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ADDRESSING THE IMPACT OF ALCOHOL ON THE PREVENTION, CARE, AND TREATMENT OF HIV IN SOUTHERN AND EASTERN AFRICA: RESEARCH, PROGRAMMING, AND NEXT STEPS

REPORT ON A PEPFAR TECHNICAL CONSULTATION HELD IN WINDHOEK, NAMIBIA, APRIL 12–14, 2011

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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Chairpersons, presenters, and moderators: Wanda Nesbitt, Ambassador of the American Embassy to Namibia; Petrina Haingura, Deputy Minister of Health and Social Services, Namibia; Rene Adams, Brad Corner, Nick DeLuca, Carina Ferreira-Borges, Katherine Fritz, Mary Glenshaw, Freida Katuta, Connie Kekwaletswe, Thomas Kresina, Phenyio Lekone, Neo Morojele, John Muturi Mwangi, Isidore Obot, Joseph Ochieno, Charles Parry, Billy Pick, Vladimir Poznyak, Kristen Ruckstuhl, Norman Sabuni, Phenyio Sebonego, Leickness Simbayi, William Sinkele, and Freda Vaughan.

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ACRONYMS

ART	antiretroviral therapy
ARV	antiretroviral
BCC	behavior change communication
CDC	U.S. Centers for Disease Control and Prevention
CORD	Coalition on Responsible Drinking
DOD	U.S. Department of Defense
MOHSS	Ministry of Health and Social Services
OGAC	U.S. Office of the Global AIDS Coordinator
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
STI	sexually transmitted infection
TB	tuberculosis
USAID	U.S. Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

Alcohol use in virtually all cultures reduces both the perception of risk and inhibitions about engaging in risky behavior. Research conducted throughout the world has documented the association between alcohol use and high-risk behaviors, including inconsistent condom use with casual partners, a greater number of lifetime and recent sexual partners, concurrency of sexual partners, intergenerational sex, the buying and selling of sex, and the experience of violent or coercive sex—and all of these, in turn, are associated with an increased risk of HIV infection.¹ Alcohol consumption continues to increase in sub-Saharan Africa, with South Africa displaying one of the world's highest volumes per capita of alcohol consumption; also, sub-Saharan Africa is still home to two-thirds of all people living with HIV. Innovative programmatic approaches to respond to hazardous alcohol use and risk of HIV infection are being implemented in several countries and are beginning to yield positive results. However, they remain underfunded and lack political support.

In response to these challenges, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) sponsored a three-day technical consultation from April 12 to 14, 2011, in Windhoek, Namibia. Eighty-seven participants attended the meeting, including researchers, PEPFAR implementing partners, and U.S. Government Mission staff from 17 African countries, all of whom expressed an interest in gathering additional information and tools for addressing alcohol and HIV (see Appendix A for the meeting agenda and Appendix B for a list of participants).

OBJECTIVES

The meeting's purpose was to share knowledge about the link between alcohol and HIV, and discuss approaches for the African context. The specific objectives of the meeting were to:

- Share the latest research methodologies and epidemiological findings from international and regional studies exploring how alcohol use may contribute to sexual risk behavior and poor antiretroviral (ARV) treatment outcomes.
- Share experiences from the field regarding current best practices in alcohol-related policy and programming with relevance to HIV prevention and treatment.
- Develop concrete country-level plans for bringing about the necessary research, program, and policy activities to reduce alcohol's negative impacts on HIV prevention and treatment efforts.

¹ Cook, R., and D. Clark. 2005. Is There an Association Between Alcohol Consumption and Sexually Transmitted Diseases? A Systematic Review. *Sexually Transmitted Diseases* 32: 156–164.

Kalichman, S., L. Simbayi, M. Kaufman, D. Cain, and S. Jooste. 2007. Alcohol Use and Sexual Risks for HIV/AIDS in Sub-Saharan Africa: Systematic Review of Empirical Findings. *Prevention Science* 8:141–151.

Zablotska, I., R. Gray, D. Serwadda, F. Nalugod, et al. 2006. Alcohol Use Before Sex and HIV Acquisition: A Longitudinal Study in Rakai, Uganda. *AIDS* 20:1191–1196.

OVERVIEW OF THE AGENDA

The meeting was opened with welcoming remarks from Her Excellency Wanda Nesbitt, Ambassador of the American Embassy to Namibia. Petrina Haingura, Deputy Minister of Health and Social Services, Namibia, provided the keynote address on the effects of alcohol and HIV in Namibia. Dr. Katherine Fritz, AIDSTAR-One Technical Lead for Alcohol and HIV, reviewed achievements in the field of alcohol and HIV since PEPFAR's first technical consultation on this topic in Dar es Salaam, Tanzania, in 2005. Subsequently, researchers from the World Health Organization (WHO), the U.S. Centers for Disease Control and Prevention, and several African- and U.S.-based research organizations summarized the biological and epidemiological evidence base, which clearly indicates that alcohol use, especially heavy, episodic alcohol use (i.e., binge drinking), is a significant contributor to sexual risk behavior, as well as to poor ARV and tuberculosis treatment outcomes.

In the morning sessions of Day 2, HIV program implementers, including several from PEPFAR implementing partner organizations, shared their experiences in designing and delivering alcohol-related programming to populations at high risk for HIV, including people living with HIV, military populations, mobile populations, people who inject drugs, and female sex workers. These presenters shared many innovative strategies, such as community-based counseling to prevent addiction and HIV risk among youth and female sex workers in urban slums, non-bar-based entertainment for truck drivers on major transnational highways, and intensive individual alcohol harm-reduction counseling implemented during clinical services for sexually transmitted infections (STIs), among others. Representatives from several national governmental agencies and WHO provided overviews of policy and advocacy strategies that are currently being used to reduce alcohol-related harm. These include legal interventions, such as taxation and controls on alcohol advertising, and advocacy strategies, such as mass media campaigns and coalition building.

During the afternoon of Day 2, participants gathered in small groups organized by country and regions, and developed recommendations for advancing research and programming on alcohol risk reduction in their countries. The small groups used the Research and Program Planning Matrix (see Appendix C) to organize their discussion and record the main themes. During Day 3, participants came together in a full group discussion to discuss actions the U.S. Government can carry out to address the issue of alcohol and HIV. On Day 3, meeting participants also had the opportunity to visit several programs, located within Windhoek, that address alcohol use and abuse in the context of HIV risk. These programs were part of the PEPFAR Alcohol and HIV Initiative in Namibia.

KEY THEMES

The following key themes emerged during the consultation.

RESEARCH AND DATA

Participants discussed the need to improve coordination and create awareness about the link between alcohol and HIV by fostering national and regional networks for sharing research results and intervention materials. They recommended using the expertise of local and regional researchers to strategically fill remaining gaps in evidence that might help country teams plan programs more effectively. Participants also identified standardization of preventative services, ethnographic studies, and resources as areas for further research.

POLICY AND REGULATION

A strong recommendation emerged that nongovernmental organizations should maximize their efforts by creating advocacy partnerships or networks to influence alcohol policy (e.g., examining ways in which alcohol control policies can help to prevent both HIV and sexual violence, and mobilizing advocates in both areas to participate in advocacy).

COMMUNITY-BASED PROGRAMS

For populations with high HIV risk and significant alcohol use, participants recommended that programs integrate standardized alcohol-related harm information with balanced messaging into existing community-based HIV prevention programs. They also recommended the development of low-cost community-based addiction recovery programs.

