International Seminar on Socio-Economic and Mental Health Burdens of HIV/AIDS in Developing Countries

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Welcome Address

Dr. Mohamed Salleh Yasin
Director - United Nations University International Institute For Global Health

Distinguished guest speakers, esteemed researchers and academicians, members of the media, ladies & gentlemen.

It is such a great honour for me as the Director of the United Nations University - International Institute for Global Health (UNU-IIGH) to welcome all of you here, in this hall to the International Seminar on “Socio Economic and Mental Health Burdens of HIV-AIDS in Developing Countries.”

I am pleased to inform you that this maybe the first Socio-economic and Mental Health Burdens of HIV/AIDS seminar held in Malaysia and its being organized by UNU-IIGH in collaboration with the Centre of Excellence of Research in AIDS (CERIA), Universiti Malaya.

I would like to extend my heartfelt appreciation to the Ministry of Health, Malaysia for supporting this seminar. I am also very glad to report that this International Seminar has brought together 21 prominent guest speakers from 14 countries (Kenya, Nigeria, Uganda, Ghana, India, Thailand, Philippines, Thailand, Yemen, Japan, USA, Switzerland and Australia including Malaysia) and that should cover all the 5 continents (Africa, Europe, Asia, Oceania and America). We have among us here in this hall- scientists, researchers, policy makers, civil society representatives, frontline workers, UN agencies and Non-Governmental Organizations (NGOs) from Malaysia and abroad to share significant findings and experiences from a multidisciplinary approach on the issue of Socio-economic and Mental health burdens of HIV/AIDS especially in Developing Countries.

Three decades have passed since HIV/AIDS first erupted in our lives. Within the framework of the Millennium Development Goals (MDGs) especially the MDG 6, HIV/AIDS still remain a public health phenomenon of international concern. Given the magnitude of the pandemic especially in low- and middle-income countries any efforts to combat it would require a multidisciplinary and multispectral approach.

This international seminar is crucial as the relation and interaction between HIV/AIDS and mental health has not been well-documented; although together they pose serious global health challenges with as high as 90% of mental health cases were related to HIV/AIDS in recent years.

Sadly, due and adequate attention has not been given to address this condition and it is worst if it relates to developing countries as more than 80% of the global population lives in low and middle income countries. Evidently, little research on mental condition related to HIV/AIDS has been carried out and in some cases, even policies formulation are not present in these countries. Perhaps, many of us here know someone who are infected with HIV/AIDS and recognized that the social and economic consequences of HIV/AIDS and mental health are not limited only to those infected - but also affect their partners’ stability, family members, caregivers, friends, neighbours and community at large. Costs involved in mitigating HIV/AIDS related problems and updating information on household socio-economic impact of HIV/AIDS are also very limited despite their importance in assessing the socio-economic burden and in guiding key policy decisions.

This seminar will focus essentially on highlighting the less addressed and/or neglected areas of Mental Health and Socio-economic Impacts of HIV/AIDS in developing countries. Identifying gaps in policies are also the reasons we are conducting this seminar. We are here today to mark the gains we have made over the last 30 years and to look ahead with hope and purpose at steps we must take in our fight against HIV/AIDS and mental health.
For us, it is imperative to include basic mental health interventions in HIV/AIDS initiatives as promoted by the World Health Organization (WHO). UNU-IIGH in its mission to promote policy relevant research, capacity development and dissemination of knowledge is ever ready to provide a platform for exchanging and discussing knowledge and experiences on a multi-disciplinary approach on issues of socio-economic and mental health burdens of HIV/AIDS.

In the next 2 days, we will share experiences, successes, failures and challenges of the healthcare providers in the developing countries in addressing issues related to the socio-economic and mental health burdens. There will be presentations on case studies and researches done based on thematic areas both related to socio-economic and mental health burdens as well as in health care delivery. Tomorrow afternoon will be allocated for the round table discussion with the aim to collate the key issues arising from the presentations and come out with a call for action. Moving forward, we will work on identifying possible solutions or realistic strategies for future policies and indeed, we must also highlight areas for further research opportunities.

We would expect active interactions among prominent scientists, researchers, policy makers, civil society representatives, frontline workers, UN agencies and Non-Governmental Organizations (NGOs) and fellow participants as this is a golden opportunity for networking towards the betterment of this marginalized member of the society. I believe that at the end of these 3 presentation sessions and the roundtable discussion, we will be able to successfully meet the seminar’s goal as well as our own objectives.

Thank you once again to our distinguished invited speakers, academics and researches for sharing your experiences and insights with us. To all participants, I wish you a fruitful seminar.

Last but not least, I would like to thank the organizing committee for the good work in making this seminar a reality.

Thank you.
SESSION 1: MENTAL HEALTH BURDEN OF HIV/AIDS IN DEVELOPING COUNTRIES
ABSTRACT

HIV/AIDS and Mental Health in Kenya: The Challenges and Opportunities

David Musyimi Ndetei
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This paper examines the relationships between mental illness and HIV/AIDS on Global Scale and then focuses on the Kenyan situation, examining Kenyan Data from 2 different perspectives - urban and rural with special emphasis on IDUs.

There is now substantial global data and evidence to support the burden posed by the cause-effect relationship between Mental Health disorders and HIV/AIDS and the attendant burden. This is a problem significantly more important in developing countries than in developed countries because of insufficient resources - both financial and human. However, there is hope that if we utilized and maximized on the resources already at our disposal, it is possible to find sustainable solutions to overcome the challenges and barriers and significantly reduce the burden.

