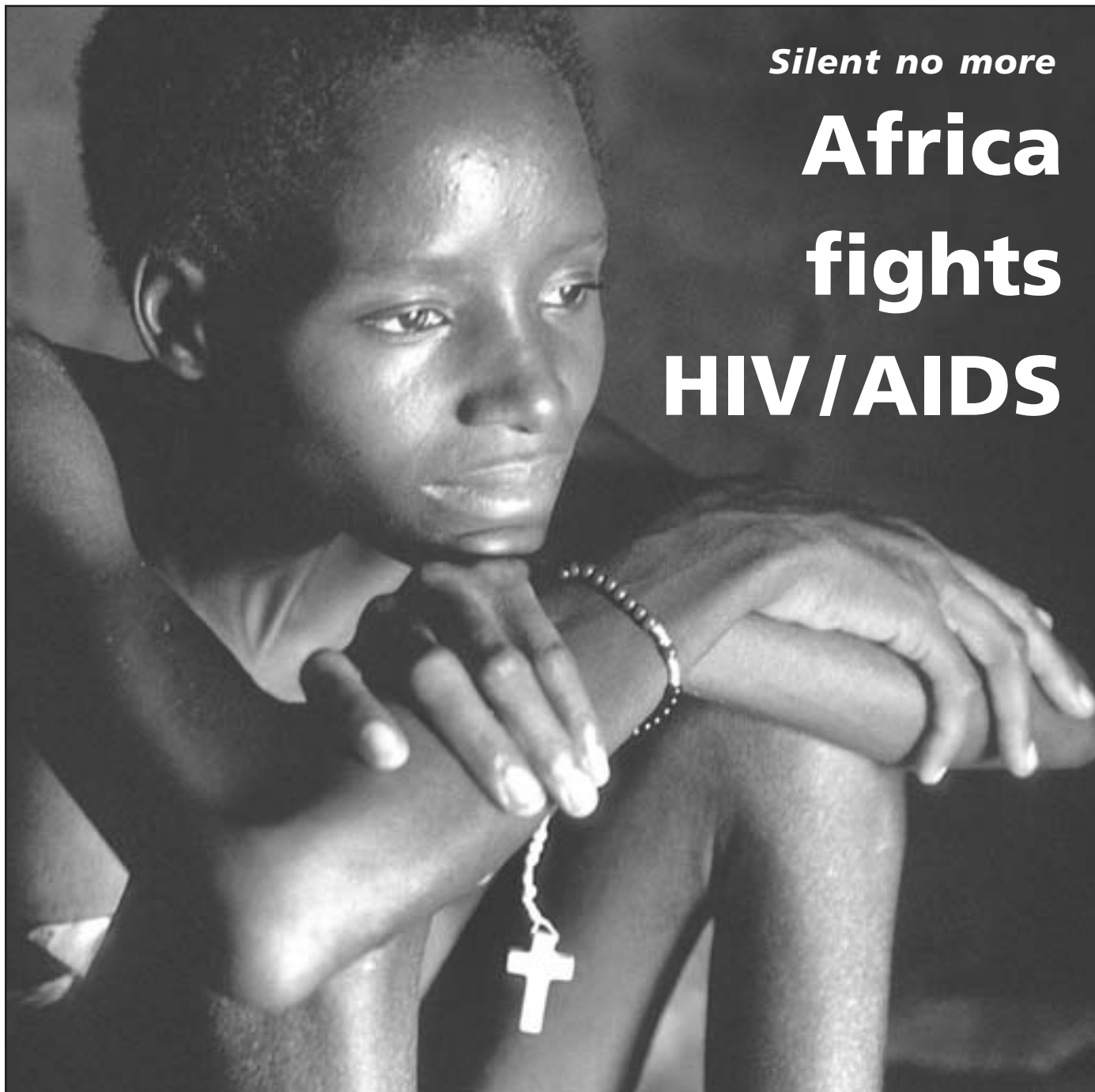


AFRICA RENEWAL

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Silent no more
**Africa
fights
HIV/AIDS**

Das Fotoarchiv / Friedrich Stark

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Tragedy and hope: Africa's struggle against HIV/AIDS

Some twenty years ago, the first cases of a mysterious illness that destroyed the body's natural defences against infection were reported in the United States. Since then, the spread of the human immunodeficiency virus (HIV) that leaves victims exposed to an array of diseases known collectively as Acquired Immune Deficiency Syndrome (AIDS), has become a global health emergency. But it is in sub-Saharan Africa, the world's poorest and least developed region, where HIV/AIDS has gone from emergency to tragedy — endangering not just the lives of its victims but the social, economic and political fabric of society.

The numbers alone are crushing. At the end of 2004 the Joint UN Programme on HIV/AIDS (UNAIDS) estimated that two-thirds of the 40 million people living with the virus were African. Some 3 million of the 5 million new infections in 2004 also occurred in sub-Saharan Africa, where infection rates are seven times the world's average. In some countries, as much as 40 per cent of the total adult population carries HIV. In a region where nearly half of the population lives on less than \$1 per day, barely 1 in 100 people in need of lifesaving anti-retroviral drugs can afford them. For the rest there is only the certainty of slow death — 2.3 million of them in 2004 alone — and a grimly uncertain future for the millions of orphans they leave behind.

This special reprint edition of *Africa Renewal* documents some of the key developments in Africa's struggle against the disease, and highlights the efforts of Africans and their international partners to turn back the tide. The articles include an analysis of the role of men in prevention, a look at efforts to reduce HIV transmission in the military, and the terrible combination of famine and HIV/AIDS in Southern Africa. Other articles examine the development impact of the pandemic, the plight of AIDS orphans and the battle to break through the price barrier to care and treatment for the poor. Africa's own efforts are detailed in articles on successful prevention campaigns in Senegal and Uganda, and on Botswana's pioneering commitment to provide care and treatment to all of its citizens with HIV. An article on two unprecedented drug treatment initiatives, one by the World Health Organization and another by the US government, bring the issue to the present, and to what many observers say is an historic moment of opportunity.

Resources for HIV/AIDS prevention and treatment programmes, though still woefully inadequate, are increasing. Many more African political leaders have taken personal leadership of anti-AIDS efforts. A vibrant, engaged and independent African civil society, increasingly led by people living with HIV/AIDS, has emerged to energize the struggle, confront stigma and discrimination and give the disease a human face. The long, damaging argument over whether to fund treatment or prevention programmes appears to have been settled in favour of a comprehensive response combining education, prevention, and care and treatment. All of these developments are reasons for hope, even if, for too many, they come too late.

As the enormity of the HIV/AIDS crisis engulfing Africa has slowly emerged from the fog of silence and denial that surrounds it, observers have struggled for words that convey its magnitude. Some draw parallels with modern political horrors, likening the pandemic to a "weapon of mass destruction" or an African "Holocaust." Others look to history for a sense of scale, comparing AIDS to the plague that decimated medieval Europe or the scourges of ancient times. Sometimes the words are heartbreakingly personal, as when UN Secretary-General Kofi Annan speaks of his experience at the bedside of a dying mother. At other times the words are angry — denouncing a world that has spent a decade bickering over trade rules and medicine patents while the death toll climbed into the tens of millions.

The words in this HIV/AIDS special issue have a more modest goal: to chronicle the path that has taken Africa to this time of opportunity. The continent's future may well depend on where we all go from here.