HEALTH CARE-BASED PROGRAMS

Participants recommended implementing interventions, using standardized materials based on the WHO Brief Intervention model, for integrating alcohol risk reduction counseling into STI and voluntary counseling and testing services, and conducting evaluations to determine the interventions' effectiveness.

IDENTIFYING RESOURCES

To initiate country programs on alcohol and HIV, local resources, policies, and laws addressing risky drinking, such as school- and/or religious-based alcohol abuse prevention programming, must be identified and analyzed for use in the local context. Participants also recommended tapping into existing national and international funding sources such as PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria, other multilateral and bilateral funding programs, and government taxes or levies on alcohol beverages to support additional alcohol and HIV prevention programming.

KEY RECOMMENDATIONS

Based on participant discussion, four overall recommendations emerged as promising approaches for achieving progress on alcohol and HIV prevention programming.

1. An Internet-based knowledge hub, based at an African institution, should be established to facilitate knowledge sharing among country teams and to maintain communication on this important topic beyond the technical consultation.
2. A joint statement by international organizations should be written and released underlining the importance of addressing hazardous drinking as part of any comprehensive response to HIV.
3. PEPFAR partners should include additional resources for HIV-alcohol programming in annual Country Operational Plans, based on initial action plans developed at the consultation.
4. The U.S. Office of the Global AIDS Coordinator should coordinate technical assistance to country teams for further development, implementation, and monitoring of the alcohol and HIV activity plans that were begun during this technical consultation.

CONCLUSION

The link between alcohol and HIV is still being investigated as an important driver for HIV risk, and the most effective ways of reducing that risk are also still being investigated. This meeting helped countries to examine the latest research on alcohol use and its association with risky sexual behavior and poor ARV treatment outcomes, and to discuss alcohol-related policy and programming with relevance to HIV prevention and treatment. Integrated alcohol and HIV prevention programming requires a comprehensive set of interventions. And while several models already exist for integrating alcohol risk reduction counseling into community- and government-based programming, further research is needed to determine the long-term impacts of these programs and identify the most effective interventions. The information in this report can serve as a resource for developing comprehensive alcohol and HIV prevention programming to reduce the spread of HIV.

MEETING OBJECTIVES

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) General Population and Youth Prevention Technical Working Group and the Most-at-Risk Populations Technical Working Group sponsored a technical consultation in Windhoek, Namibia, from April 12 to 14, 2011. Eighty-seven people attended the consultation, including representatives of the U.S. Government (the U.S. Agency for International Development [USAID], the Centers for Disease Control and Prevention [CDC], the Department of Defense [DOD], the Office of the Global AIDS Coordinator [OGAC], and the Substance Abuse and Mental Health Services Administration), multilateral organizations such as the World Health Organization (WHO), select PEPFAR implementing partners from across Eastern and Southern Africa, and U.S. Government Mission staff from 17 countries: Angola, Botswana, Democratic Republic of the Congo, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Sudan, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. (See Appendix A and B for agenda and list of participants.)

The specific objectives of the meeting were to:

- Share the latest research methodologies and epidemiological findings from international and regional studies exploring how alcohol use may contribute to sexual risk behavior and poor antiretroviral (ARV) treatment outcomes.
- Share experiences from the field, especially regarding the work conducted in Namibia through the PEPFAR Alcohol and HIV Special Initiative, about current best practices in alcohol-related policy and programming with relevance to HIV prevention and treatment.
- Develop concrete country-level plans for bringing about the necessary research, program, and policy activities to reduce alcohol's negative impacts on HIV prevention and treatment efforts.

This report summarizes the main themes discussed during the three-day consultation. It is intended to complement the presentations given at the meeting, which are available on the AIDSTAR-One website (www.aidstar-one.com/focus_areas/prevention/resources/technical_consultation_materials/alcohol_hiv_namibia).

INTRODUCTION TO THE TECHNICAL CONSULTATION

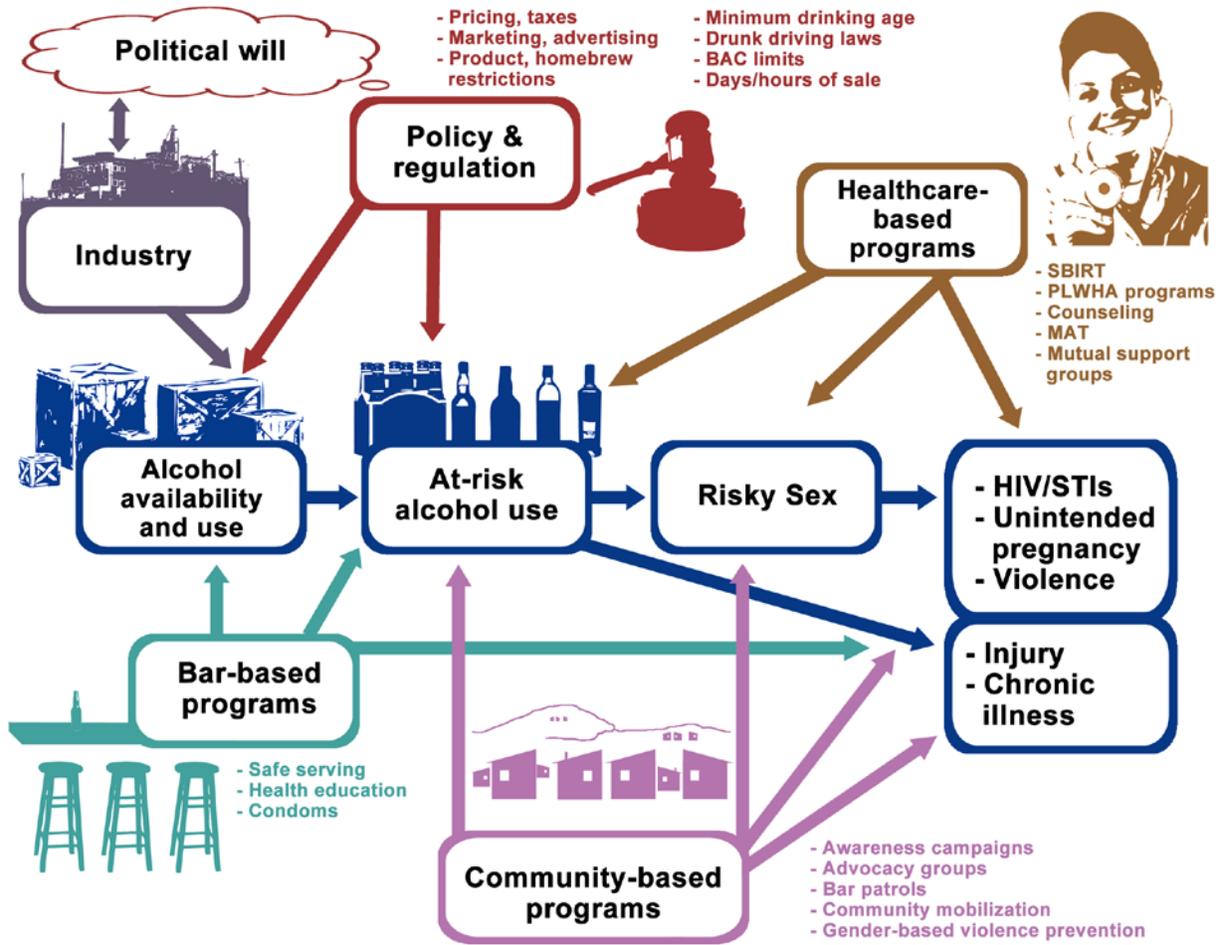
THE ALCOHOL AND HIV RESPONSE IN EASTERN AND SOUTHERN AFRICA: WHERE ARE WE NOW AND WHERE ARE WE GOING?