The emerging data from a PEPFAR support HIV/AIDS surveillance in a rural setting in Kenya clearly suggests that people with HIV/AIDS are not only living much longer but are also striving to achieve normal lives including routine activities of daily living. All this is thanks to the increased availability of ARVs and the much reduced stigma against HIV/AIDS. Despite the wide availability of ARVs and reduced Stigma, the ability to function normally and achieve full compliance with the ARVs is severely compromised by brain diseases that are secondary to the viral involvement of the brain or as a result of life stressors, presenting as cognitive dysfunctions that seem to have an independent course despite the ARV treatment but also co-morbid depressive illness whether casual or causal. Depressed people may have a pessimistic view of themselves, thus compromising ARV compliance or may compromise the immunological progression as a result of the HIV/AIDS, independent of the ARVs.

This calls for integration of the HIV/AIDS and mental health management in diagnosis, and treatment. This poses a challenge to understaffed clinics and overworked staffs with no mental health skills and even if they had the skills, they do not have the time needed for adequate psychiatric interviews and MSE for the diagnoses and management of mental disorders. However, this can be overcome by devising easy to administer screening and diagnostic instrument such as the GMHAT with suggested management. This approach not only facilitates dual diagnosis and management, but will help to integrate the information systems on those two conditions.
ABSTRACT 2

Psychosocial Needs of Children and Families Affected by HIV/AIDS

Meena Cabral de Mello

World Health Organisation (WHO), Geneva, Switzerland.

Children and their families living in communities affected by HIV/AIDS face many varied problems. It is well established that multiple risks such as poverty, malnutrition, poor health and unstimulating home environments detrimentally affect cognitive motor and social-emotional development in young children. These disadvantages are known to set up a cycle of poor school performance and subsequent low income, high fertility and poor care environments for their children in turn. Furthermore, evidence suggests that interventions are at hand to modify risks and ameliorate the impact.

Young children face HIV/AIDS related threats in a number of facets of their wellbeing as their caregivers are lost, their security is threatened, their livelihoods are overshadowed and they, themselves are exposed to illness and infection. The children in an HIV/AIDS affected environment are subjected to material and emotional deprivation, overwhelming grief, multiple bereavement, social upheaval, stigma and discrimination and, at times, forms of social exclusion. Much of this is couched in a backdrop of poverty and stretched resources. The best predictor of outcome for children suffering from parental loss is the quality of subsequent care.

Family needs: Community and programme responses are required to incorporate these needs, to strengthen caregivers and households’ capacity to respond and ensure the wellbeing of all children. These need to be contained in an enabling series of national policies which may need to earmark reserves, mobilize new reserves or integrate programmes at the highest level. The very young child is best nurtured and protected in the folds of the family and to date such family provision has been the mainstay of the response to children and HIV/AIDS. There is convincing evidence that early child development programmes can be effective.

Quality child development: Emotional development, psychological development and physical development overlap. What is important for young children is unconditional love, parenting with permanence, pathways to learning and quality environment. Children live in a variety of families, nuclear, reconstituted, extended, foster/adoption situations and changeable environments. The quality of care is seen as a key determinant of adaptive outcome.

Strengthening at the family level is good for children wellbeing. Many individual based programmes are generated in response to HIV, specifically in relation to prevention, care and treatment. However, for young children, a response at the family level is needed to protect, support, enable, and promote psychological wellbeing of young children as they develop. Protective environments and responses that support and enrich such environments not only promote resilience and coping adaptation in children as they grow - they also act as an investment for adaptive children who grow into adulthood. The absence of responsive and sensitive care has been associated with developmental problems, emotional difficulties, childhood malnutrition and failure to thrive. The presence of sensitive care with responsive and sustained input is associated with healthy cognitive and social development. These provisions are best provided or enhanced within a family setting.
ABSTRACT 3

Reasons for Living among PLHIV in the Philippines

Maria Isabel Echanis-Melgar
Ateneo de Manila University, Philippines.

The prevalence of suicide ideation and suicide attempts during the early months of diagnosis have been observed during clinical work by the author with some of the men and women newly diagnosed with HIV. Depression, hopelessness and grief among positive clients were among the common psychological and emotional conditions that have put PLHIV at risk for ending their lives. These negative psychological conditions were mainly attributed to the stigma and shame associated with the dreaded disease as well as the life threatening nature of this disease. However, many have survived this critical phase and moved on with their lives remarkably well. A review of local literature revealed no single study ever done to investigate the predictors and protective factors against suicidality among Filipino PLHIV. The aim of this study is to explore and identify the reasons for living and other psychosocial factors that have helped our PLHIV respondents lived well with HIV. The present study surveyed 96 people with HIV with ages ranging from 22 to 50 years where the duration of illness ranged from one month to 21 years or a mean of 45 months. There were 67 males and 28 females who participated in the study. In terms of religion, 74% were Roman Catholics. Survey questionnaires administered were the Filipino Reason for Living Scale (FRLS), the Rosenberg Self Esteem Scale, the Coping Self Efficacy Scale and a Personal Profile Form. Respondents obtained a mean high score of 149.5 (S.D. =13.5) on the FRLS where the maximum possible score was 162. A factor analysis of the FRLS responses revealed that the most critical dimensions underlying the reason for living were a strong relationship with God and the support received from the family. Among the variables, the coping mechanisms utilized by PLHIV respondents were found to be correlated with reasons for living. Furthermore, this study found that the top coping strategies used by PLHIV were praying to God; making new friends; standing firm and fighting for what they want; engaging in positive talk; doing something positive when discouraged; and getting support from the family. All the other variables such as self-esteem, extent of disclosure about their status, employment and years of diagnosis had very little relationship with reasons for living. These findings show that faith in God and support from the family may bolster resilience and protect against suicidality among people living with HIV and AIDS. Moreover, this study highlights the key role of HIV counsellors in helping clients disclose their HIV status to family members and in enlisting the positive support of the latter. The study also identifies spiritual counselling as a critical component particularly in the early stages of HIV diagnosis. The motivation to live an inspired life amidst the fact that there is no cure for this condition and AIDS stigma remains strong in the society is a lifelong challenge for those infected and affected by HIV.
ABSTRACT 4