AIDS: a 'real weapon of mass destruction'

UN Secretary-General urges greater action

Late last year, UN Secretary-General Kofi Annan spoke to the British Broadcasting Corporation (BBC) about the global struggle against HIV/AIDS. The interview was broadcast on World Service Radio and posted on BBC's website on 28 November. The full interview can be heard at: <http://news.bbc.co.uk/2/hi/africa/3244564.stm>. The transcribed excerpts below are reproduced with permission of the BBC. They have been edited slightly for clarity.

BBC: I want to start by asking you about the enemy. When did you first realize what a serious enemy you were up against with AIDS?

Annan: I think it was when I discussed the issue with the World Health Organization [WHO] and UNAIDS [the Joint UN Programme on HIV/AIDS] and looked at the figures and the statistics and the devastation it was causing in many African countries, and at the attitude of the leaders. We needed leadership. We needed leadership at all levels. But it was most important to get the presidents and the prime ministers speaking up and that was not happening. I thought we should do whatever we can to raise awareness and to get them involved.

BBC: Have you been out there on the ground talking to sufferers?

Annan: I've been out there on the ground talking to sufferers.... I've seen the situation in parts of Africa where I've visited AIDS patients in villages, where you see a grandmother and

lots of grandchildren but no mother, no father.... I've also lost some very close friends, including people who worked here in the UN, and that also hits you. For me it's not statistics. I've seen the human suffering and the pain.

What is even more difficult is when you see somebody lying there dying who knows that there's medication and medicine somewhere else in the world that can save her, but she can't have it because she's poor and lives in a poor country. Where is our common humanity? How do you explain to her that in certain parts of the world AIDS is a disease that can be treated, that one can live with and function, but in her particular situation it's a death sentence. It's a tough one....

BBC: And how do you explain it?

Annan: You try to explain to them about what you are trying to do and what you are trying to get the governments to do to increase assistance — not only in areas of treatment, prevention

and education and also getting the youth and the women's organizations involved. It may not necessarily help her particular situation, but at least it's good for her to know that action is contemplated, action is on the way. If it will not save her it will save others. That in itself is consoling, but it's not good enough. This is why I'm rather pleased with [WHO Director-General Lee Jong Wook]'s approach of trying to get the AIDS medication to 3 million people in five years [sic]. Today we have 300,000 people on the medication.

BBC: This is the World Health Organization initiative?

Annan: Yes.

BBC: It's called three by five. Three million by the year 2005.

Annan: Yes.

BBC: We'll talk about that in a moment, but first I want to get a sense of how you feel when you're faced with these people asking you, "Why can't I have the drug?"

Annan: It is extremely difficult and I can tell you I've really tried very hard. You may know that I've had several meetings with the chairmen of the seven top pharmaceutical companies to press for reduction in the prices of these medications — to get across to them that whilst I respect and support intellectual property, it is extremely difficult not to make the medication accessible to the poor. We need to be able to balance it. And they have reduced some of the prices. In some cases, like nevirapine, in some countries they're giving it away free.

BBC: This is the drug for mother-to-child transmission for pregnant mothers?

Annan: Exactly, which I consider the cruellest of all transmissions. So you press and push and try and get as much as you can. And governments are becoming engaged. For the person who is lying there you [sometimes] are able to get them some assistance, but it doesn't always happen that way. With others you cannot immediately get them assistance.

I feel angry, I feel distressed, I feel helpless to live in a world where we have the means, we have the resources, to be able to help all these patients, and what is lacking is the political will.



AFP / Getty Images / Simon Maina

How do you generate that political will to ensure that assistance reaches them? And of course with somebody like myself who tries to speak for the poor and the voiceless, you sort of feel you're failing, you're not getting enough done.

BBC: What more can you do, though?

Annan: I think we should continue our efforts to mobilize the societies to play a role. We should get the leaders to speak out against discrimination, the stigma that is attached to it. We need resources. We need resources to assist these people. We are operating at a relatively low level. We estimate that by 2005 we will need \$10 bn worldwide per annum to fight the disease.

BBC: But that money is not forthcoming, is it? The Global Fund [to Fight AIDS, Tuberculosis and Malaria] has been able to hand out \$2 bn over two years. You're miles short. Does that make you feel that there's some failure on your part?

Annan: Failure on my part and insensitivity on the part of those with power and the resources — insensitivity on the part of those who should develop the political will to do it... [We need] to raise the level of contribution to the Global Fund, which has to date given grants to about 93 countries. Wherever I go, they tell me how helpful this has been, and of course they are all looking for additional support. If we do not replenish the funds and the Global Fund were to fail, I think it would be a very serious indictment of the leadership in the world today.

BBC: And how do you do it? Say I'm sitting across from you now, I'm George Bush.

I've just announced that I'm going to provide \$15 bn for AIDS over five years, but I'm only going to give a small part of that to the United Nations and the rest I'm going to hand out piecemeal myself. How do you persuade me?

Annan: I explain that if you want to start from scratch and develop it yourselves and build the necessary administrative structures and mechanism, obviously you're not going to be able to spend the \$3 bn or so in a year. But if you were to use existing structures which the Global Fund and the UN family have established, you should be able to use much of that money to reach the needy who need it today and not

Secretary-General Kofi Annan (right) visiting Matola Health Centre in Mozambique. In the middle is the Secretary-General's Special Envoy for HIV/AIDS in Africa, Stephen Lewis.



United Nations / Eskinder Debebe

tomorrow. And that I'm also encouraging them to put as much of the money as possible into the Global Fund. Initially they had said \$1 bn to the Fund and I said "well if it is \$1 bn initially, it's not too bad." But then I discovered that it was \$1 bn over five years.

BBC: We talked about what you want from the developed world. Now let's talk about the leadership in those countries faced with epidemics emerging. What's the problem with leadership? Why isn't it coming?

Annan: Some refuse to talk about this because of cultural reasons. We had a situation where one African leader was going to give a speech — I don't want to embarrass him by naming him — and the speech was prepared for him, where he was urged to encourage young people and the population to use condoms to protect themselves. He said, "I can't utter the word condoms, I'm the father of the nation. You can't ask me to encourage the youth to be promiscuous." But this is saving lives.

BBC: And is that what you said to him?

Annan: Yes... I spoke to another African leader who was also entirely against the use of condoms and said, "Mr. Secretary-General, we don't want to associate you with the word condoms. You shouldn't even be using that word or speaking about it." I said, "Mr. President, I've even written to the Pope about it to see how we can work with the Catholic Church on prevention, on education, on treatment and care." And

he looked at me and said, "Mr. Secretary-General, when it comes to condoms, the Pope and I are one." I said, "Mr. President, but your people are dying. We're talking about saving lives. This is a very serious business — and God will understand."

BBC: Did you change his mind?

Annan: I didn't. And this is the frustration. These are the painful experiences you sometimes have to go through. And then if I walk away to see one of the dying patients and they were to look up and say, "Help me — get our president and the leaders to help us." You can't tell them the attitude of their president.

BBC: And is it an indictment of them on a humanitarian basis or is there an argument from self interest that you can use to persuade them?

Annan: Both. From humanitarian — from moral — grounds and self interest. Basically, it is a security problem in some of these countries. I mean, if you take some of the African countries in Southern Africa, AIDS is taking away not just the present but the future. It's taking away some of the most productive men and women. Schools are losing teachers. Hospitals are losing doctors. The civil service is depleted.