Dr. Katherine Fritz, AIDSTAR-One Technical Lead for Alcohol and HIV, reviewed achievements in the field of alcohol and HIV since PEPFAR held its first technical consultation on the topic in Dar es Salaam, Tanzania, in 2005. Progress included:

- An improved understanding of the contribution of alcohol to the global burden of disease and the causal association between alcohol use and sexual risk behavior
- A greater understanding of the role of alcohol in HIV disease progression and uptake/adherence to ARV medications
- A rapidly growing body of programmatic work that illustrates promising ways to intervene on alcohol-related HIV risk (including individual-level counseling, community- and bar-based programs, and mass media behavior change communication [BCC])
- A growing understanding of the complex social, economic, political, and behavioral factors that underlie patterns of alcohol use and associated HIV risk.

A conceptual framework designed for this consultation by the meeting organizers (see Figure 1) illustrates the relationship between alcohol availability and numerous hazards, including overuse, risky sex, and violence. The model illustrates the overlapping benefits of combination programming, based on the assumption that the best approach for reducing alcohol-related harm (including HIV) will include a multi-sectoral approach that combines policy and government regulation, programs in bars and within the community, and health care-based programs. Based on this framework, the organizers of the meeting developed a Research and Program Planning Matrix tool (see Appendix C) that country teams used during the meeting to develop an agenda of research, programming, and policy advocacy for their respective countries.

Figure I. Conceptual Framework Showing Risks of Alcohol Abuse and Resources to Address Abuse



SESSION I: RESEARCH AND EPIDEMIOLOGY

Presenters summarized the current state of the evidence on the role of alcohol as a contributor to the burden of disease globally and in sub-Saharan Africa, including the role of alcohol in HIV acquisition and disease progression.

WORLD HEALTH ORGANIZATION GLOBAL STATUS REPORT ON ALCOHOL, HEALTH, AND POLICY FRAMEWORKS

Dr. Vladimir Poznyak, Coordinator, Management of Substance Abuse at WHO, provided an overview of WHO's 2011 *Global Status Report on Alcohol and Health*.² This report represents a major milestone in WHO's activity to monitor alcohol consumption, alcohol-related harm, and policy responses. It provides data at global, regional, and country levels that can be used by researchers and country programmers to understand and respond to patterns of alcohol use and abuse.

There is no international framework convention on alcohol (such as exists for tobacco) that would legally bind nations to specific standards governing how alcohol can be marketed and sold. However, in 2010, the World Health Assembly endorsed a global strategy to reduce the harmful use of alcohol, and WHO is working with member states to develop policies, laws, and programs to reduce the burden of disease associated with alcohol. In addition, there are several documents available from WHO to help guide development of interventions (see Appendix D).

ALCOHOL AND HIV: THE STATE OF THE LITERATURE

Dr. Isidore Obot, Director of the Centre for Research and Information on Substance Abuse in Nigeria and editor of the *African Journal of Drug and Alcohol Studies*, provided a summary of major findings about the behavioral mechanisms that link alcohol to HIV, noting that research to date has not been able to fully analyze the many factors that mediate the relationship between alcohol and risky sex. These factors include alcohol's disinhibiting effect on behavior and the immediate environment in which people drink, which may trigger certain high-risk behaviors. More longitudinal and randomized controlled studies will need to be conducted for researchers to fully explain the causal mechanisms linking alcohol to risky sexual behavior.

² World Health Organization. 2011. *Global Status Report on Alcohol and Health*. Geneva, Switzerland: WHO.

ALCOHOL AND HIV EPIDEMIOLOGY IN AFRICA: RESEARCH UPDATES

Dr. Leickness Simbayi, Executive Director of the HIV, STIs and TB Research Programme at the Human Sciences Research Council of South Africa, provided an update about the epidemiology of alcohol and HIV in sub-Saharan Africa, with a focus on Southern Africa. Until recently, alcohol abuse was neither acknowledged nor well-documented as a contributing factor in the HIV epidemic. However, over the past decade, a growing body of studies, many conducted in Southern Africa, have clarified the relationship between alcohol and HIV for that region, where a pattern of hazardous use (defined as heavy, intermittent use) prevails. Research, including meta-analyses, clearly shows that greater quantities of alcohol consumption are associated with greater sexual risks, and that alcohol contributes to sexual violence (coerced sex or rape).

KNOW YOUR EPIDEMIC: MEASURING ALCOHOL USE AND ASSOCIATED HIV RISKS—A CASE STUDY FROM NAMIBIA

Dr. Mary Glenshaw, Epidemiologist at CDC, shared how she and colleagues from CDC's office in Namibia developed context-specific measures of alcohol use for a population-based survey conducted in Windhoek, Namibia, in 2009. The method used for measuring alcohol intake—quantity and frequency—varies greatly depending on how people drink. Glenshaw adapted standard alcohol use questions by showing photographs of different-sized containers and asking survey participants to identify which type they used, whether the container was shared, and if so, among how many people. Samples of alcohol types, including the full range of home-brewed varieties, were sent to a local laboratory to determine their alcohol content. Using this information, the study documented the amount and frequency of alcohol consumption in a sample of randomly selected neighborhood residents. Glenshaw's methods may be easily adapted and used in other sub-Saharan African countries.

SESSION 2: CURRENT STRATEGIES

In this session, presenters provided examples of national and international strategies for reducing alcohol-related harm, with a focus on approaches most relevant for HIV prevention, care, and treatment.

THE WORLD HEALTH ORGANIZATION'S REGIONAL STRATEGY FOR AFRICA: REDUCING HARMFUL USE OF ALCOHOL

Dr. Vladimir Poznyak, Coordinator, Management of Substance Abuse at WHO, presented on WHO's recent work with member states in Africa to implement a regional strategy for reducing harmful use of alcohol. A total of 2.4 percent of all deaths in the region are attributed to alcohol, making alcohol the eighth highest risk factor for mortality. The regional strategy tasks member states with making progress on several fronts: political leadership, health sector response, community awareness and action, and enactment of laws and policies to decrease alcohol's affordability and availability and control its marketing. The WHO Africa regional office is providing support to member states in their efforts to implement the regional strategy over the coming several years.

THE PEPFAR ALCOHOL INITIATIVE IN NAMIBIA

Dr. Nick DeLuca, Prevention Advisor, CDC-Namibia, provided an overview of the PEPFAR Alcohol Initiative in Namibia. In 2007, PEPFAR allocated U.S.\$2.5 million for a four-year PEPFAR alcohol initiative, a collaboration among OGAC, CDC, USAID, DOD, and the Substance Abuse and Mental Health Services Administration. Most of the initiative's activities were implemented in Namibia (though some were also implemented in Rwanda and Botswana). One activity in Namibia, a population-based assessment in a peri-urban community, suggested the magnitude of the alcohol problem: nearly two-thirds of adults drank alcohol at harmful or hazardous levels, as measured by *The Alcohol Use Disorders Identification Test*.³ Other Namibian activities included a randomized controlled trial of a brief alcohol screening and counseling program with voluntary HIV counseling and testing of clients, as well as pilot programs, carried out in communities where nearly one out of three households sells alcohol, in which community members and bar owners collaborated to seek solutions to alcohol misuse. Importantly, the initiative has also supported a Namibian network of governmental, nongovernmental, and private industry stakeholder organizations, the Coalition on Responsible Drinking (CORD), which coordinates the nation's policy and programmatic response to hazardous alcohol use. Finally, the initiative supported the development of small and large media

³ Babor, T. F., J. C. Higgins-Biddle, J. B. Saunders, and M. G. Monteiro. 2001. *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care*. Geneva, Switzerland: WHO. Available at http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf (accessed March 2012)

BCC packages that are being used throughout Namibia to raise awareness and mobilize community-level advocacy about the social and health harms that result from hazardous alcohol use.

