SESSION 1-2

« HIV and sexually transmitted diseases »

Wednesday, September 11th

Room : D 113 à 15h00

Mphatso Kamndaya

Town : Johannesburg, South Africa

Job Title : PhD student

Company : No indicated

Title of the presentation : « Material Deprivation Effects on HIV-related Youth Sexual Risk-Taking in South African Urban Informal Settlements »

Abstract :

Abstract Background: Urban informal (slum) settlements, defined as densely populated, neglected parts of cities with exceptionally poor housing and living conditions, are identified as providing environments associated with increased vulnerability to HIV. Young people in these areas are a key target for interventions, in part due to their sexual risk-taking which is linked to securing socio-economic advantage. Few studies have explored this relationship with material deprivation, an alternative economic indicator, in small and medium-sized cities in Africa. Objectives: To explore material deprivation effects on HIV-related youth sexual risk-taking in South African urban informal settlements. The findings are used for designing a research study aimed at development and application of statistical models together with qualitative methods to explore how multiple measures of material deprivation may combine to influence youth sexual risk-taking in Blantyre urban informal settlements, Malawi. Methods: Drawing from the social determinants of urban health conceptual framework of the Commission on Social Determinants of Health, we use cumulative ordinal logit models to analyse secondary cross-sectional data from 267 females and 263 males aged 18-23 years who participated in the 2011 loveLife evaluation survey and resided in urban informal settlements in South Africa. The survey was carried out by the Human Sciences Research Council (HSRC) in four provinces (Gauteng, KwaZulu Natal, Eastern Cape and Mpumalanga) and was approved by the HSRC Research Ethics Committee (Protocol Number REC 2/16/02/11). Results: We found that 50% of males and 33% of females reported high levels of sexual risk-taking; 20.9% of males and 21.6% of females were food insecure; 26.6% of males and 17.2% of females indicated not receiving needed health care. Approximately 66.3% of males and 67% of females reported living in overcrowded housing. Adjusted cumulative ordinal logit models suggested that a composite material deprivation measure was significantly associated sexual risk-taking for both males [O.R. = 1.02; 95% C.I. = (1.10-

5.58); p ≤ 0.05] and females [O.R. = 1.43; 95% C.I. = (1.35-3.28); p ≤ 0.05]. However, individual categories of material deprivation, such as food, housing and healthcare deprivations did not yield significant results. By far, our general category of deprivation, which used financial difficulty as a proxy to capture other deprivations not associated with food, housing and healthcare deprivations, was the most salient influence on female sexual risk-taking [O.R. = 2.11; 95% C.I. = 1.66-2.70; p ≤ 0.01]. Conclusions: Our findings highlight the importance of developing and supporting programs and policies that ensure young people's ability to meet essential needs for survival related to food, housing, and medical or health care in urban informal settlements as a way not only to reduce disparities in HIV-related risk-taking for this population but diminish HIV infection as well. Findings also suggest that single-item measurement deprivation categories may be inappropriate to describe material deprivation. Statistical models that allow multiple-item measurement and analysis of material deprivation categories may yield different results, and is an area that warrants further investigations.

Barbara Tempalski

Town : New York City, United States

Job Title : Co-Investigator

Company : Institute for Infectious Disease Research, National Development & Research Institutes, Inc.

Title of the presentation : « Surveillance of HIV risk populations to inform policy: Examples from the Community Vulnerability and Response to HIV Project »

Abstract :

Little information is available on the numbers of people who inject drugs (PWIDs) in different metropolitan areas. The absence of such data has posed several challenges to public health. It has made it difficult to understand whether variations across time and space in reported numbers of HIV cases among PWID are a function of variations in HIV incidence among injectors or of variations in the underlying PWID population size. It has also made it difficult to determine the adequacy and determinants of prevention programming for injectors, and to study the structural determinants of PWID prevalence and of HIV among PWIDs. The Community Vulnerability and Response to HIV (CVAR) project has created methods to estimate PWID population size and related epidemiologic indicators for 96 large US metropolitan areas from 1992-2007. To date we have created estimates of the number of injectors per capita; HIV prevalence among PWID; and mortality among PWID living with AIDS. We have also created estimates of these epidemiologic indicators for PWID subpopulations defined by race/ethnicity, gender, and age. These epidemiologic data have let us document important temporal and spatial variations in PWID prevalence, in HIV

