGN?

The HIV Stigma Campaign was developed by Ontario's Gay Men's Sexual Health Alliance, a broad coalition of gay men and their allies from community-based AIDS service organizations, public health, government and research, as well as other community members. This campaign aimed to:

- diminish HIV stigma
- create greater support for HIV-positive men
- make HIV disclosure safer
- discourage reliance on disclosure to prevent HIV transmission
- encourage testing

Unlike other campaigns, which are often based on one key message, this campaign was based on a provocative question: "If you were rejected every time you disclosed, would you?" This question was aimed at encouraging gay men in Ontario to think about, and have conversations with each other about, the effects of HIV stigma. The question was circulated through billboards, in media aimed at gay and ethnoracial communities, in online ads and on standard outreach materials (condom packs, posters, t-shirts and postcards). The point was to lure participants to the [hivstigma.com](http://hivstigma.com) website, the crux of the campaign.

The website included information, a community forum and a listing of relevant organizations in Ontario (including HIV testing sites, AIDS service and other health-related organizations, gay community groups and social groups).

### HOW DID THE WEBSITE WORK?

When someone first visits the website, they are presented with the question: "If you were rejected every time you disclosed, would you?" and an option to click "yes" or "no." They also see a short video that uses casual language and makes a few key points about such things as how stigma discourages disclosure and why disclosure cannot be relied on as an HIV prevention technique.

For five months, eight campaign bloggers—HIV-negative and HIV-positive gay men—facilitated lively online discussions on a range of topics, through ongoing postings and videos.

### HOW WAS THE CAMPAIGN EVALUATED?

The HIV Stigma Campaign was evaluated by two independent researchers in consultation with the Gay Men's Sexual Health Alliance. By using surveys for gay and bisexual men before and after the campaign was launched, the researchers were able to assess if the campaign had an impact on attitudes about HIV stigma, HIV testing and disclosure in gay and bisexual men who had seen the campaign.

*Before* the campaign was launched (September 2008), the evaluators invited members of a popular gay cruising website via email to participate in an online survey about

stigma-related attitudes and behaviours, risk practices and demographics (called a “pre-test”). Nearly 2,000 men responded.

Then, *after* the campaign ended (April 2009), the evaluators again invited the members of this website to fill out a survey (called a “post-test”). This survey asked all of the questions from the first survey as well as a few others about their awareness of HIV stigma and how they had come to know about the campaign (Did they get a condom pack? Did they visit the website?). Nearly 1,800 men responded.

By comparing the pre-test and the post-test survey responses, it was possible to determine if the men who had seen the campaign had changed their attitudes, compared to the men who had not seen the campaign.

## WHAT DID THE EVALUATORS FIND?

The evaluators determined that the campaign succeeded in increasing awareness of HIV stigma among gay and bisexual men in Ontario.

The men who had seen the campaign were

- more likely to recognize the stigma that HIV-positive men may face (81% compared to 70% of those who had not seen the campaign)
- more able to recognize that poz gay men might be reluctant to disclose their HIV status to sex partners because they don't want to be rejected (73% versus only 65% of the men who had not seen the campaign)
- better able to understand why some HIV-positive men don't disclose their HIV status—they recognized that there might be a reason for non-disclosure in certain circumstances

The evaluators concluded that these outcomes were the result of using a *combination* of traditional social marketing (the ads), new social media strategies (the website, videos, blogs) and community outreach activities.

## WHAT'S THE VERDICT?

The HIV Stigma Campaign struck a cord with many gay men in Ontario: Over the course of the campaign, a total of 20,844 people visited the website. And 4,000 of those people visited the site more than 10 times. This suggests that many people followed the dialogue on the blogs and that the campaign's impact had not only breadth (reaching many people) but also depth. These findings demonstrate that many gay men will take an interest in such a campaign and that newer social media approaches to awareness-raising can be useful.

While there is no evidence to show that this campaign had an effect on the HIV testing and transmission behaviours of gay and bisexual men, the campaign did prove to be successful in increasing awareness of HIV stigma and its role in HIV transmission, and in generating conversations about how stigma can contribute to situations of vulnerability to HIV transmission. It was a forum that provided men with a collective space to work through perceptions and understandings of HIV risk in their everyday lives.

Social marketing campaigns to address HIV stigma that combine traditional social marketing advertisements, community outreach and a website/blogs can generate dialogue among gay men on important issues related to stigma and HIV transmission. Campaigns that build on strong community-based outreach and use a collaborative approach, as the hivstigma.com campaign did, may have the potential to have a big impact on how men think about HIV stigma and HIV transmission.

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### REFERENCE

Adam BD, Murray James, Ross Suzanne et al. hivstigma.com, an innovative web-supported stigma reduction intervention for gay and bisexual men. *Health Education Research*. 2011 Jan 17.

Source : CATIE-News: Bite-sized HIV/AIDS news bulletins, 3 February 2012, [www.catie.ca](http://www.catie.ca)



## First Nations Quebec and Labrador Health and Social Services Commission

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Wendake, Quebec, G0A 4V0  
Tel: 418 842-1540 • Fax: 418 842-7045  
www.cssspnql.com

### Our mission:

Improve the physical, mental, emotional and spiritual well being of First Nation and Inuits individuals, families and communities in respect of their local autonomy and culture. By helping the communities that wish to initiate, develop and promote comprehensive health & social programs and services as designed by First Nations and Inuits organizations recognized by our First Nations and Inuits.

The role of the FNQLHSSC is to assist Quebec and Labrador First Nations and Inuits communities and organizations in the defence, maintenance and the exercise of their inherent rights IN HEALTH AND SOCIAL SERVICES as well as to help them in the realization (delivery) and the development of THESE programs.

- 1 To ensure services shall be available to assist as requested by First Nations and Inuits communities and MEMBER organizations of the FNQLHSSC in exercising our inherent rights and autonomy to design and control health and social services delivery to members of our respective nations.
- 2 Upon request from First Nations and Inuits communities to promote SUCCESSFUL community models and to provide technical support to First Nations and Inuits organizations for health and social services innovative and traditional practices, research, development and training.
- 3 In respect of existing community practices and needs, to maintain AND IMPROVE communication and consultation with First Nations and Inuits communities and MEMBER organizations of THE FNQLHSSC in order to ensure that health and social services programs are adapted to our needs.
- 4 To promote, facilitate and support the exchange of information and ideas between First Nations and Inuits communities and MEMBER organizations of the FNQLHSSC on all aspects of health and social services development initiatives.
- 5 Upon request, to support and assist First Nations and Inuits communities and MEMBER organizations of the FNQLHSSC to ensure recognition of our full jurisdiction and/or authority over health and social services.
- 6 To support the development of capacity building within First Nations and Inuits communities and member organizations of the FNQLHSSC to be able to take on increased health and social services responsibilities at the community level.

You may, at any time, address your comments or suggestions concerning the NEWSLETTER's content at  
FNQLHSSC, 250 Michel Laveau, 1<sup>st</sup> floor, Wendake (Qc) G0A 4V0  
Tel: 418 842-1540, Fax: 418 842-7045, Email: ltanguay@cssspnql.com cgsioui@cssspnql.com

It will also be our pleasure to publish your messages, articles or advertisement!

The FNQLHSSC would like to thank the  
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