NAMIBIA MINISTRY OF HEALTH AND SOCIAL SERVICES STRATEGY FOR ALCOHOL CONTROL

Rene Adams, Social Worker with the Namibian Ministry of Health and Social Services (MOHSS) and Coordinator of CORD, presented Namibia's national alcohol control strategy. The MOHSS has developed a comprehensive approach for alcohol control that includes legislation and policy, the health sector, communities, and the environment or context of alcohol consumption. The establishment of CORD was a significant element in implementing the strategy. This multi-sectoral coalition, which operates in all 13 regions of Namibia at a grassroots level, conducts campaigns to raise awareness, school programs, bar patrols, community cleanups, and other activities.

SESSION 3: RESPONDING TO THE NEEDS OF SPECIFIC POPULATIONS

The purpose of this session was to explain the relationship between alcohol and the HIV prevention, care, and treatment needs of several key populations.

PEOPLE LIVING WITH HIV, ALCOHOL, AND ANTIRETROVIRAL THERAPY ADHERENCE

Dr. Connie Kekwaletswe, Senior Scientist at the Medical Research Council of South Africa, shared information about the effect of alcohol on adherence to antiretroviral therapy (ART), areas for future research, and opportunities for intervention. Adherence (the extent to which patients carry out behaviors and treatments as recommended by health care providers) is a multidimensional construct that includes patients' compliance with regimens, as well as their retention and engagement in care. In the United States, alcohol use is associated with suboptimal adherence to ART, with the quantity consumed serving as a robust predictor of adherence. Several studies in sub-Saharan Africa confirm the positive association between alcohol use and non-adherence to ART. Potential mediators between alcohol and ART adherence include forgetting to take the regimen, consciously skipping the regimen, and depression, hopelessness, or pessimism about the efficacy of ART. Screening and brief intervention for alcohol use is a crucial health promotion strategy for HIV patients.

ALCOHOL USE, HIV, AND TUBERCULOSIS

Dr. Charles Parry, Director of the Alcohol and Drug Abuse Research Unit of the Medical Research Council of South Africa, presented information about the relationship between alcohol use and tuberculosis (TB), and made suggestions for potential interventions and areas of further research. The prevalence of alcohol use is markedly higher in TB patients than in the general population, and people who drink more than 40 grams of alcohol per day have a threefold higher risk of active TB. Furthermore, people who drink heavily show higher TB relapse rates; one study showed that heavy drinkers were 18 times more likely to have early relapse than those who did not drink heavily. Further research needs to be conducted to understand rates of non-adherence and default for different levels of alcohol use among patients with TB, and randomized clinical trials are needed to improve and tailor interventions to prevent and treat heavy alcohol use during TB treatment.

ALCOHOL PROGRAMMING AS A COMPONENT OF POSITIVE HEALTH, DIGNITY, AND PREVENTION

Dr. Nick DeLuca, Director of Prevention Programming for CDC-Namibia, provided an overview of prevention activities for people living with HIV (PLHIV) and the inclusion of alcohol screening as a routine part of provider services. Preventing alcohol abuse among PLHIV can improve health and reduce risk of transmission to sexual partners and children, and is becoming a critical part of care for PLHIV. In clinical settings, health care providers who meet with patients regularly can deliver consistent, targeted prevention messages and strategies during routine visits. These providers, as trusted resources for patients, can address the links between alcohol and sexual risk-taking.

ALCOHOL/DRUG/HIV RISK REDUCTION IN KIBERA SLUMS, NAIROBI

William Sinkele, Director of Support for Addictions Prevention and Treatment in Africa, presented information about the Prevention Awareness Program implemented in Kibera, Kenya (an urban slum). Prevalence of both HIV and substance use disorders is higher in urban slums, compared to the national prevalence in Kenya. Among female sex workers and youth, substance use disorders are very high. The Prevention Awareness Group is a community-based, integrated substance abuse and HIV prevention program targeting such vulnerable populations. The results of an evaluation of the Prevention Awareness Group showed limited success among female sex workers, although they did report less drinking, fewer blackouts, and more consistent condom use. Youth reported reduced drinking, increased ability to stop drinking once they had started, and greater ability to carry out their expected duties.

SESSION 4: PROGRAMMATIC APPROACHES

The purpose of this session was to provide participants with information about innovative programmatic, surveillance, and treatment approaches for addressing alcohol and HIV.

COMMUNITY- AND BAR-BASED PROGRAMS

Dr. Neo Morojele, Deputy Director of the Alcohol and Drug Abuse Research Unit of the Medical Research Council of South Africa, shared the design and results of a multicomponent intervention in bars in Tshwane (Pretoria), South Africa. Bar patrons are at particularly high risk for both substance abuse disorders and HIV infection, and bars may be ideal settings in which to deliver HIV and alcohol prevention interventions for heavy alcohol users. The intervention had several components: working with bar staff to promote responsible alcohol use, working with bar patrons as change agents to promote risk reduction and responsible alcohol use, having counselors available to conduct brief intervention counseling and motivational interviewing, having condom demonstrations, and distributing condoms as well as information, education, and communication materials.

THE PHAPHAMA BRIEF RISK REDUCTION INTERVENTION TO REDUCE BOTH ALCOHOL USE AND HIV/SEXUALLY TRANSMITTED INFECTION RISKS IN CLINICAL AND COMMUNITY SETTINGS

Dr. Leickness Simbayi, Executive Director of the HIV, STIs and TB Research Programme at the Human Sciences Research Council of South Africa, presented information about the Phaphama alcohol studies that have taken place in South Africa. The Phaphama (“Wising Up”) project, first implemented as a pilot delivering a 60-minute one-on-one intervention to clinic clients with repeat sexually transmitted infections (STIs), resulted in lower rates of unprotected intercourse and significant increases in risk reduction practices. The next step was the inclusion of a 15-minute alcohol reduction counseling component. The results showed that this component was effective in reducing HIV transmission risks for up to six months among STI patients within the clinic setting.

INTEGRATED SURVEILLANCE AMONG PERSONS ATTENDING ALCOHOL CONSUMPTION VENUES IN GABORONE, BOTSWANA

Dr. Phenyo Lekone, Monitoring and Evaluation Program Officer at CDC-Botswana, discussed an alcohol and HIV surveillance study underway in Gaborone, Botswana, where HIV prevalence among people aged 15 to 49 is 23.9 percent. The project consists of two phases. The first phase includes a desk review, in-depth interviews, and a census of venues that sell alcohol. In the second phase, researchers will use the time-location sampling methodology to estimate HIV prevalence among men and women attending alcohol selling venues in Gaborone, and to identify risk behaviors associated with HIV transmission. These baseline surveillance data will help CDC, in collaboration with the Government of Botswana, to design and monitor appropriate alcohol and HIV programs and policies.