Challenges in Delivering Effective Mental Health Services to People with HIV Infection in Custodial Setting

Muhammad Muhsin Ahmad Zahari1,2, Adeeba Kamarulzaman1, Frederick Altice3

1Centre of Excellence for Research in AIDS (CERiA), University of Malaya, Malaysia.
2University of Malaya Centre for Addiction Sciences (UMCAS), Malaysia.
3Yale University, USA.

People with HIV have higher prevalence in the custodial settings as compared to the general population. HIV infection in many countries has been closely related to the use of illicit drugs via intravenous route. In Malaysia there are significant proportion of HIV infection are transmitted via this way. There was around 95% of HIV infected prisoners were heroin addict who injected themselves

This is even more important when the use of illicit drugs has been criminalised. The criminalisation of illicit drug which has been the primary approach in tackling drug problems results in the difficulties in delivering health service to those have been detained due to the use of illicit drugs.

There are growing positive evidence which shows medical and psychosocial modes of treatment for tackling drug related harms resulted in better outcomes.

Issues of co-morbidity in those who use drug are also important consideration when providing mental health service to individuals with HIV infection. It is even more complex when these people are incarcerated

These issues are discussed in this presentation. This will be based on researches (HARAPAN Project) which are undertaken in one of the prison facilities.
ABSTRACT

Mental Health Aspects of HIV/AIDS - Indian Perspective

Kasi Sekar¹, Sudeep Jacob Joseph¹, Arthur Joseph²

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²Centre for Addiction Medicine, NIMHANS, Bangalore, India.

India is a country with low HIV prevalence, yet, has the third largest number of people living with HIV/AIDS. An estimated 2.39 million people live with HIV/AIDS with an adult prevalence of 0.31%. The estimates highlight an overall reduction in adult HIV prevalence, incidence and AIDS related mortality in India (NACO, 2011).

Psycho-social factors that impinge upon HIV progression include emotional well-being, stressors, coping skills and psycho-social support. The multi-centric study by NIMHANS supported by NIH highlights the effects of HIV stigma leading to mental health consequences like loss of self-esteem and self-worth. It is imperative to address stigma to improve the quality of life of PLHIVs (Ramakrishna et al., 2010).

The frequency of AIDS Dementia Complex has declined to less than 20% and is seen in 1-2% of persons on HAART in India (Satishchandra et al., 2000). The mental health conditions seen at the NIMHANS HIV Clinic include depression being the commonest and its lifetime prevalence going upto 60%. Anxiety disorders are also common conditions among PLHIVs with around one-third having feature of it. Delirium has a prevalence of 40-60%. Psychosis is less common, but occurs in 4-10 % of PLHIV. Sleep disorders and Suicidality are commonly reported in the above diagnoses (Prabhachandra, 2011).

Sexuality minorities being special groups have special mental health needs and are subject to immense marginalization. LGBT people are at higher risk for depression, anxiety, and substance use disorders (Ranade, 2003). The use of any mind altering substance causes serious problems to a person’s physical and mental health as well as to the family (Prathimamurthy, 2011).

Given this close intertwining of multiple factors in PLHIVs, a psycho-social model of care was developed by NIMHANS to address the mental health needs of PLHIVs through a cascading capacity building through training of trainers to train professional and lay counsellors. The capacity building kit has been standardised through the process of training Master Trainers for the country.
ABSTRACT 6

Mainstreaming Mental Health into the Development Priorities in the United Nations

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Mental health represents a critical indicator of human development, serving as a key determinant of well-being, quality of life, and hope. As such, mental health has an impact on a range of development outcomes. There is growing recognition within the international community that mental health is one of the most neglected yet essential development issues.

The adoption of the Convention on the Rights of Persons with Disabilities in 2006 by the United Nations General Assembly provided momentum to highlight the importance of the nexus between disabilities and mental health in the context of human rights, peace and security, humanitarian activities and in development work including response to AIDS. In addition, the Ministerial Declaration on Implementing the Internationally Agreed Goals and Commitments in Regard to Global Public Health, in the high-level segment of the substantive session of the Economic and Social Council in July 2009, highlighted the importance of integrating mental health into the implementation of the MDGs and other internationally agreed development goals and commitments, in order to achieve development outcomes.