In the past we talked of training people and civil servants. Here in some of these countries we may have to talk of replenishment or perhaps even bringing in people from outside. It's decimating the security forces and the police. It is a really serious problem, and it's not just in Africa. It's spreading very fast in Asia, in Eastern Europe and in the Caribbean, and even in this country it's on the way up. So those who think AIDS is over are dreaming. It is one of

the most serious epidemics the world has ever faced and we need to really, really get serious about it.

BBC: *It's very hard, isn't it, because a lot of the groups most affected by AIDS are very marginalized groups anyway.... People who are marginalized can't speak up for themselves. If their governments aren't going to speak up for them, then who is?*

Annan: This is the real test. This is why I speak out as often as I can. But I think we need to also get civil society [involved]. NGOs have been very effective partners and they've been active in sometimes embarrassing and pushing the governments to do the right thing.

We've seen women's organizations at the grassroots level, and this is very important because today in Africa, AIDS has a woman's face. Over 50 per cent of the infected are women and often they are the innocent victims. We really need to empower the women to take care of themselves and get the young people involved. And I have seen countries where the campaign is mounted by the head of state and it goes down all the way to the village level.

In Senegal, for example, they are even using griots — a griot is an oral historian — to talk to the people about it. We visited them a couple of years ago and my wife asked this woman griot, "Are you embarrassed to talk about sex and all these things frankly to the people in their village?" She said, "This is death. There is no embarrassment in death. There is no embarrassment in trying to save lives." And it's that kind of spirit that I want to see in the African leaders and the leaders around the world whose populations are threatened. I want to see them adopt the attitude of this griot.... She was very inspirational.

BBC: *Are you winning the war?*

Annan: Well, I would wish to think so, but I'm not. I'm really not winning the war. I'm not winning the war because I don't think the leaders of the world are engaged enough. I also appeal to communities and societies everywhere to become engaged in the struggle. They cannot leave it to their leaders alone.

BBC: *So in a way you're talking to the people over the heads of their governments.*

Annan: I'm talking to people over the heads of their governments. They should take on this fight. They should not be afraid to speak up. They should not be afraid to challenge their

Activists of the AIDS Therapeutic Treatment Now group protest in Durban, South Africa, to demand provision of anti-retroviral drugs.



AFP / Getty Images / Rajesh Jantial

governments to do something about the epidemic. It is their lives. It is the lives of their children, their sisters, their mothers and their brothers and fathers. And they have the right to demand support. They have the right to demand action from leaders whose main and major responsibility, after all, is to ensure the safety and welfare of their people....

I'm also hoping that the world will wake up.... In some of the countries we are talking about, AIDS is the real weapon of mass destruction, and what are we doing about that?

BBC: *Some say there was a tragic missed opportunity. That the world was gearing itself up to tackle AIDS. But then on September 11 the twin towers came down, the attack on the Pentagon and the whole world changed. It became the war on terrorism. Is that how you see it?*

Annan: Let me put it this way. I hope if we had not had 9/11, many more resources would have gone to AIDS. But I can't be sure. I can't be sure because I have seen other situations where it has not happened.

BBC: *On that point, your special envoy on AIDS in Africa, Stephen Lewis, has called spending on the Iraq war and the war on terror obscene and he mentioned a figure of \$200 bn and set it alongside the annual spending on AIDS — a total of possibly \$3 bn. Is that obscene?*

Annan: My own view is that we need to fight all the threats. I call the fight against terrorism and weapons of mass destruction the sort of hard threats — hard threats because people see immediate blood, immediate war. But the soft threats — poverty, the AIDS epidemic, environmental degradation — are also with us. And in many societies they are wreaking much more

havoc than the terrorists are and we need to tackle all these threats. We don't have a choice. We don't have an option.

BBC: *We mentioned talking to people over the heads of their government. What would you like to say to all the listeners to the BBC World Service about AIDS? About what they should do to help?*

Annan: I think what I would want to tell them, that we face a real serious epidemic — an epidemic that is destroying societies and countries. And the leaders of these countries — if they're going to have a country and a country with a future to lead — they'd better pay attention to this epidemic. They'd better pay attention to the youth, the vulnerable groups in society, particularly the women who are not empowered, who are often abused and are often subject to violence, which also leads to increase in the AIDS epidemic.

The [leaders] should speak up. They should end the silence and the stigma and the discrimination that is attached to the disease. And that when it comes to AIDS, silence is death. And if they do not speak up and help their people, their deaths will be on their consciences

BBC: *Three million people, we think, died of AIDS this year — 2 million of them in Africa.... As an African . . . does that feel like injustice?*

Annan: It is worse than that. It does feel like injustice, but it also indicates a certain incredible callousness that one would not have expected in the 21st century.

BBC: *And how will history judge us for what you describe as this incredible callousness?*

Annan: Harshly. Very harshly. And I don't think we will have any defence. ■

In AIDS fight, men make a difference

Campaigns in Africa seek to change male behaviour

By Vincent Nwanma

Lagos

Nigeria, like other African countries, is marked by a "patriarchal society," says Mr. Owei Lakemfa, a leader of the Nigerian Labour Congress (NLC). "Men think they have the liberty to have as many wives or girlfriends as they want," thereby contributing greatly to the spread of HIV/AIDS. Given this reality, he explains, Nigeria's central trade-union federation believes that "a lot of attention should be given to men" in the struggle to combat the disease.

Mr. Ubon Akpan, a Nigerian media executive, agrees. He highlights the inordinate power that men have over women in economic, political and family life. "The man has the financial backing," he says, "as well as the backing of tradition." In many African cultures, he points out, adultery is considered a "female crime," while men are permitted to "parade" multiple women.

Ms. Nkechi Nwankwo of the Women Leadership Group, a non-governmental organization (NGO) in Nigeria, believes that aspects of traditional culture can themselves be utilized to alter men's behaviour. Although men exercise considerable power over women in traditional

African cultures, she says, those norms also obligate men to take care of their wives, children and other family members. "Real men protect women from HIV/AIDS," proclaimed T-shirts worn by participants in a workshop for media practitioners from Nigeria and Ghana organized by the NGO in Jos, Nigeria.

In Zimbabwe, another group, known as Padare/Enkundleni, argues that prevailing notions of male roles and behaviour can be changed, both through more open dialogue with women and through critical self-examination by men themselves. Initially organized by a group of male friends, Padare has since grown into a network of 13 groups of men across Zimbabwe, one of its founders, Mr. Jonah Gokova, told *Africa Recovery* in New York. The organization received an "Africa Leadership Prize" from The Hunger Project, a US-based international NGO, in October.

"Now it's time to take on the challenge and begin to find a way of discovering who we are and encouraging each other to project a positive image of manhood that is not dependent on the oppression and abuse of women," Mr. Gokova says. In addition to questioning gender stereotypes, Padare addresses the spread of HIV/AIDS, asking men: "What role have men played in perpetuating unhelpful assumptions that have resulted in women taking the burden of HIV and AIDS?"

Such examples of positive action are in line with the "Men Make a Difference" campaign of the Joint UN Programme on HIV/AIDS (UNAIDS) and other anti-AIDS organizations. Their goal is to complement prevention programmes for women and girls with work that more directly involves men as well. "The time is ripe to start seeing men not as some kind of problem, but as part of the solution," declared a May 2000 UNAIDS report.*

Pushing condom use

Recognizing that women are at a disadvantage in negotiating sexual relations with men, Nigeria's NLC takes a very practical approach, by trying to convince the many men who belong to its affiliated unions to use condoms.