APPROACHES IN TANZANIA

Dr. Norman Sabuni, Principal Medical Officer at the Ministry of Health and Social Welfare in Tanzania, provided information about the roll-out of a multipronged national program that includes policy, community mobilization, mass media, and training of health care workers and HIV test counselors in brief motivational interviewing for alcohol risk reduction. In Tanzania, there had been no large-scale public health interventions to address alcohol consumption before this intervention was launched in 2009. Roll-out is ongoing and will include an assessment phase in 2011. Initial experiences have been positive, but resource and capacity constraints are a challenge, as is creating consensus among stakeholders, not all of whom agree that the risks of alcohol use outweigh the benefits to the country's economy or to individuals in terms of their personal enjoyment of drinking.

ALCOHOL ABUSE AND HIV IN MILITARY POPULATIONS

Dr. Freda Vaughan, Country Manager at the U.S. DOD, gave an overview of the HIV risk behaviors of military personnel and potential interventions for working with the military. HIV prevalence is not necessarily higher in the military than in the general population, but there is a clear link between soldiers' drinking and having unplanned, unprotected sex, especially with sex workers. Intervention strategies might include discipline and enforcement of regulations. Pre-deployment training for peace-keeping missions to high HIV-prevalence countries must contain HIV prevention education, including information about the role alcohol may play in triggering risky sex while on mission.

ROADS TO A HEALTHY FUTURE PROJECT: ALCOHOL USE AND HIV RISK AMONG MOBILE MEN

Joseph Ochieno, Coordinator of the Family Life Education Program at FHI, provided information about programs that address alcohol use among mobile populations. Truck drivers spend significant periods of time away from their families and often report feelings of stress and isolation. There are few recreational activities besides pubs and lodges along their routes or corridors. To address the

lack of recreational venues and improve access to and uptake of health services, the project formed SafeTStop Resource Centers. These centers are alcohol-free settings with services including HIV education, HIV testing and counseling, condom distribution, STI diagnosis and treatment, and men's discussion groups. Alcohol counseling groups were added specifically for men at high-traffic centers. The ROADS project in Busia, Kenya, established a nondenominational alcohol counseling group that linked with local ART services for cross-referral. The program in Busia has grown from 1 group with 15 people in 2007 to 106 groups with 1,592 members currently.

SESSION 5: LEGISLATIVE AND POLICY INTERVENTIONS

The purpose of this session was to describe structural interventions (legislative, environmental, and policy approaches) for alcohol risk reduction and their relation to HIV prevention.

ALCOHOL USE AND ITS EFFECT ON HIV IN AFRICA: DESIGNING EFFECTIVE POLICY RESPONSES

Dr. Charles Parry, Director of the Alcohol and Drug Abuse Research Unit of the Medical Research Council of South Africa, presented information about policy-based approaches to reducing alcohol abuse. Policies that regulate the availability, price, and marketing of alcohol are likely to reduce consumption, especially heavy drinking. Such policies include reducing the number of outlets, limiting the number of hours when alcohol is sold, increasing taxes on alcohol, banning advertising targeted at youth, and working with police to decrease alcohol use by minors by enforcing underage drinking laws. Policies in health facilities, such as screening alcohol patients for alcohol-related HIV risk, should also be part of the prevention response.

THE ALCOHOL LEVY IN BOTSWANA AND OTHER GOVERNMENT INTERVENTIONS ON ALCOHOL ABUSE

Phenyo Sebonego, Chief Health Officer in the Alcohol and Substance Abuse Department of the Botswana Ministry of Health, provided an overview of the alcohol levy in Botswana and its use in combating and minimizing the effects of alcohol abuse. The 30 percent levy was first introduced in November 2008 to promote projects to mitigate excessive drinking, and has since increased to 40 percent. Since it began, U.S.\$79 million have been collected. The revenue supports public school campaigns on the harms of alcohol abuse, alcohol-free youth activities, alcohol dependency treatment programs, and enforcement of limits on alcohol advertising at sporting events.

ALCOHOL LEGISLATION IN KENYA: CONTRIBUTING TO HIV PREVENTION MANAGEMENT

Aggrey Busena, Coordinator of the National Campaign Against Drug Abuse Authority, reviewed the successes and challenges of the Alcoholic Drinks Control Act, implemented in 2010, which aims to control the production, sale, and consumption of alcoholic drinks. The act includes a reduction in

drinking hours and additional restriction on sale and access to alcoholic drinks by minors. Packaging and labeling has increased public awareness of the dangers of alcohol use. However, there have been challenges, including resistance from industry and consumers, weak regulatory and enforcement framework, and limited understanding of the link between alcohol use and HIV. To address these challenges, stakeholders need to be engaged in the process, and the public needs to be regularly informed about the provisions and benefits of the act. Furthermore, there is a need for training to increase engagement within the law enforcement sector.

RECOMMENDATIONS AND PLANNING FOR THE FUTURE

OUTCOMES OF COUNTRY-LEVEL DISCUSSIONS AND PLANNING

The meeting included three afternoon sessions during which participants met in small groups, organized by country and region, to discuss what they were learning from the meeting presentations, its relevance to their country contexts, and how they could promote more national and regional research and programming on alcohol and HIV. The small groups used the Research and Program Planning Matrix (see Appendix C) to organize their discussion and record the main themes, which are summarized as follows.

RESEARCH AND DATA

A common theme within discussions held at the meeting was the need to benefit from the rigorous research data already gathered in many sub-Saharan African countries about the links between alcohol and HIV risk, and between alcohol and poor ARV treatment outcomes. Participants discussed whether the linkages needed to be independently validated in each and every country—a seemingly unnecessary duplication of effort. Instead, participants recommended using the expertise of local and regional researchers to strategically fill remaining gaps in evidence that might help country teams plan programs more effectively. Additional research needs included the following:

- *Standardization.* Participants noted that researchers should use standardized instruments and measures across countries. They also called for collaborative development of regional research agendas.
- *Ethnographic studies.* Participants identified the need for more ethnographic or other types of qualitative research to supplement quantitative surveys, as this type of information is often lacking but crucial to creating interventions tailored to local context.
- *Resources.* Resources need to be allocated to program evaluation in the area of alcohol and HIV to build evidence about what interventions work, as well as their cost-effectiveness.

POLICY AND REGULATION

A strong recommendation emerged that nongovernmental organizations should maximize their efforts by creating advocacy partnerships or networks to influence alcohol policy. Nongovernmental organizations could use synergies between related issues to build these networks (e.g., examining ways in which alcohol control policies can help to prevent both HIV and sexual violence, and mobilizing advocates in both areas to participate in advocacy). Attendees also expressed interest in more information, as follows:

- *Examples of success.* Participants wanted more information about successful local and national initiatives to create and enforce alcohol levies and taxes and enforce controls on advertising, drunk driving, the drinking age, and bar operating hours. Attendees wanted details about how these campaigns were undertaken, including how government and industry leaders became champions of these policies. Meeting participants were particularly interested in how the Botswana tax model could be replicated elsewhere, as well as how WHO would help establish recommendations in this area and engage government leaders to embrace such a policy.
- *Consequences of regulatory campaigns.* Participants expressed a desire to learn about any actual or potential unintended consequences of alcohol control policies. For example, is there a risk that raising the price of commercially produced beer (through taxation) will cause an increase in the amount of home-brewed alcohol that is sold or that people will begin using other, cheaper drugs as a substitution? In addition, participants wished to know more about how to ensure that training for police and the wider legal system will support, rather than undermine, such policy shifts.