Based on these new developments, the Department of Economic and Social Affairs (DESA) of the United Nations and the World Health Organisation (WHO) issued the “United Nations-WHO Policy Analysis: Mental Health and Development: Integrating Mental Health into All Development Efforts including MDGs” in 2010. This document serves as a foundation for further mainstreaming of mental health into the development agenda including response to AIDS in the United Nations system and the broader international community.

In the area of HIV, the United Nations Population Fund (UNFPA) integrated mental health into one of three goals and an outcome of its Strategic Plan: Universal access to reproductive health and comprehensive HIV prevention for improved quality of life. Based on this, UNFPA started to integrate mental health into its fund-wide policies and guidelines, and programmes at regional and country levels. In addition, the United Nations Children’s Fund held a round table on adolescent mental health with partners in April 2011, and placed an emphasis on mental health and AIDS among adolescents.

Poor mental health is both a cause and a consequence of ill-health including issues related to HIV, poverty, compromised education, gender inequality, violence and other global challenges. It impedes the individual’s capacity to realize their potential and make a contribution to their community. On the other hand, positive mental health is linked to a range of development outcomes. Dialogue and consultations on a post-MDGs framework will present critical opportunities to ensure the explicit inclusion of mental health in any emerging development framework for 2015 and beyond. In addition, utilizing best practices from UNFPA and others, it is also important to continue efforts to integrate mental health into strategic plans and other policies and programmes of the United Nations implementing entities. Now is the time to include mental health as an integral part of development through increased recognition of the link between development and mental/emotional well-being, as well as the inclusion of persons with mental and intellectual disabilities, to achieve development for all.
SESSION 2: SOCIO-ECONOMIC BURDEN OF HIV/AIDS IN DEVELOPING COUNTRIES
ABSTRACT 7

Addressing HIV Infection Risks and Consequences among the Elderly (> 50 years) Sub-Saharan Africans

Niyi Awofeso

School of Population Health, University of Western Australia, Australia.

Although Africa is home to about 14.5% of the world’s population, it is estimated that 67% of all people living with HIV and about 72% of all HIV/AIDS-related deaths in 2009 occurred among Africans. Between 2009 and 2010, life expectancy in Sub-Saharan Africa (SSA) was 52 years, Gross National Product per capita was $US1,165 and adult literacy rate was 62%. SSA’s average Human Development Index (HDI) - a composite international measure of trends in education, income and life expectancy- rose modestly from 0.456 to 0.522 between 1990 and 2005. The life expectancy component of the HDI in SSA showed even slower progress, from 0.482 to 0.508, mainly due to HIV/AIDS-related premature mortality. Macroeconomic model studies funded by the Economic Commission for Africa in the most HIV/AIDS affected African countries indicate annual average decline in GDP per capita as far as 2025 would be in the order of 0.3% and 1.0%, due to the observed trends that HIV affected poorer and least productive sectors of the economy. However, such models focus on productivity in the formal sector, ignoring the reality in SSA, where subsistence farming, unpaid carer duties by the elderly and vulnerable employment constitute a critical portion of SSA’s economy. Also, SSA lags behind other regions in terms of hunger reduction. Based on the 2010 Global Hunger Index report, between 1990 and 2010 there was no significant change in the proportion of chronically hungry people in SSA - about 390 million people or half of SSA’s population are chronically hungry - i.e. subsist regularly on less than 1800 calories/day. The combined effects of poverty, under-nutrition and high HIV/AIDS have important socio-economic and mental health implications for elderly residents in SSA. AIDS stigma, linked mainly to social and religious mores which associate HIV/AIDS infection with homosexuality and promiscuity. Stigma encumbers efforts at early case detection, and precipitates social exclusion for those affected. Elderly Africans living with HIV/AIDS are particularly vulnerable to such social exclusion and discrimination, given the massive erosion of social capital consequent upon HIV/AIDS diagnosis among this cohort.

HIV/AIDS affects social and economic development at many levels: individual, household, community, business, governmental, and macroeconomic. This presentation focuses on the socio-economic implications of HIV/AIDS among SSA’s elderly. SSA’s elderly currently endure the triple burden of having high HIV prevalence, lacking adequate social safety net, work fitness, or family support to fund management of the disease, and having to care for grandchildren orphaned by high injury, non-communicable disease and HIV/AIDS infection rates among younger adults. Evidence-based policies and programs to address HIV infection risks and consequences among SSA’s elderly are discussed.
ABSTRACT 8

Socio-Economic Impact of HIV/AIDs and Mental Health

Syed Mohamed Aljunid

HIV/AIDS and Mental Health are two chronic diseases with huge economic burden in developing countries. For HIV/AIDS, this year marked three decades since HIV/AIDs first identified with more than 34 million people in the world are living with this chronic condition with 2.6 million new cases.

More than 90% of cases are adult in their economically productive life and nearly half are women. Even though HIV/AIDs incidence fell by more than 25% in 33 countries for the last ten years, the existing burden is still huge. Africa, the least resource continent in the world bears most of the brunt of this chronic condition housing nearly two thirds of global HIV positive cases. It is estimated that the available resources for HIV/AIDs in 2009 is USD 15.9 billion, there is a shortage of nearly USD10 billion. Only one third of these countries make HIV/AIDs a high budgetary priority. Mental illness is a chronic non-communicable disease responsible for 37% of global healthy life years lost. It was also estimated that in 25% of the patients visiting any health facilities, at least one suffer from undiagnosed mental health, neurological or behavioural disorder. The current global cost of mental health is estimated at USD 2.5 trillion. This will increase to USD 6.1 trillion in 2030. More than two thirds of this cost is indirect cost mostly due to loss in productivity. Managing these two conditions posed great challenges to low and middle income countries. Huge economic burden means that additional source of funding should be sought with full participation of all stakeholders. Mobilizing resources at the community level should be seriously considered. Support for community to provide long term care for HIV/Aids and mental health patients should be adequately supported by governments through properly targeted and well organized programme. Incentives and disincentives to influence efficient and effective performance should be put in place with innovative financing approach.