The labour federation does not preach, says Mr. Lakemfa, or tell its members "don't do this or that." It seeks instead to help its members identify the dangers and issues involved. "All you can do is to help a man reach his own conclusions and make his decisions."

The NLC has a membership of about 5 million. It encompasses all industrial labour unions in Nigeria, as well as teachers, non-academic staff at educational institutions up to the universities and employees of the local government councils. "Most of our members are men," Mr. Lakemfa says, adding that the congress's size and composition place it in a "unique position" to carry the anti-AIDS message down to the grassroots.

As part of its campaign against the spread of HIV/AIDS, the NLC has held several workshops of trade union leaders, coordinated by full-time union staff employed specifically to work on its AIDS campaign. "The strategy is to get the union leaders sufficiently enlightened and organized, and let them mobilize their own members," says Mr. Lakemfa. For example, at an AIDS rally on 16 October 2001 in Abuja, the capital, the NLC invited union leaders from the states and mandated them to hold similar rallies in the 36 state capitals. In turn, other rallies and events will be held at the unions' 778 local government council headquarters throughout Nigeria.

In Zimbabwe, Padare/Enkundleni is finding it harder to promote condom use. "There's quite a high level of awareness," says Mr. Gokova, "but it is very difficult for a man who is married to agree to use a condom with his wife, since condoms are [considered to be] for prostitutes." This is one of the beliefs that need to be changed,

*For more information on the UNAIDS Men Make a Difference Campaign, see the Website <www.unaids.org/wac/2001/index.html>. UNAIDS has programme advisers in most African countries who can help involve local groups in the campaign.

Women's empowerment is also crucial

In the fight against AIDS, intensified efforts are needed to "challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys," declares the Declaration of Commitment adopted at the UN General Assembly's 25-27 June special session on the disease. At the same time, says the declaration, the "empowerment of women" is fundamental for reducing their vulnerability to infection.

Specifically, this should include "the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls." The declaration also cites discrimination in inheritance. In many parts of Africa, there are no effective legal provisions for women to inherit land and assets from their deceased husbands, often leaving widows destitute. Legal reforms backed by implementation mechanisms would go a long way toward preventing the downward spiral into poverty that makes women and children even more vulnerable to infection.

he says, to achieve some meaningful results in the “Men Make a Difference” campaign.

According to UNAIDS, “In many cultures, fathering a child is regarded as a proof of masculinity. This belief virtually proscribes condom use, providing increased opportunities for HIV infection within the family, and possibly to the next generation through mother-to-child transmission.”

Messengers of change

The Planned Parenthood Federation of Nigeria (PPFN), an affiliate of International Planned Parenthood, has also been involved in the campaign to reach men. It enlists community-based “agents” to talk to men in rural areas about sex, health and family planning issues. The agents include tailors, barbers and other rural professionals who are trained by the PPFN in sexual and reproductive health matters and are expected to share that knowledge with other men as they pursue their trades.

“The idea is that as other men come to patronize them in their shops, the agents will educate them, and also sell health kits to them,” says Mr. David Omorebokhae, a PPFN communications officer. The programme is based on the assumption that the selected agents “know the men in the community who are exposed to risk, and can counsel them on the need for change in sexual behaviour and use of contraceptives.”

The federation sells the agents non-prescription contraceptives. They in turn sell the contraceptives to the men who visit their shops, retaining a 25 per cent sales commission as an incentive.

Targeting truckers

The PPFN is currently developing another campaign aimed at men, specifically truck drivers. “They are responsible, to a large extent, for the spread of HIV/AIDS,” says Mr. Omorebokhae. The first known AIDS patient in Nigeria — discovered in 1986 — was a truck driver.

UNAIDS has identified long-distance truck haulers as a group that is especially exposed to risk in the HIV/AIDS epidemic. Their jobs take them away from homes for days or weeks, and they often move from one region to another, engaging in sexual relations with different women along their routes.

The PPFN programme, launched in October 2001, seeks to recruit and train drivers

to educate their fellow truckers about the need for safe sex and other AIDS-prevention issues, starting initially in the states of Edo, Kano, Niger and Jigawa. It will include the use of community theatres to entertain the drivers at major stopover points. So in addition to education, the campaign will provide the drivers with alternative forms of relaxation, other than sex with the commercial sex workers who ply their trade along the truck routes.

In Zimbabwe, the National Employment Council for the Transport Operating Industry works with truck drivers on similar programmes.

Churches also involved

The Assemblies of God Church, Ikate, in Surulere, a suburb of Lagos, holds Sunday evening programmes to educate its 2,000

and teach more about the purpose of marriage. We should be able to teach men that the purpose is not only sex.” The church, he says, emphasizes the Biblical injunction that men honour their wives and give them due respect.

Need for dialogue

Dr. Eze told of one case in which a husband was HIV-positive and the wife HIV-negative, but she insisted on sex without a condom so that she could conceive another child. Such complex responses to the anti-AIDS message emphasize the importance that UNAIDS and other campaigners attach to greater dialogue on sex and family matters among and between the sexes. They insist that men, women, children and other community members talk openly and frankly about issues that were previously

An AIDS awareness advocate showing truck drivers in Zimbabwe the correct way to use a condom.



Jathila Photos

members about the dangers of HIV/AIDS. It brings in outside speakers, such as Dr. Dickson Eze of the Lagos University Teaching Hospital, who recently explained to parishioners how men are far more likely to infect women with HIV than the other way around.

“We want to create awareness by bringing in experts to speak on this deadly disease,” explains Rev. Samuel Oshodipe, the church’s pastor. While the education programme is for every member of the church, he says the prime target is the younger members.

The church now makes HIV/AIDS testing a pre-condition for the marriages it conducts, “so that an innocent party does not enter into trouble unknowingly,” says Rev. Oshodipe. He realizes how difficult the campaign will be, but believes it will make an impact if “we can preach more

regarded as the exclusive preserve of men. Efforts to promote such dialogue require sensitivity and a lack of recrimination, they say, since neither men nor women should be blamed for the disease’s spread.

In talking with their children in particular, says Ms. Nwankwo of the Women Leadership Forum, fathers need to learn to listen to open discussions about sexual subjects that have long been regarded as taboo. They also need to know that “shouting their children down is not the answer.”

Meanwhile, ways need to be found to help women negotiate safe sex with their partners, Ms. Nwankwo argues. Improved education will be key, since women “tend not to know what to do.” Above all, she says, women “need to be encouraged to be assertive.” ■

AIDS prevention in the ranks

UN targets peacekeepers, combatants in war against the disease

By **Michael Fleshman**

It is now widely accepted that the HIV/AIDS pandemic is, as Secretary-General Kofi Annan asserts in his report on AIDS to the General Assembly special session, “the most formidable development challenge of our time.” World leaders increasingly call for a “war” on the deadly infection, and often note that the disease has killed more people in Africa than all of the continent’s recent conflicts combined.

But there is strong evidence that war itself is a factor in the rapid spread of the virus in Africa. Conflict brings economic and social dislocation, notes the Joint UN Programme on AIDS (UNAIDS), including the forced movement of refugees and internally displaced people and resulting loss of livelihoods, separation of families, collapse of health and education services, and dramatically increased instances of rape and prostitution. All this contributes to conditions for the rapid spread of HIV and other infectious diseases. Military personnel, too, risk contracting or spreading the fatal illness, whether deployed as belligerents or peacekeepers.