COMMUNITY-BASED PROGRAMS

Participants felt that the evidence base is still developing regarding what specific community-level interventions could be effective in reducing alcohol-related HIV risk, but one clear way forward is to begin integrating content on alcohol-related harm into existing community-based HIV prevention programs. This is especially true for existing community outreach to specific populations with high HIV risk and significant alcohol use—women who engage in transactional sex, young people (especially the urban poor), migrant populations, military personnel, and men who have sex with men, for example. Other suggestions included the following:

- *Standardized intervention materials.* These could be developed as approaches are piloted.
- *Balanced messages.* Programming should ensure that punitive or stigmatizing messages toward those who abuse alcohol (and who may be dependent) are balanced with messages on recovery: how and from whom to seek help.
- *Community rehabilitation resources.* Clearly, resources for addiction recovery programs are extremely limited in all sub-Saharan African countries. Community-based addiction recovery programs, as opposed to high-cost inpatient programs, hold promise for rapidly expanding the reach of these resources and communities should invest in them.

HEALTH CARE-BASED PROGRAMS

Models already exist for integrating alcohol risk reduction counseling into STI and HIV voluntary testing and counseling services using adaptations of the WHO Brief Intervention model.

Participants recommended that these intervention materials be standardized, including the materials for training the health care workers who will implement them. Through this process of standardization, it will also be important to address some of the common challenges faced in implementing these interventions: the technical expertise required, difficulty in keeping the interventions brief enough to be easily integrated into existing services, and the lack of alcohol dependency treatment services for referral of patients who are identified as needing such services. Additional suggestions included the following:

- *Comprehensive integration.* A less understood but equally important area for future programming is how to integrate screening and counseling for hazardous alcohol use into ART adherence and prevention programs for PLHIV.
- *Implementation guidance and evaluation.* There remains a great need for dissemination of guidance and technical assistance for implementing such programs, and also for ongoing evaluation to determine the programs' effectiveness over time.

IDENTIFYING RESOURCES

- *Identify existing resources.* Participants recommended that before seeking financial and technical resources from country teams, stakeholders should first understand the community assets that are already available for tackling risky drinking. Local resources may include existing alcohol abuse prevention programming that is provided in schools or religious institutions. This programming was not noted by country teams because they focused exclusively on HIV. Likewise, policies or laws that support alcohol risk reduction may already exist but are not being enforced for lack of training or resources. Identifying and capitalizing on these latent opportunities is one way to kick-start programming.
- *Seek national and international support.* New fiscal resources for alcohol programming can include funding from PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria, or other bilateral or multilateral funding agencies, as well as government taxes or levies on alcoholic beverages. WHO and the Joint U.N. Programme on HIV/AIDS should also play an important role in helping countries include alcohol in HIV national strategic plans and in facilitating the technical assistance needed to operationalize these plans.

KEY RECOMMENDATIONS

Based on these discussions, four key recommendations emerged as promising approaches for achieving progress in the near term:

1. Create a web-based knowledge hub on alcohol and HIV, based at an African institution, to share policy advancements, research findings, intervention tools, and program evaluation data. In particular, the knowledge hub should include a working group to spur the further adaptation and standardization of tools for implementing the WHO Brief Intervention model for health care settings, provide a forum to help advocates and policymakers learn from each others' efforts and build collaborative national and regional networks, and link those in need with Africa-based providers of technical assistance.
2. Seek a joint public statement from OGAC, the Joint U.N. Programme on HIV/AIDS, and WHO outlining the importance of addressing alcohol within any comprehensive HIV response, followed by cross-sectoral country-led forums to identify opportunities and gaps in current programs, policy, and funding, and to spur action planning.
3. Inclusion of additional resources by PEPFAR country teams in their Country Operational Plans for HIV and alcohol programming, based on initial action plans developed at this technical consultation.
4. Facilitation/coordination by OGAC of technical assistance to country teams for further development, implementation, and monitoring of the alcohol and HIV activity plans that were begun during this technical consultation.

APPENDIX A: AGENDA

PEPFAR Southern and Eastern Africa Technical Consultation on Alcohol and HIV Prevention, April 12–14, 2011, Windhoek, Namibia

Day One: Tuesday, April 12

8:00 a.m.–8:30 a.m.

Registration

8:30 a.m.–10:00 a.m.

Introductions and Welcome

Moderated by Dr. Nina Hasen, OGAC, United States

Official Welcome

Her Excellency Wanda Nesbitt, Ambassador of the American Embassy to Namibia

Keynote Address

Petrina Haingura, Deputy Minister of Health and Social Services, Namibia

State of Alcohol Programs in Eastern and Southern Africa: Where are We Now and Where are We Going?

Dr. Katherine Fritz, AIDSTAR-One and the International Center for Research on Women, United States

Review of Agenda and Site Visits

Dr. Mary Glenshaw, CDC, United States

10:00 a.m.–10:30 a.m.

Break

10:30 a.m.–12:30 p.m.

Research and Epidemiology

Moderated by Rene Adams, MOHSS, Namibia

Alcohol and HIV: State of the Literature

Dr. Isidore Obot, Department of Psychology, University of Uyo; Centre for Research and Information on Substance Abuse, Nigeria

Alcohol and HIV Epidemiology in Africa: Research Updates

Dr. Leickness Simbayi, Human Sciences Research Council, South Africa

Know Your Epidemic: Measuring Alcohol Use and Associated HIV Risks—A Case Study from Namibia

Dr. Mary Glenshaw, CDC, United States

- 12:30 p.m.–1:30 p.m. **Lunch**
- 1:30 p.m.–3:15 p.m. **Current Strategies**
Moderated by Freida Katuta, MOHSS, Namibia, and Brad Corner, USAID, Namibia
- Global Status Report on Alcohol and Health and Policy and Program Update from the World Health Organization**
 Dr. Vladimir Poznyak, WHO, Switzerland
- The World Health Organization’s Regional Strategy for Africa: Reducing Harmful Use of Alcohol**
 Carina Ferreira-Borges, WHO Regional Office for Africa, Congo
(Presented by Dr. Vladimir Poznyak, WHO, Switzerland)
- The PEPFAR Alcohol Initiative in Namibia**
 Dr. Nick DeLuca, CDC, Namibia
- Namibia Ministry of Health and Social Services Strategy for Alcohol Control**
 Rene Adams, MOHSS, Namibia
- 3:15 p.m.–4:30 p.m. **Small Group Work and Rolling Break**
- 5:00 p.m.–6:00 p.m. **Social Event**

Day Two: Wednesday, April 13

- 8:00 a.m.–8:15 a.m. **Review of Day One and Day Two Agenda**
Moderated by Dr. Mary Glenshaw, CDC, United States
- 8:15 a.m.–10:00 a.m. **Responding to the Needs of Specific Populations**
Moderated by Kristen Ruckstuhl, USAID, United States, and Brad Corner, USAID, Namibia
- People Living with HIV, Alcohol, and Antiretroviral Therapy Adherence**
 Dr. Connie Kekwaletswe, Medical Research Council, South Africa
- Alcohol Use and Tuberculosis**
 Dr. Charles Parry, Medical Research Council, South Africa
- Alcohol Programming as a Component of Positive Health, Dignity, and Prevention**
 Dr. Nick DeLuca, CDC, Namibia

Alcohol/Drug/HIV Risk Reduction in Kibera Slums, Nairobi
Dr. William Sinkele, Support for Addictions Prevention and Treatment in Africa, Kenya

10:00 a.m.–10:30 a.m.

Break

10:30 a.m.–1:00 p.m.