Vertical programme should be avoided while more integrated approach with significant task shifting should be given a priority to ensure success and sustainability. In conclusion, policy makers in low and middle income countries should take positive measures to ensure that HIV/Aids and mental health is properly addressed by mobilising efforts from all stakeholders.

Emmanuel Ayifah¹, Rebecca Nana Yaa Ayifah²

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²International Food Policy Research Institute, Accra, Ghana.

Background: The government of Ghana in 2002 launched a comprehensive programme to prevent mother-to-child transmission (MTCT) of HIV/AIDS. The Prevention of Mother-to-Child Transmission (PMTCT) of HIV/AIDS programme was first piloted in Atua government hospital and St Martin’s de Porres Hospital, in the Yilo and Manya Krobo Districts. In Ghana PMTCT services are free. It is however worth noting that, with the ever increasing public health expenditure in recent years, the government cannot foot the bill on PMTCT all alone. There is therefore the need for individual contributions to ensure sustainability of HIV/AIDS and other health care interventions; hence the study to determine how much pregnant women will be willing-to-pay to prevent MTCT of HIV/AIDS.

Materials and Methods: The study used the open ended bid elicitation method to assess pregnant women’s hypothetical Willingness-to-Pay (WTP) for PMTCT of HIV/AIDS. Respondents (n=200) were drawn from two antenatal clinics (Atua Government Hospital and St. Martins Deporres Hospital) in Ghana. The Ordinary Least Squares (OLS) regression was used to evaluate the determinants of WTP. Verbal informed consent was received from participants.

Results: About 84 and 94 percent of respondents from the Atua Government Hospital and St Martin’s de Porres Hospital respectively were WTP for PMTCT of AIDS. WTP amount ranged between GH¢ 0.5 - GH¢ 20 ( $0.4 - $14.3) with Mean WTP being GH¢3.2 and GH¢ 3.6 ($2.3 - $2.6) for Atua Government Hospital and St Martin’s de Porres Hospital respectively. Significant determinants of WTP for PMTCT of HIV/AIDS include Income, HIV/AIDS status and Level of education.

Conclusions: Pregnant women in the Yilo and Manya Krobo Districts of Ghana would be willing to participate in cost sharing schemes that target HIV/AIDS prevention if introduced, as indicated by their WTP for PMTCT of HIV/AIDS. Income is the most significant factor influencing WTP.
ABSTRACT

People Living With HIV/AIDS and Their Households: Impact Mitigation: The Need For Strategic Action

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Background: Thailand HIV/AIDS epidemics have been driven in specific populations from homo/bisexuals through pregnant women, youths and mobile population. Strategic actions for impact mitigation on people living with HIV/AIDS and their households are needed.

Methodology: Economic impact of HIV/AIDS morbidity on case (with HIV/AIDS)/ control households in rural Thailand and coping mechanisms was conducted in two districts of Phayao province in Northern Thailand: among 300 households in Mueng district (or active villages) and 300 households in Pong district (or less active villages). Main economic indicators from the historical and alternative simulation with 20 percent decrease in health care to change of historical-alternative simulation was performed.

Results: Main economic indicators from the historical simulation showed that total income, consumption and saving per capita in case respectively was 69, 47 and 265 percent lower than in control. From alternative simulation with 20 percent decrease in health care showed negative percentage change of historical-alternative simulation while alternative simulation with 20 percent increase in health care showed positive change. From follow-up studies, action to minimize distress was followed and mobilization of control to case household was demonstrated. Scope of accessibility was created and sustained such as medical services e.g. VCT, OI prophylaxis, ART and specific laboratory support including CD4 and viral load.

Conclusion: The studies showed that total income, consumption and saving per capita in case was lower than in control households and increase in health care support was an important mechanism to mitigate the impact of HIV/AIDS to households. Strengthening the partnership between the communities, governments, donor agencies, NGO, private sectors in mitigating the impacts of HIV/AIDS are potential focus areas for strategic mainstreaming at the household level. The remaining questions are how social networks affect the impact, vulnerability and responses to HIV/AIDS and poverty. The extension of studies beyond rural economy and dissemination of information are essential further actions.
Socio-Economic Burden of HIV/AIDS in Developing Countries: Education Sector Response

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HIV and AIDS is not only a health issue but also a development issue because it affects health, income level, education level as well as the productivity and the development of a nation. The rate at which it is expanding, its cumulative effect will impact, global, regional, national as well as local economy.