On 10 January 2000 the UN Security Council focused international attention on the links between conflict and the disease during an unprecedented debate on the threat of HIV/AIDS to Africa. The Council followed its first-ever consideration of a health issue with the adoption of Resolution 1308 in July, declaring HIV/AIDS “a risk to stability and security” and requesting Mr. Annan to strengthen AIDS education and prevention training for peacekeeping personnel through the UN Department of Peacekeeping Operations (DPKO). Addressing the Security Council’s fourth meeting on HIV/AIDS in January 2001, the executive director of UNAIDS, Dr. Peter Piot, applauded the sustained attention: “The simple fact that the Security Council regards AIDS as a significant problem sends a powerful message,” he said. “The Council now regards support for the global fight against AIDS as among its core business.”

— African armies and UN peacekeepers are grappling with how to halt the spread of AIDS within their ranks. —



AMA / Santos Finesses

Uncertain impact

The degree to which conflict contributes to the spread of HIV remains uncertain. The conditions which increase the risk of HIV infection in war zones also make it difficult to collect accurate information about infection rates or identify patterns of transmission. The limited data available, however, is alarming. A study of Nigerian troops returning from peacekeeping operations in West Africa, for example, conducted by the non-governmental Civil-Military Alliance to Combat HIV/AIDS (CMA), found infection rates more than double that of the country overall. Significantly, the study also found that a soldier’s risk of infection doubled for each year spent on deployment in conflict regions — suggesting a direct link between duty in the war zone and HIV transmission.

Part of the problem, DPKO Medical Unit head Dr. Christen Halle told *Africa Recovery*, is that conflict tends to bring together two groups at very high risk of HIV infection — commercial sex workers and 15-24-year-old men. “Among refugees and displaced people it is common for the number of commercial sex workers to increase because women feel they have no other way to keep their families alive.”

A similarly risky dynamic, he said, occurs among soldiers. “Military culture tends to

exaggerate male behaviour,” he explained, by removing thousands of young men in their sexual prime from the behavioural constraints of family and community, inculcating a sense of risk-taking and invincibility, and promoting aggression and toughness as the male ideal — attitudes that extend to sexual behaviour and often lead to contact with commercial sex workers.

A study of Dutch soldiers on a 5-month peacekeeping mission in Cambodia found that 45 per cent had sexual contact with prostitutes or other members of the local population during their deployment. With 18 violent conflicts, tens of thousands of troops in the field and some 8 million refugees and internally displaced people, Dr. Halle noted, it would be surprising if war were *not* a major factor in the spread of HIV in Africa. “There is a whole context [in combat areas] which contributes to the spread of infectious diseases, including sexually transmitted diseases like HIV.”

High infection rates

The behaviour of the Dutch contingent in Cambodia lends statistical weight to a truism of military life: that for as long as there have been wars and young men to fight them, soldiers have found opportunities for sex and, inevitably, for the transmission of sexually



transmitted diseases. Until very recently such illnesses were considered among the least of a soldier's worries — often handled with “a wink and a nod” by local commanders and a strong dose of antibiotics from the medics. But amid evidence that infection rates for the AIDS virus are soaring among African military and police personnel, African governments, the UN and the international community are taking a closer look at the link between the uniformed services and AIDS, and are expanding education and prevention programmes.

Even in peacetime, UNAIDS estimates, HIV rates are 2-5 times higher among soldiers than for the populace as a whole. During operational deployment in conflict areas, infection rates among military personnel can be as much as 50 times higher than among civilians back home. When CMA first began working with African military leaders in 1993 to develop HIV education and prevention programmes, said CMA Associate Director Dr. Rodger Yeager, the usual response was denial. “For years we were told that AIDS was only a problem for homosexuals and drug addicts in the West,” he said. “It was only when AIDS began to degrade readiness” — the ability of an army to put forces in the field with the training, manpower and equipment to accomplish its mission — “that the high command stopped denying they had a problem and started asking ‘what can we do?’”

For soldiers and police already infected with HIV, the answer is very little. African militaries, like the states they defend, lack the resources to provide the afflicted with life-saving medications. Indeed, said Dr. Yeager, while almost all African militaries have adopted model “best practice” policies to provide troops with voluntary testing and counselling, few can afford to actually provide such services. Nor is there any guarantee that individual soldiers would step forward for voluntary testing, given the stigma that still surrounds the disease in many countries and the danger of dismissal from the armed services if tested positive.

African military leaders and the international community have focused instead on preventing the illness, developing HIV education and prevention materials for inclusion in existing military training programmes. In Uganda, President Yoweri Museveni told the African Development Forum in December (see *Africa Recovery* January 2001), the military has a

strict policy of non-discrimination against HIV-positive soldiers. The former guerrilla commander, who is widely credited for Uganda's success in halving the country's rate of new infections, stressed that infected personnel are kept in the military and assigned less strenuous duties until they become too ill to serve.

A few other African countries already are beginning to focus some of their limited resources on HIV education for the military. In February, Burkina Faso's defence and health ministers met with the top armed forces officers to agree on a plan of action against HIV/AIDS in the military, as one component of the government's national anti-AIDS programme. This followed earlier, confidential studies on the extent and nature of the epidemic within the army. The plan of action provides for:

- reducing the rate of new infections among soldiers by 5 per cent annually through educational and preventive measures;
- ensuring that new recruits are HIV-negative;
- voluntary, anonymous and confidential testing of military personnel;
- counselling and the provision of generic medications to ill soldiers;
- social and economic assistance to the families and survivors of ill soldiers.

During 2001, the total cost of the plan is estimated at CFA 178 mn (about \$250,000), with the funding coming from the UN Development Programme, World Bank, a dozen bilateral donors and several national anti-AIDS organizations. Col. Ali Traoré, the armed

forces commander, pledged that the fight against AIDS would henceforth feature in the annual defence plan.

In other countries, bilateral assistance to African military organizations also has begun to arrive. In October, for example, the US Department of Defence launched a \$10 mn Leadership and Investment in Fighting an Epidemic (LIFE) project to assist its African military partners in HIV prevention. According to LIFE Policy Director David Hamon, the US effort is focused on “training the trainers” in HIV prevention, providing technical assistance in the development of ongoing training methods and underwriting research on the prevalence and transmission of HIV in the uniformed services.

Are peacekeepers spreading HIV?

The policies and attitudes of member states, particularly those of the major troop contributors, are central to the UN's own efforts to combat HIV among peacekeeping personnel. Troop contributing states are responsible for the training and outfitting of the soldiers they make available to the UN, and DPKO can advise — but not dictate to — member states about their HIV/AIDS programmes. The issue has grown in significance amid concerns that the UN itself may be an unwitting agent for the spread of the virus around the world. “I regret to say,” the former US Ambassador to the UN, Richard Holbrooke, told the Security Council in January 2000, “that AIDS is being spread, among other people, by peacekeepers.”

‘Advocates and actors’ against AIDS

From 11-13 December 2000, the Joint UN Programme on AIDS (UNAIDS) convened a group of experts in Stockholm to review current DPKO procedures to combat the disease and recommend improvements. Peacekeeping personnel should be understood as “advocates and potential actors” in the fight against HIV/AIDS, the group declared, and all UN policies should be geared toward equipping them for that role. Key recommendations include:

Training: The UN must develop minimum standards for pre-deployment training on HIV/AIDS for use by troop-contributing countries and UN training personnel. The number of UN Training Assistance Teams must be increased to reflect increased peacekeeping deployments with emphasis on “training the trainers.” Education and training for mission personnel should continue during and after deployment.