Programmatic Approaches

Moderated by Kristen Ruckstuhl, USAID, United States, and Brad Corner, USAID, Namibia

Community- and Bar-based Programs

Dr. Neo Morojele, Medical Research Council, South Africa

The Phaphama Brief Risk Reduction Intervention to Reduce Both Alcohol Use and HIV/Sexually Transmitted Infection Risks in Clinical and Community Settings

Dr. Leickness Simbayi, Human Sciences Research Council, South Africa

Integrated Surveillance Among Persons Attending Alcohol Consumption Venues in Gaborone, Botswana

Dr. Phenyo Lekone, CDC, Botswana

Approaches in Tanzania

Dr. Norman Sabuni, Ministry of Health and Social Welfare, Tanzania

Alcohol Abuse and HIV in Military Populations

Dr. Freda Vaughan, DOD, United States

Alcohol and Mobile Populations: Program Responses

Joseph Ochieno, Family Life Education Program, Kenya

1:00 p.m.–2:00 p.m.

Lunch

2:00 p.m.–3:30 p.m.

Legislative and Policy Interventions

Moderated by Dr. Thomas Kresina, Substance Abuse and Mental Health Services Administration, United States

Alcohol Use and Its Effect on HIV in Africa: Designing Effective Policy Responses

Dr. Charles Parry, Medical Research Council, South Africa

The Alcohol Levy in Botswana and Other Government Interventions on Alcohol Abuse

Phenyo Sebonego, Ministry of Health, Botswana

Alcohol Legislation in Kenya: Contributing to HIV Prevention Management

Aggrey Busena, National Campaign Against Drug Abuse Authority, Kenya

3:30 p.m.–5:00 p.m. Small Group Work and Rolling Break

Day Three: Thursday, April 14

8:00 a.m.–9:30 a.m. Full Group Discussion: Bringing It Home
Moderated by Billy Pick, USAID, United States

9:30 a.m.–10:00 a.m. Break

10:00 a.m.–12:00 p.m. Full Group Discussion: Bringing It Home (Continued)
Moderated by Billy Pick, USAID, United States

12:00 p.m.–12:30 p.m. Close of Meeting
Moderated by Dr. Nina Hasen, OGAC, United States

12:30 p.m.–1:30 p.m. Lunch

1:30 p.m.–5:30 p.m. Site Visits

APPENDIX B: PARTICIPANTS

Name	Country	Organization
Adams, Rene	Namibia	MOHSS
Agaba, Denis	Uganda	Communication for Development Foundation Uganda
Amaambo, Taimi	Namibia	WHO
Anania, Bilibela	Angola	U.S. DOD Angola
Asefa, Wondwossen	Ethiopia	USAID
Ayingoma, Jean Pierre	Rwanda	National AIDS Control Commission
Bauer, Father Rick	Namibia	Catholic AIDS Action
Botsang, Ofitlhele	Botswana	Botswana Ministry of Trade
Buruga, Patrick	South Sudan	IntraHealth International
Corner, Brad	Namibia	USAID
Cummings, Beverley	Mozambique	CDC
Da Graca Neto, Maria Bela	Angola	Angola Armed Forces
DeLuca, Nick	Namibia	CDC
Du Preez, Verona	Namibia	MOHSS
Engelbrecht, Salen	Namibia	Nawalife Trust
Eshete, Hailegnaw	Ethiopia	Ethiopian Public Health Association
Fakory, Ladan	United States	USAID
Ferrao Simbine, Ana Paula	Mozambique	CDC
Fertziger, Rebecca	South Africa	USAID
Fritz, Katherine	United States	AIDSTAR-One/International Center for Research on Women
Gakuo, Wairimu	Kenya	USAID
Glenshaw, Mary	United States	CDC
Hasen, Nina	United States	OGAC
Hurwitz, Elizabeth	United States	John Snow, Inc., AIDSTAR-One
Johansen, Anna	Angola	USAID
Jones, Melissa	Namibia	USAID
Kagoya, Harriet	Namibia	Society for Family Health
Kalombo, Olivier	Democratic Republic of the Congo	U.S. DOD Democratic Republic of the Congo
Kandjii, Manfredine	Namibia	MOHSS
Kategile, Upendo	Tanzania	USAID
Katutua, Frieda	Namibia	MOHSS
Kawogo, Malisela	Tanzania	U.S. DOD
Kekwaletswe, Connie	South Africa	Medical Research Council

Name	Country	Organization
Kitenge, Francois	Democratic Republic of the Congo	CDC
Kresina, Thomas	United States	Substance Abuse and Mental Health Services Administration
Kuleba, Ilda	Angola	Population Services International
Kunene, Patrick	Swaziland	DOD
Langa, Antonio	Mozambique	DOD
Lekone, Phenyoy	Botswana	CDC Botswana
Lifuka, Eda	Zambia	DOD, PEPFAR
Louw, Annelize	Namibia	MOHSS
Maiuri, Allison	Namibia	CDC
Maker, Aadielah	South Africa	Soul City
Makuach, Lia	South Sudan	SPLA HIV/AIDS Secretariat
Maloney, Libet	Namibia	IntraHealth International
Manzi Mukankusi, Gloria	Rwanda	CDC
Maringa, Hilda	South Africa	CDC
Matiko, Eva	Tanzania	CDC
Mebratu, Afework	Ethiopia	CDC
Morojele, Neo	South Africa	Medical Research Council
Muhenje, Odylia	Kenya	CDC
Murargy, Shadit	Mozambique	USAID
Muremi, Hon. Nimrod	Namibia	Kavango Regional Council
Mushaukwa, Cletius	Namibia	Society for Family Health
Musonda, Joanne	Zambia	Peace Corps
Muturi, John	Kenya	National Campaign Against Drug Abuse Authority
Mwamburi, Emma	Kenya	USAID
Ndubani, Phillimon	Zambia	CDC
Oaes, Angela	Namibia	ERRC
Obot, Isidore	Nigeria	University of Uyo
Ochieno, Joseph	Kenya	Family Life Education Program
Onsarigo, Alice	Kenya	FHI
Parry, Charles	South Africa	Medical Research Council
Pepin, Amy	United States	John Snow, Inc., AIDSTAR-One
Phiri, Ngaitila	Zambia	USAID
Pick, Billy	United States	USAID
Poznyak, Vladimir	Switzerland	WHO
Ritzenthaler, Robert	Kenya	FHI
Ruckstuhl, Kristen	United States	USAID
Sabuni, Norman	Tanzania	MOHSS
Sebonego, Phenyoy	Botswana	Ministry of Health

Name	Country	Organization
Shigwedha, Ethiopies	Namibia	Society for Family Health
Shityuwete, Jane	Namibia	LifeLine/ChildLine Namibia
Simbayi, Leickness	South Africa	Human Science Research Council
Sinkele, William	Kenya	Support for Addictions Prevention and Treatment in Africa
Stash, Sharon	United States	John Snow, Inc., AIDSTAR-One
Tembo, Prisca	Botswana	CDC/Botswana-USA Partnership
Tibihenda, Hardson	Uganda	DOD
Tiruneh, Desta	Namibia	WHO
Tlhong, Boikanyo	Botswana	University Research Corporation
Vaughan, Freda	United States	U.S. DOD
Victor, Aune	Namibia	DOD
Voetsch, Karen	Botswana	CDC/Botswana-USA Partnership
Whittaker, Clarice	Namibia	Ministry of Regional Local Government, Housing and Rural Development
Woldesenbet, Endeshaw	Ethiopia	Federal HIV/AIDS Prevention and Control Office
Zimulinda, Eugene	Rwanda	DOD

APPENDIX C: RESEARCH AND PROGRAM PLANNING MATRIX

COUNTRY: _____

	1. Data and Research	2. Policy, Legislative, and Environmental Approaches	3. Health Sector Approaches	4. Community, BCC, and Health Education Approaches
<i>What is known?</i>				
<i>What has been implemented or planned?</i>				
<i>What is not known that would be helpful in program planning?</i>				
<i>What are possible data sources?</i>				
<i>What opportunities exist for planning, conducting, implementing, and evaluating activities?</i>				
<i>What are threats to planning, conducting, implementing, and evaluating activities?</i>				

Instructions: Please note currently implemented and planned activities related to alcohol misuse prevention, or alcohol control as a driver of the HIV epidemic in your country. Be sure to list any activities related to alcohol use alone, and alcohol use in conjunction with HIV prevention, care, and treatment activities. Please see the following page for guidance.