The impact of HIV/AIDS on schools and education is particularly severe. HIV/AIDS reduces the supply of education by reducing the number of teachers who are able to carry out their teaching. The epidemic affects the quality of education with the strains it imposes on material and human resources of the education system as a whole and on the health of learners. The education sector nonetheless has credible tools which could be used to turn these impacts into opportunities for changes. The largely uninfected age group (0-14) are found in the sector and this represents a window of hope for prevention of new infections. Schools offer an organized and efficient way to reach large numbers of school-age youth. The education sector provides comparative advantage with an existing framework - the curriculum. It is now unanimously recognized that the education sector has a key role to play in HIV prevention and in mitigation of the impact of AIDS; not only in its capacity to reach large numbers of the most at risk group (the youth) but also in its ability to change the negative attitudes, behaviours and practices that put staff and learners at all tiers of the education sector at risk.

The Dakar framework for Action adopted by the International Education Community during the World Education Forum (Dakar, Senegal) drew attention to the urgent need to combat HIV/AIDS if Education For All (EFA) goals are to the achieved. Such a target is seriously threatened by HIV/AIDS epidemic and its impact on the demand for and supply of education. Millennium Development Goals for Education which seeks to “ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling”, cannot be achieved without urgent attention to HIV/AIDS. UNGASS targets and the MDG for HIV/AIDS, malaria and other diseases cannot be achieved without the active contribution of the education sector. Mainstreaming HIV/AIDS prevention education and mitigating the impact of HIV/AIDS on schools and education are therefore two priority actions that have implications for the achievement of global targets in education. Although nationwide awareness and mobilization of the populace is improving steadily some problems remain. These include: (1) Slow sectorial interventions; (2) The education sector lacks adequate information, data, impact studies, researchers to enable it intervene effectively.

There is therefore a need to build the capacity of educators and educationists in information and knowledge to handle HIV/AIDS prevention, mitigation, care and support programmes. Other recommendations include: (1) Conducting impact studies and researches; (2) Improving the information data bank on HIV/AIDS in this sector; (3) Prioritization of interventions, mobilization of resources, effective planning and co-ordination of programmes as well as monitoring and evaluation at all stages of implementations.
ABSTRACT 12

Towards an Extended Economic Life of the Destitute People with HIV/AIDS: An Islamic Microfinance Approach

Khalid Ghailan


HIV/AIDS impacts negatively on the individual as well as household economy. The conventional financial system considers the destitute people with HIV/AIDS are highly risky borrowers. It is not only because of their low economic-standing but also for less or no productivity, rapid health-erosion and shorter life-span. That is why they are indisposed to get access to the conventional financial system.

This paper aims to develop an operational model of Islamic Microfinance (IsMF) that can extend financial privileges to the poor HIV/AIDS patients in order to illustrate their productive life by means of economic activities.

This model has been drawn based on the previous literature and our study on the economic impact of HIV/AIDS on the patients and their households in Malaysia.

This model suggests “family-based financing” instead of “solidarity and woman-only approach” of the conventional Microfinance System. Simultaneously it proposes the mechanism of refinancing or loan-transformation to charity, where the general practice of the contemporary Microfinance is “financing based on repayment” approach. The viability of this model does not assert the operational self-sufficiency (OSS) or profitability of the Islamic Microfinance Institute (IsMFI); rather it emphasizes on enhancing the economic-performances of the poor people with HIV/AIDS. The implementation of this model may help to reduce productivity-loss and stigma while simultaneously increase human security of the HIV/AIDS patients and their families and increase adherence to treatment. The study can introduce a new product in the context of IsMF and be equipped as a part of the Corporate Social Responsibility (CSR) of the financial intermediaries.
ABSTRACT 13

Averting Economic Disaster: Addressing HIV Risk in the Business Product Outsourcing Industry in the Philippines

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The rise in HIV transmission in the Philippines has been linked to the local call center industry. The Philippines overtook India as the largest provider of business product outsourcing (BPOs) in 2009; and over half a million young Filipinos are working in what has been locally termed a “sunshine industry”. Voice services or “call centers” make up 70% of the local BPO industry. Because BPOs are seen as a high growth area of the economy, linking the nascent HIV epidemic with it has been a politically thorny issue. Three local studies have looked at this purported association.

An International Labour Organisation-funded cross-sectional study on risk behaviors in call centers found a high prevalence of risky behaviors among call center workers’ including early sexual activity, low condom use, and promiscuity. A University of the Philippines Population Institute study compared sexual behaviors of call center workers to non-call center workers and showed 150% and 450% higher rate of engagement in risky sexual behavior in male and female call center workers compared to their non-call center counterparts respectively. Gangcuangco et al. tested a convenience sample of 406 men who have sex with men (MSM) in Manila and identified employment in a call center as a significant risk factor for testing positive for HIV. Forty eight persons (12%) tested positive for HIV. While one-third of those tested indicated that they worked in the call center industry, one-half of those who tested positive reported being call center agents.

The economic impact of a generalized HIV epidemic on the Philippine economy will be significant. Using figures specific to the BPO sector, the entry level salary for a BPO employee is more than double the average compensation rate for the Philippines (US$4,631/year versus US$1,980). At a current median age of diagnosis of 28 years old [8], most persons will develop AIDS and die within ten years if not treated with antiretroviral (ARVs). Each missed AIDS diagnosis therefore removes at least 27 years of productivity for these workers, assuming a retirement age of 65 years old. Without taking into account costs of excess hospitalization, increased wages with promotion, or losses from declining health, this translates into a lost productivity cost of more than US$125,000 per person infected. Treating an HIV-positive individual costs the Philippine government US$600/year. Latest figures from Africa show that early treatment restores life expectancy and should likewise restore productivity. Using current life expectancy estimates from the National Statistics Office [12] of 69 years for males and 74 years for females, the lifetime cost of treatment is US$24,600 and US$27,600 for men and women respectively. This translates to recovered productivity of approximately US$100,000 per person successfully identified and appropriately treated with ARVs in the BPO industry.