Codes of conduct: The UN should encourage the development of updated and enforceable codes of conduct for troops, governing all aspects of contact with civilian populations and emphasizing HIV/AIDS prevention. Mission commanders should be empowered to repatriate peacekeepers in gross violation of the code.

Testing: In light of the complexity of the issue, the executive director of UNAIDS and the under-secretary-general for peacekeeping operations should urgently establish a senior expert panel to analyze and develop a comprehensive proposal on the issue of HIV testing.

While researchers agree that Mr. Holbrooke's statement is almost certainly true, a lack of data makes it impossible to accurately gauge the severity of the problem. Only a handful of cases have been publicly documented, and the most reliable way to measure the risk — mandatory testing of personnel before and after deployment abroad — is favoured by only a few countries.

The concern is justified: "We are huge movers of young people across borders and between continents," Dr. Halle noted. "Some come from non-endemic countries for deployment in endemic areas. Others come from endemic countries to non-endemic areas. It is a huge concern of ours that the legacy of the UN not be that of bringing the virus into the local environment. The legacy to the country

"They have the will to do it. They have the policy to do it. But they do not have the financial means to do it." There has been some indication that industrialized countries are willing to underwrite the cost of VCCT by the UN, but even then, said Dr. Halle, there are serious human rights and ethical issues: "It is important in a way that the results belong to us," and not the soldier's government, he asserted. "Because then we can oversee the way we use it so that the results are not used to discriminate.... The confidentiality issue is important here." Like many of the issues surrounding HIV testing, however, there is no consensus among member states about UN testing of peacekeepers. Some countries have reportedly insisted in preliminary discussions that any future HIV test results be made available to the soldier's government.

programmes reach mission personnel and humanitarian workers, and that cooperation with local and international civil society organizations is enhanced. Condom distribution has been greatly increased, available not just in the medical tent, but wherever soldiers congregate — in the bathrooms, dining halls, bars and recreational facilities. The first test of the new approach began in Sierra Leone in March.

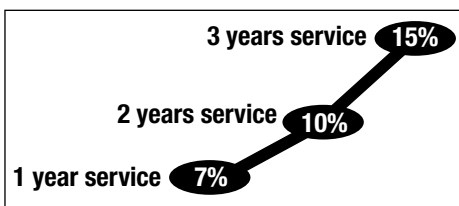
Changing attitudes

For Dr. Halle, the real challenge of reducing HIV in UN ranks comes not from the difficulty of developing culturally appropriate training materials, but in changing the attitudes that lead to unsafe and unacceptable behaviour — particularly towards women and children. For that reason, Dr. Halle noted, DPKO's HIV/AIDS initiative is guided as much by Security Council Resolution 1325 emphasizing the rights of women and children in conflict as it is by Resolution 1308 on HIV and conflict. Rape and prostitution are often seen as inevitable consequences of war, he observed, "but they shouldn't be. These things should be no more tolerated in war than they are in peacetime."

By changing attitudes, he said, DPKO hopes not just to change the behaviour of peacekeeping troops in the mission area, "but to make them activists and advocates to stop the spread of HIV when they get back home. We are trying to develop responsible peacekeepers — responsible not only in the way they handle their weapons and their direct tasks as peacekeepers, but responsible also in the way of handling their relationship to the population in the mission area and back home."

In the struggle to change attitudes, Dr. Halle said the UN's greatest allies are the religious leaders who accompany their troops into the field. For all the differences in culture, policy and approach, he concluded, there is a standard of decency and behaviour common to all humanity. "I do not expect a Muslim imam to promote the use of condoms. Nor do I expect a Catholic padre to do that. But what I have every right to expect, and where they do comply, is in talking about how you treat the people around you, especially the most vulnerable, the women and children. If you do that within the context of the Universal Declaration of Human Rights, within the context of global ethics, then you do something to contain the epidemic." ■

HIV prevalence among Nigerian troops (according to years of duty as peacekeepers)



Source: Adefolalu A. 3rd All African Congress of Armed Forces and Police Medical Services, 1999, Pretoria

Focus on prevention

While the debate over testing continues, the UN is greatly expanding its education and prevention programmes among both civil and military members of peace missions. On the eve of a 19 January 2001 Security Council meeting, UNAIDS and the peacekeeping department initialed a cooperation agreement formalizing a joint effort to "develop the capacity of

peacekeepers to become advocates and actors for awareness and prevention of HIV transmission." The existing 50-page DPKO booklet on HIV/AIDS will be simplified and released as a pocket card to every peacekeeping soldier. The card will be printed not just in the UN's official languages but in the languages of all major troop-contributing states, and tailored to the cultural norms and sensibilities of the readers.

In line with the recommendations of a UNAIDS experts meeting on HIV and peacekeeping in Stockholm last December (see box, previous page), regional centres, including two in Africa, will be established to encourage greater cooperation among countries. Dr. Halle, as DPKO's chief medical officer, has been designated the focal point for all DPKO efforts to combat the disease. All future UN peace missions will include a similar HIV/AIDS focal point to ensure that HIV awareness and prevention is integrated into all aspects of peace-making and post-conflict peace-building, that

providing the peacekeepers should not be to have them bring the HIV virus back home."

The principle objection to mandatory testing of peacekeepers, he explained, is on human rights grounds. "We cannot force a person to take a test that would exclude him or her from their chosen profession. Until we have a guarantee from troop contributors that the soldier found HIV-positive will not be discriminated against, we will find it very hard to change the policy."

Current DPKO policy as established by the General Assembly is to strongly encourage member states to offer voluntary and confidential counselling and testing (VCCT) to peacekeeping personnel, and encourage troop contributing countries to strengthen HIV/AIDS education and prevention courses in national military training programmes.

One of the biggest obstacles to voluntary testing, however, is cost. "Africans are the most vocal about the need for [voluntary] testing, but also that testing is expensive," said Dr. Halle.

Women: the face of AIDS in Africa

More action needed against high female infection rates

Three-quarters of all Africans between the ages of 15 and 24 who are HIV-positive are women. That astonishing figure, just released by UNAIDS, highlights the growing concern of international agencies, African governments and AIDS activists over the 'gendered' impact of AIDS in Africa. It also has spurred the beginnings of a campaign to help young African women counter the disease.

By Michael Fleshman

There are days when Mary Mwasi does not know where she will find the strength to get out of bed. But sickness, exhaustion and despair will not feed the children or fetch the water, and so, somehow, she wills herself erect and steps into the sunlight of another Kenyan morning. "I have to look for food for the children day by day," she told a counselor for the US charity World Vision. "Life is difficult. Unless I get help from well-wishers, we cannot afford to eat."

Like many other residents of Ghaza, a village near the port city of Mombasa, Mrs. Mwasi is infected with HIV, the virus that causes AIDS. At least one of her three children is also HIV-positive and the others are often ill — whether from the disease or malnutrition, she cannot be sure. Her husband left in search of work two years ago and never came back, so she lives on sufferance on her in-laws' land — fearful that they will learn of her condition and expel her from the community. Her only financial assets are a few chickens, held in reserve to buy medicine for the kids.

She knows there is no hope for her. Her concern is for her children. "We say, 'When you pour water on the ground, you cannot pick it up again,'" Mary told the counselor. "I did not think of so many things before, so many worries. I am trying to leave everything to God."