prevalence among PWID, and in AIDS-related mortality among PWIDs, overall and for specific subpopulations. Additionally, by combining these epidemiologic data with data on a wide range of social, economic, political, policy, and intervention program indicators (e.g., rates of unemployment and drug-related arrests, drug treatment program coverage for PWID, laws concerning non-prescription syringe access), we have studied structural determinants of PWID prevalence, HIV prevalence among PWIDs, AIDS mortality among PWID, drug treatment program coverage and syringe exchange program coverage. Thus far, analyses have found that indicators of "need" do not predict program presence or coverage, but that popular activism and other political indicators do; that changes in arrests per capita for heroin and cocaine possession do not predict changes in PWID population density, but do predict changes in mortality among PWID living with AIDS; that income inequality is associated with higher mortality among PWID living with AIDS; that changes in unemployment rates are associated with changes in PWID population density; and that the proportion of PWID in the population aged 15–29 has been increasing in most metropolitan areas since HAART was created. This research has informed advocates, decision-makers and policy-makers at the local, state, and federal levels in the US and internationally. Our methods and findings have been used by public policy bodies such as the (US) White House Office of National AIDS Policy, the Reference Group to the United Nations on HIV and Injecting Drug Use, and the Interior Ministry of Argentina. It has helped the US Centers for Disease Control, state health departments, and other government agencies create estimation and cost-effectiveness models of populations at risk; design infectious disease projection models; and plan public health responses. Our team will be happy to help other researchers to develop similar or parallel national or regional projects. Keywords: Injection Drug Abuse, Surveillance, Policy, Program Response, Coverage, Structural Determinants, Epidemiological Data, Metropolitan Areas

Maguelone Vignes

Town : Bruxelles, Belgium

Job Title : No indicated

Company : Université Saint-Louis, Bruxelles / DySoLa - Université de Rouen

Title of the presentation : « Chroni-cité. Gestion urbaine de la santé et parcours urbains de soins de personnes vivant avec le VIH/sida. Approche comparative des cas de Bruxelles et Rouen. »

Abstract :

Thème traité : accès de malades chroniques à l'offre de soins Problématique : Comment des personnes atteintes d'une maladie chronique spécifique, le VIH/sida, se saisissent-elles de l'offre de soins disponible dans leur ville, tour au long du cycle de vie avec la pathologie ?

Comment la gestion urbaine de la santé, soit la géographie et la composition de l'offre de soins ainsi que son insertion historique dans le tissu urbain, influence-t-elle leur action ? La chronicisation du VIH/sida depuis la fin des années 1990 et la disponibilité de nouvelles thérapies implique une forme de dépendance des personnes séropositives au monde médical et un travail de coordination de leur part pour articuler leurs occupations courantes à leurs recours aux soins et éventuellement à l'aide sociale, mais aussi pour harmoniser ces différentes sollicitations des services psycho-médico-sociaux. Au fil des étapes de la vie avec le VIH, l'enchaînement des recours représente un véritable parcours aussi bien social que spatial : un « parcours urbain de soins ». Le rapport à l'espace des personnes séropositives et leur mobilité, catalysant l'ensemble des enjeux qui interviennent dans le fait de se soigner, apparaissent comme des révélateurs précieux de leur travail de coordination. La configuration de gestion urbaine de la santé dans laquelle elles les développent, plus qu'un contexte, façonne leur manière de se saisir de l'offre de soins. Méthodologie : Cette recherche de sociologie qualitative s'appuie sur 70 entretiens individuels menés auprès de personnes séropositives (récits de vie) et de professionnels psycho-médico-sociaux (semi-directifs), à Bruxelles (Belgique) et Rouen (France). L'étude de documents d'histoire, d'architecture, de sociologie et de publications des services de soins complète l'analyse. Résultats : Selon leurs supports sociaux, les personnes séropositives se créent différents potentiels de mobilité. Trois régimes d'action se dégagent de chacune des deux séquences du cycle de vie avec le VIH que nous avons retenues. Dans la séquence « d'installation dans le diagnostic », on distingue 1) une mise en place de supports et une recomposition du rapport à l'espace, 2) une mobilité restreinte mais redéployée autour des activités médico-associatives, 3) une mobilité faiblement anticipative et contrainte (notamment par l'accès au logement et à l'aide sociale). Dans la séquence suivante d' « aménagement de la vie dans la dégradation potentielle ou effective de la santé », on trouve : 1) un recentrage sur soi et une modification des attentes qui débouchent sur des changements de recours, 2) un recentrage sur l'hôpital et une transformation des supports, 3) un recentrage sur le proche et une polarisation des recours entre ville et hôpital. L'étude des configurations de gestion urbaine de la santé montre que si la prise en charge du VIH apparaît partout très hospitalo-centrée, Bruxelles présente une offre hospitalière diversifiée et multipolaire tandis que Rouen propose une offre unique et centralisée. Pourtant cette divergence fait peu varier les régimes d'action. Les personnes s'approprient inégalement l'offre de soins spécialisés. Alors que certains se soignent à Bruxelles comme s'ils étaient à Rouen (en configuration fermée), d'autres font l'inverse (en configuration ouverte). Mots clefs : Parcours de soins, Mobilité, VIH/sida, maladie chronique, accès aux soins