Although more comprehensive studies are needed to corroborate these findings, the rapid acceleration of confirmed HIV cases in the Philippines means that HIV prevention and education campaigns need to be ramped up to address increasing risk in young people. Whether or not risk and infection rates are truly increased in the BPO sector, the large proportion of young, sexually active individuals employed in this industry means that the progression to a generalized HIV epidemic will have a severe socio-economic impact on the country.
SESSION 3: CARE DELIVERY AND RESPONSE FROM THE FRONTLINE
ABSTRACT 14

Counselling for Newly Diagnosed HIV Patients in Malaysia: Challenges and Best Practices

Andrew Tan

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Kuala Lumpur AIDS Support Services Society (KLASS).

A HIV positive diagnosis greatly affects the psychological and emotional well-being of the person receiving the blood test results. The newly diagnosed patient is usually in shock even though they may be subconsciously aware that they have put themselves at risk. Immediate counselling must be provided by trained counsellors to ensure that the patient has access to timely support and correct information specific to the patient’s needs in order to increase understanding and acceptance of the diagnosis.

The establishment of hospital based Hospital Peer Support Programmes (HPSP) and development of non-hospital based Support Services; be it Self-help Groups or Support Groups; to strengthen the treatment services provided at Treatment Centres. People Living with HIV (PLHIV), including those representing various marginalised communities, are trained and equipped with the skills and knowledge to provide the much needed support services.

Challenges still abound in the efforts to increase acceptance to the set-up and running of PLHIV provided HPSP services; as well as address resistance toward the presence of non-medically trained personnel in a healthcare setting. Benefits of having targeted community-specific HPSP counsellors available at Treatment Centres can assist in ensuring acceptance of diagnosis; enhance observance to follow-up and monitoring appointments; greater comprehension to treatment procedures; increased readiness to commencing HAART; and encourages improved adherence and compliance.

Concerted efforts must be placed on actively recruiting and providing training to PLHIV from various marginalised communities in order to strengthen the support services currently available at Treatment Centres.

It is essential that the Ministry of Health, Director Generals of all hospitals, as well as doctors and nurses of Infectious Diseases clinics understand the benefits of putting in place Community-specific HPSP services.
Global Policy Trend of HIV and Non-Communicable Diseases: Leveraging the HIV Experience

Satoshi Ezoe

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There has never been a more appropriate moment than this point in time to discuss HIV and non-communicable diseases (NCDs) as we saw two important meetings in the UN history this year. One is UNGA High Level Meeting on HIV in June and the other is UNGA High Level Meeting on NCDs in September 2011.

At the United Nations General Assembly High Level Meeting on AIDS in New York this June Heads of State and Government adopted a new Political Declaration on HIV/AIDS. As well as setting bold targets to scale-up the response to HIV by 2015, the declaration also included a commitment to work with partners to strengthen advocacy, policy and programmatic links between HIV and non-communicable diseases (NCDs).

On 19-20 September 2011, Heads of State and Government came together at the United Nations in New York again to address the prevention and control of NCDs worldwide. The High Level Meeting of the United Nations General Assembly on the Prevention and Control of NCDs provided unique opportunity for both NCDs and HIV communities to work together for a common agenda.

In fact, UNAIDS and WHO together with the US Government and the Government of South Africa co-hosted an official event during the HLM on NCDs to unite participants around a common agenda to address NCDs and HIV. The panel included the Director-General of WHO, the Executive Director of UNAIDS, the South African Minister of Health, the US Global AIDS Coordinator, WHO’s Goodwill Ambassador for Cancer Control and a representative from civil society.

Experience in addressing HIV and NCDs shows that many of the challenges are common; organizing and delivering adequate prevention services; chronic treatment and care; addressing the social and environmental determinants of these health issues; and reaching people without access to services.

In this presentation, the author wishes to elaborate on the discussion made in the above event as well as on recent relevant findings and policy trend in the area on HIV and NCDs with the attention to implication to mental health.
The Roles of NGOs in Promoting Mental Health for the PLHIV Community in Malaysia

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The first support for HIV/AIDS intervention for the PLHIV community in Malaysia was initiated by non-governmental organisations (NGOs) particularly to sustain positive living and to reduce the mental health and psychosocial impact of HIV/AIDS. While there may be several studies pertaining to mental health and HIV/AIDS carried out in Malaysia, there are limited studies on the role of the Malaysian HIV/AIDS NGOs in promoting mental health. The mental health conditions of the PLHIV community cannot be easily summarised as the side effects of the infectivity as the contributory factors affecting the PLHIV's mental health are varied according to their needs and groups of community particularly due to the stigmatisation of the pandemic in Malaysia.

The HIV/AIDS NGOs which initially started as support groups are now challenged with more intensified and wide-ranging task particularly with the introduction of the Malaysian National Strategic Plan in 2006. However, the capability of the small number of HIV/AIDS NGOs to cater for the needs of over 90,000 cases of HIV/AIDS in Malaysia remains unrequited. These NGOs have played a crucial role in providing diverse services and have become the core intermediaries to the various groups of stakeholders. Yet, there is still a serious need to strengthen their effort in promoting mental health as a mission for the PLHIV community's well-being. Promoting mental health demands specific skills to enable the PLHIVs to accept cope and manage their condition: an expertise which HIV/AIDS NGO members need continuous training and guidance. With a majority of volunteers' involvement and limited professional workers, the NGOs face a great challenge in realising its aims of promoting mental health among the PLHIV community.