As HIV/AIDS enters its third calamitous decade, Mary Mwasi's plight has become tragically common in East and Southern Africa, the regions hit hardest by the global epidemic. With 10 per cent of

the world's population, impoverished sub-Saharan Africa is home to two-thirds of its HIV-positive population. But it is only recently that doctors, governments and the Joint UN Programme on HIV/AIDS (UNAIDS)* have realized that not only does the global struggle against AIDS have an African face, it is increasingly the face of an African woman. As infection rates mount, scientists and researchers are scrambling to understand the causes and to fashion new policies and programmes in response.

Young women an 'endangered species'

The need for urgency is clear. In July, UNAIDS announced that of all Africans aged 15–49 who are HIV-positive, women make up a disproportionate 57 per cent. Even worse, noted UNAIDS

Deputy Director Kathleen Cravero, of those in the 15–24 age group, fully 75 per cent were young women. "That's a remarkable figure," she told *Africa Renewal*. "We're actually looking at young women becoming almost an endangered species in Africa due to this epidemic."

Part of the explanation for the staggering rates, she continued, is biological. Because of their reproductive systems, women's bodies are more susceptible to infection by the human immunodeficiency virus than are men's bodies. That is particularly true of sexually active young women, whose bodies are still developing.

Bringing women out of their shells

Despite the danger of being ostracized from her community or even stoned to death, 19-year-old Yinka Jegede-Ekpe went ahead and announced to her fellow Nigerians that she was HIV-positive. In a country where women's public voices are muted, she went on to set up a group to encourage her compatriots to speak out, fight stigmatization and raise awareness.

"The organization was formed to bring women out of their shells, because we have been trapped for far too long," Ms. Jegede-Ekpe, who is now 25 years old,

told *Africa Renewal* in New York in September. "We believe women should come out and speak about their concerns about the HIV prevalence rate as well as treatment issues." Far too often the voices of the few women brave enough to attend mixed-gender gatherings could not rise above those of men, she said. And it was the men who would speak for them on issues that primarily concerned women.

"More women than men in Africa are infected. It is they who care for people who are sick," the activist noted. "The issue of



UNICEF / C-1698 / Pizzi

The progression of the epidemic itself is another factor. It was in Africa that the virus first spread, leaving more people vulnerable to infection for a longer period than in other parts of the world. “But it is much more a function of the social and economic position of women,” Ms. Cravero continued. “This is what happens when countries don’t pay enough attention to the impact of HIV/AIDS on women.”

Facing the future

In January 2003, therefore, UN Secretary-General Kofi Annan asked UN Children’s Fund (UNICEF) Executive Director Carol Bellamy to establish a task force on women and HIV/AIDS to examine the links between the spread of the disease and the socioeconomic status of women in Southern Africa. The 27-member task force included Namibian Health Minister Libertina Amathila, Vice-President Justin Malewezi of Malawi, Ms. Terezinha da Silva, head of the Mozambican non-governmental organization Forum Mulher, and South African parliamentarian Ruth Bengu.

The task force’s July 2004 report, *Facing the Future Together*, examined both the causes of the high infection rates among women and the economic and

social burden of the pandemic on women in the home and community. It faulted both regional governments and the international community for favouring men in the design of HIV/AIDS programmes or adopting what it termed a “fictional” gender-neutral approach to HIV/AIDS education, prevention and treatment. Only a “gendered” approach that accounts for the different effects of the disease on men and women will be able to reduce infection rates, the report stated.

The researchers found a clear link between gender discrimination and the disproportionate impact of HIV/AIDS on women and girls in six areas, including:

- prevention programmes
- education
- violence
- women’s property and inheritance rights
- home and community-based caregiving
- access to care and treatment

The task force noted that in some Southern African countries adult women are still legally minors, and thus unable to own or inherit land and other property. This is a major contributor to the impoverishment of AIDS widows and orphans and underscores the urgent need for legislative reform and enforcement of women’s legal rights.

The report cautioned that governments

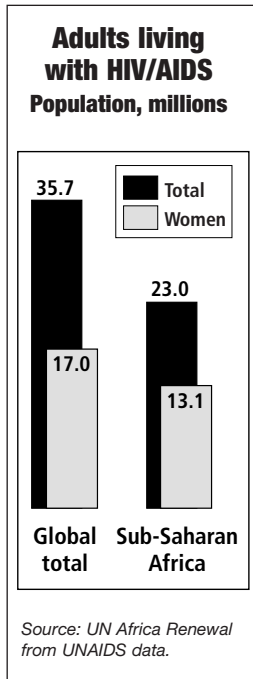
and donors could not continue to rely on unpaid women’s labour to care for the sick and orphaned in the home and community. The task force urged donors to establish small grant schemes and training programmes for caregivers and called for the drafting of a “volunteer charter” establishing basic rights and obligations for both men and women struggling to meet the needs of the ill.

The report also noted that as life-prolonging anti-retroviral drugs and other medications become more widely available in Africa, treatment programmes must be structured and monitored to ensure equal access for women.

Targeting ‘sugar daddies’

Among the task force’s most important findings was a link between the extraordinarily high infection rates among young women and their sexual relationships with much older men, “sugar daddies,” in exchange for money and gifts.

Existing somewhere between romantic relationships and prostitution, such inter-generational, “transactional” sex is a “key driver” of the epidemic in impoverished Southern Africa and a major target for education and prevention programmes, Ms. Cravero said. “You have an infection cycle that’s going from the older men to the young girls. The girls in turn infect their slightly older boyfriends, who grow up to give it to the young girls they start seeing. If we could collapse this bridge of inter-generational sex, we could go a long way towards breaking the hold of this epidemic on young girls.”



preventing mother-to-child transmission does not necessarily concern men. It is women who need to know how to protect their children.”

In 2001, Ms. Jegede-Ekpe joined forces with other women to form the National Community of Women Living with AIDS. It teaches women about their rights and gives them gender-specific information on HIV/AIDS. Under-staffed and ill-financed, the organization still operates only in Lagos state, even though it aims for a national reach.



Ms. Yinka Jegede-Ekpe

Africa Renewal / Midlune

Speaking out has not been easy. When Ms. Jegede-Ekpe revealed her HIV status while still in nursing school, the principal tried to expel her. Her dorm-mates locked her out of the women’s bathrooms and relegated her to menial chores. But she fought for her right to continue studying. Finding out that she had been infected through the unhygienic practices of her dentist, Ms. Jegede-Ekpe fought for changes in dental procedures.

The fight has been worth it because of the changes she sees taking place in the communities of Lagos. “Right now, if a man comes to the podium and tries to speak for the women and children, I am sure that a woman will stand up from the crowd and say, ‘Please don’t talk for me while I’m here.’”

Ms. Jegede-Ekpe was awarded the 2004 Reebok Human Rights Award in New York for courage in changing her country’s response to HIV/AIDS. Her organization is currently working on setting up a crisis fund for women and an educational trust fund for orphans.

The task force noted that because transactional sex is driven by poverty and growing consumerism, the long-term solution is sustained economic development, with expanded career and educational opportunities for young women. In the meantime, the report called for an explicit focus in education and prevention programmes on the dangers of transactional sex, as well as pressure on older men by political, religious and community leaders not to exploit poor women for sex.

Beyond 'ABC'

Rising infection rates among women are also raising questions about the widely praised "ABC" prevention strategy (Abstain, Be faithful or use a Condom). That approach has been credited with dramatically reducing HIV-infection rates in Uganda. But recent research showing high infection rates among monogamous married women in Africa — combined with gender inequality and what Ms. Cravero terms a global "epidemic" of sexual violence — suggests that for many women ABC offers no real choices at all.