1. Data and research

- a. What types of alcohol are used?
- b. What is the quantity and frequency of alcohol use among adults?
- c. What patterns of alcohol abuse have been documented or observed?
- d. What is the prevalence or correlation of alcohol use and/or abuse among sexually active adults? PLHIV? Persons with TB? Unintended pregnancies? STIs? Violence? Gender-based violence?
- e. How do drinking patterns vary by age and by sex?

2. Policy, legislative, and environmental approaches

- a. What alcohol control laws exist in your country?
 - i. Minimum drinking age?
 - ii. Days/hours of alcohol sales?
 - iii. Drunk driving policies, minimum blood alcohol content?
 - iv. Alcohol taxation?
 - v. Restrictions on types of alcohol made/sold?
 - vi. Restrictions on advertising?
- b. How is revenue from alcohol sales/imports/exports used for health programming?
- c. How is revenue from alcohol taxes used for health programming?
- d. Have any alcohol sales venue (i.e., bars) programs been instituted to promote harm reduction?
- e. Does alcohol control feature in the national HIV prevention and control strategy?

3. Health sector approaches

- a. What health care services exist for identifying or treating alcohol misuse?
- b. What training is provided for health care workers related to alcohol screening and brief intervention?
- c. What inpatient or outpatient treatment services (including support groups) are available?
- d. How is alcohol addressed in HIV testing programs?
- e. How is alcohol addressed in HIV care and treatment programs?

4. Community, BCC, and health education approaches

- a. What public messaging or mass media campaigns about alcohol misuse have been disseminated?
- b. What “small media,” BCC, or information, education, and communication materials exist regarding alcohol misuse?
- c. What community programs exist that address alcohol hazards?
- d. How do school health education programs address alcohol use among youth?
- e. Do any programs address alcohol use among most-at-risk populations (military, sex workers, men who have sex with men, mobile populations)?

APPENDIX D: WORLD HEALTH ORGANIZATION WEB RESOURCES

Global Strategy to Reduce Harmful Use of Alcohol:

www.who.int/substance_abuse/activities/gsrhua/en/index.html

Screening and Brief Interventions for Alcohol Problems in Primary Health Care:

www.who.int/substance_abuse/activities/sbi/en/index.html

The ASSIST Project—Alcohol, Smoking, and Substance Involvement Screening Test:

www.who.int/substance_abuse/activities/assist/en/index.html

Mental Health Gap Action Programme: Scaling up Care for Mental, Neurological, and Substance Use Disorders: www.who.int/mental_health/mhGAP/en/

Integrated Management of Adolescent and Adult Illness (IMAI) Modules:

www.who.int/3by5/publications/documents/imai/en/

APPENDIX E: INVITATION LETTER

31 March 2011

Dear [participant name]:

We are pleased to announce that you have been recommended to participate in the technical consultation, “PEPFAR Southern & Eastern Africa Technical Consultation on Alcohol and HIV Prevention” to be held 12-14 April 2011 at the Safari Court Hotel in Windhoek, Namibia.

The three-day technical consultation will explore approaches to alcohol risk reduction programming in sub-Saharan Africa, with input from WHO, PEPFAR, national governments, non-governmental programs, and subject matter experts. This consultation will provide an opportunity for stakeholders to exchange and promote best practices for reducing alcohol-associated sexual risk behaviors. A draft agenda is attached to this invitation.

Representatives from the following countries have been invited: Angola, Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

The consultation is scheduled for three days. Sessions will begin promptly at 08:00 and end between 17:00 and 17:30. Lunch will be provided on site, along with coffee breaks throughout the day. Breakfast is provided for hotel guests.

At the request of PEPFAR, AIDSTAR-One is coordinating the logistics for this technical consultation. **Please follow the steps detailed below to prepare for the event.**

- 1) **Confirm your participation as soon as possible** by registering at <http://guest.cvent.com/d/4dqbbh>.
- 2) **Make individual travel arrangements:** Participants based outside of Windhoek should plan to arrive no later than Monday, 11 April and depart no earlier than 17:30 on Thursday, 14 April.
Please note that it is your responsibility to make all travel arrangements and acquire any monies needed for participation.
- 3) **Book lodging via meeting registration site:** A block of rooms are reserved for participant accommodation at the Hotel Safari. For additional information on rates and booking, visit <http://guest.cvent.com/d/4dqbbh/1K>.
Hotel address:
Hotel Safari
Corner of Auas and Aviation Streets
Windhoek, Namibia
Hotel website: <http://www.safarihotelsnamibia.com/home.html>
For information on booking your reservation, visit: <http://guest.cvent.com/d/4dqbbh/1K>
- 4) **Obtain visa letter (if needed):** If you need a visa letter, please contact Amy Pepin at aepin@jsi.com.
- 5) **Complete Research and Program Planning Matrix:** A pre-event program planning tool is attached, requesting an analysis of Strengths, Opportunities, Weaknesses, and Threats (SWOT)

of your country's current alcohol and alcohol/HIV related policies and programs. We ask that the participants from each country work as a team to complete this matrix and email it to aepin@jsi.com no later than 31 March, 2011. Guidelines are provided in the matrix.

- 6) **Gather materials for social event and materials sharing:** On the evening of Day 1 (April 12), please join us for a social and networking event. Please bring copies of your "Research and Program Planning Matrix" for distribution to other country teams. Tables will be set up for each country team to display their matrix along with examples of alcohol prevention materials available from their country. Please include examples of guidelines, policy documents, Information and Education Communication (IEC) materials, programmatic tools, local alcohol beverage containers, or other items of interest.
- 7) **Register for site visits:** On the afternoon of Day 3 (April 14), site visits to local Namibian alcohol program activities will be available. We will send instructions about registering for the site visits after March 18th. Sites include:
 - Etegemeno Rehabilitation and Resource Center and local support groups
 - Community meeting of a local chapter of the Coalition for Responsible Drinking (CORD)
 - A drive through of Evaline Street, a high density area of bars (sheebens)
 - Alcohol and HIV research sites

We look forward to hearing from you!

Please do not hesitate to contact: Amy Pepin with any questions at aepin@jsi.com or +1 703-310-5167.

Regards,

PHPEHRB (MARPs)TWG Co-Chairs

Clancy Broxton, USAID

Rich Needle, OGAC

**Anne Thomas, U.S. Department of
Defense**

Linda Wright-De Agüero, CDC

**General Population and Youth Prevention TWG
Co-Chairs**

Shanti Conly, USAID

Nina Hasen, OGAC

Linda Wright-De Agüero, CDC

For more information, please visit aidstar-one.com.

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