This paper looks into some of the ways for mental health programme inclusion in HIV/AIDS NGOs and concludes with some future directions in identifying a collaborative agenda with various stakeholders as well as policy adjustment that will enable to sustain mental health promotion for the PLHIV community in Malaysia.
ABSTRACT 17

Running an Effective Psycho-Social Support Programme for HIV Positive MSM in Malaysia

Kevin Baker

PT Foundation, Malaysia.

The reality is positive MSM in Malaysia often suffer double discrimination due to their sexuality and status. In a focus group PT Foundation ran in 2009 clients described various forms of stigma and discrimination they suffered, ranging from work place discrimination on disclosure of their status to family exclusion. Often a support programme is the only place where MSM can come together and discuss their status and the issues it presents in their lives. With this in mind PT Foundation set-up MSM Poz to cater to these very specific needs of positive MSM. The programme has 3 full time staff who runs a monthly support group attended by 20-30 positive MSM each month.

The support group is a safe space moderated by trained facilitators which allows the participants to access information on treatment, general health and wellbeing including sessions provided by trained counsellors, doctors and psychiatrists. Outreach services are provided by staff at the 3 main HIV primary care facilities in Kuala Lumpur providing much needed support for newly diagnosed cases as well as newly medicated and long term PLHIV. Online counselling is offered by a closed Facebook group moderated by trained facilitators and face to face counselling is offered by staff daily in the office in Kuala Lumpur. Well-being programmes such as yoga, nutrition and sexual health screening referrals are also offered. Findings of the annual analysis done on the programme showed that overall feedback from respondents was very positive with 85% of clients saying they felt happier since attending the programme. 64% said they felt their health had improved, with 47% saying they adhere to their medicine more and 63% had increased CD4 counts.

Education levels had also significantly increased with 85% saying they know more about their HIV. Peer support was also shown to be a significant success factor with 79% of respondents saying they had made friends in the group who could support them. Overall feedback from respondents was very positive with 85% of clients saying they felt happier since attending the sessions. 64% said they felt their health had improved, with 47% saying they adhere to their medicine more and 63% had increased CD4 counts. HIV education levels had also significantly increased with 85% saying they know more about their HIV. Peer support was also shown to be a significant success factor with 79% of respondents saying they had made friends in the group who could support them.
ABSTRACT 18

Psychiatric Disorders in HIV-Positive Individuals in Urban Uganda

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Aims and Method: The study examined the prevalence of psychiatric disorders in people with HIV/AIDS attending the AIDS Support Organisation (TASO) clinic at Mulago Hospital, Kampala, Uganda and the preparedness of AIDS counsellors to deal with mental disorders. Forty-six patients were interviewed using the Mini International Psychiatric Interview to ascertain DSM-IV diagnoses. All 15 counsellors working at the clinic were interviewed.

Results: The total prevalence of psychiatric disorder was 82.6% (38 out of 46 patients). Depressive and anxiety disorders were common. Nonaffective psychoses were present in eight patients (17.4%), bipolar affective disorder in eight (17.4%) and major depression with melancholic features in five (10.9%); 8 (13%) had current suicidal thoughts. None of the people with psychiatric disorders were receiving mental health treatment. The prevalence of disorder as estimated by the counsellors ranged from 0 to 33%. Only one counsellor had received any formal training in mental disorders and only two thought that they could deal with these if they arose. The attitudes of counsellors towards people with mental disorders were mixed, but most believed that they should be trained to provide care.

Conclusions: There is a need to provide additional mental health services to the TASO clinic through appropriate training of TASO counsellors to improve their awareness of psychiatric disorders, delivery of some psychological therapies and liaison with the psychiatric services at Mulago Hospital, in addition to public mental health education. The psychiatric disorders experienced by those attending the clinic might put them at greater risk of contracting HIV/AIDS.
ABSTRACT 19

HIV, Mental Health and Refugees

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Persons with HIV infection are vulnerable to mental health problems. The most common mental health problems among those infected with HIV are Depressive Disorders and Anxiety Disorders. HIV infection can also have direct effects on the central nervous system resulting in neuropsychiatric consequences like HIV encephalopathy, depression, mania, cognitive disorder and dementia. Substance use disorders are also common co-morbid conditions present among HIV infected persons.

Refugees and asylum seekers are at a greater risk to develop mental health problems compared to the general population. Depressive Disorders, Anxiety Disorders and Post Traumatic Stress Disorder are commonly detected among refugees who seek health care. Thus being a refugee and also being infected by HIV increases the risk of developing mental health problems.

Mental health problems have implications on treatment seeking behaviours and treatment adherence. There is a reluctance to report psychological distress because of the stigma associated with psychiatric illnesses especially for HIV infected individuals who are already living with the stigma of HIV. The lack of skill of many health care professionals in detecting psychological symptoms also impacts on the making of diagnoses of psychiatric disorders in this population of patients. These factors are of importance because mental health issues have a negative impact on treatment adherence.

This presentation will aim to explore mental health issues pertinent to refugees who are infected by HIV utilizing a few case studies.
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