"Across the globe," she notes, "women, particularly young women, are not in a position to abstain. They are not in a position to demand faithfulness of their partners. In many cases they are in fact faithful, but are being infected by unfaithful partners." Similarly, researchers report that women in transactional or dependent relationships are often unable to compel the use of condoms by their partners or are unwilling to even raise the issue for fear of rejection or physical assault.

"A woman who is a victim of violence or the fear of violence is not going to negotiate anything, let alone fidelity or condom use," Ms. Cravero continues. "Her main objective is to get through the day without being beaten up. Real-life prevention strategies for women include reducing the levels of violence against women, protecting their property and inheritance rights and ensuring their access to education."

Global Coalition for a global crisis

The scale and complexity of the HIV/AIDS crisis in Africa has served as the catalyst for a desperately needed focus on the special vulnerabilities and

needs of African women. But the steady rise of HIV-infection rates among women globally is a grim reminder that, while the need for action is most urgent in Africa, the problem extends far beyond its borders.

In February 2004, a group of international organizations and non-governmental women's rights and anti-AIDS activists, including UNAIDS Director Peter Piot and UN Population Fund Executive Director Thoraya Obaid launched an informal network called the Global Coalition on Women and AIDS. Its goal is to focus international attention on the "feminization" of the AIDS epidemic and mobilize greater political and

More care is needed for women living with HIV/AIDS.

financial resources for practical and effective responses.

The coalition, which is guided by a 28-member steering committee, is based on six key principles:

- women are not victims
- young women and girls are at particular risk
- many women at great risk of infection do not themselves engage in high-risk behavior, a situation termed "the paradox of low risk and high vulnerability"
- the factors contributing to women's vulnerability can be changed with sufficient commitment and resources
- the involvement of women living with HIV and AIDS is vital for success
- efforts to reduce the burden of HIV/AIDS on women must also engage boys and men

Despite its global mandate and broad principles of unity, Ms. Cravero explains, the coalition is intended to promote practical solutions to specific problems. These include women's property and inheritance



Jorgen Schuyt / Peter Arnold

rights, access to care and treatment services, protection from violence and the development of new prevention technologies, including anti-viral foams and female condoms, which women can control.

She acknowledged that the solution to the crisis of women and AIDS lies in the fundamental transformation of women's economic and social status. But transformation can be viewed both as an ultimate goal and as "a day-to-day process." By supporting the efforts of women themselves and emphasizing concrete and short-term legislative, political and policy responses in key areas, she concludes, "we can reduce the level of violence against women, improve their chances of remaining in school and challenge discriminatory legislation. Even if we don't immediately transform women's place in society, we can make a difference in the lives of women and girls." ■

* Get more information on UNAIDS and its activities against the disease at: www.unaids.org

Massive AIDS campaign gears up

But financing for treatment remains short of needs

By Michael Fleshman

Almost a decade ago, the development of an effective treatment for the human immunodeficiency virus (HIV) that causes AIDS opened an ugly new gap in the global divide between rich and poor. People in wealthy countries could get the expensive new drugs, known as anti-retrovirals (ARVs), and live. For people in poor countries, there would be no drugs, only the certainty of a slow and agonizing death. And die they did, in the millions.

Declaring the inability of the poor to obtain HIV/AIDS medications “a global health emergency,” the director-general of the UN’s World Health Organization (WHO), Dr. Lee Jong-wook, launched a global drive to provide life-extending ARVs to 3 million people, including 2 million in Africa, by the end of 2005. It is known as the “3x5” campaign.

About 6 million people worldwide currently require ARVs, which are prescribed only to those in the last stages of the disease. It is also a long-term commitment, since the drugs do not cure the disease and must continue for life. “To deliver anti-retroviral treatment to the millions who need it we must change the way we think and change the way we act,” noted Dr. Lee. “Business as usual will not work. Business as usual means watching thousands of people die every single day.”

For 30 million HIV-positive people in Africa, it is a matter of life or death. HIV, which attacks the body’s natural defences against infection, has had its greatest impact in sub-Saharan Africa, where poverty, weak public health systems, fear of stigmatization and the high cost of testing and treatment have allowed the virus to spread virtually unchecked. The UN estimates that no more than 100,000 of the over 4 million Africans who need ARV medications receive them.

The campaign will be modelled after

AIDS
activists in
South Africa:
anti-retroviral
medicines
now give
some
hope for
the future.



AFP / Getty Images / Rajesh Jantilal

WHO’s emergency response to the SARS epidemic, a highly infectious respiratory illness that was quickly contained by a coordinated global effort last year. WHO technical experts will be dispatched to countries to help local authorities establish testing, distribution and treatment facilities. WHO will also develop standardized and simplified treatment protocols, design training schemes for 100,000 additional health workers and create a central information clearing-house on drug quality, availability and prices.

It is a hugely ambitious undertaking, intended to increase the number of people on ARV treatment 10-fold in just two years. It is also a victory for Africa, said Ms. Milly Katana, the lobbying and advocacy director for the non-governmental Health Rights Action Group in Uganda. Speaking from her home in Kampala, Ms. Katana, who also sits on the board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, told *Africa Recovery* that “for years we argued with the donors, the multinational drug companies and even some private foundations and non-governmental groups that treatment was possible. And we heard every kind of excuse why it could not be done.” Now, the argument is not whether to treat the poor but how. “That is the breakthrough,” she said. “The 3x5 campaign is a victory for the efforts

and struggles of people in Africa living with HIV/AIDS.”

Treatment ‘must be possible’

But can it be done? Interviewed by *Africa Recovery* in New York in early February, the 3x5 campaign director, Dr. Paolo Teixeira, readily acknowledged that the technical, financial and political obstacles to success are enormous. “It will take a huge effort, an unprecedented effort, by all the stakeholders if we are to go from having 300,000 people in poor countries [on ARVs] to 3 million in just two years,” he said. “Governments, civil society, donors, multilateral agencies, drug companies, non-governmental organizations [NGOs], and even WHO must come together as never before.... Our targets are difficult but they are possible,” he continued. “They must be possible. Think of the lives that are at stake.”

Dr. Teixeira, an architect of Brazil’s model national treatment programme before joining WHO, argued that a number of factors make this the right time for a global commitment to treatment access, including:

- *Drug prices.* Pressure from people living with HIV/AIDS and competition from low-cost manufacturers of generic copies of patented ARV drugs have seen prices drop in recent years

from \$12,000 — \$15,000 annually to as low as \$300 per year in developing countries. A recent agreement between some generics manufacturers and former US President Bill Clinton could bring the price down to \$140 a year — less than 40 cents per day.

- *Greater political will.* More political leaders in Africa and other developing regions, after years of denial, have taken leadership of national HIV/AIDS efforts.
- *Proven models.* Uganda's success in sharply reducing HIV infection rates with aggressive education and prevention programmes demonstrates that the disease can be halted even in very poor countries. Pilot programmes by Médecins sans Frontières and other non-governmental groups have proved that HIV/AIDS can be treated in countries without sophisticated health services.
- *Improved technology.* The development of a single pill that combines three of the most effective ARV compounds has greatly reduced the cost and complexity of treatment programmes. The new tablet, together with improved testing, monitoring and diagnostic techniques, has eliminated many technical barriers to treatment in developing countries.

"We know what to do, we know how to do it and we know it can be done," Dr. Teixeira said. "Now it is a question of will."

Under existing treatment programmes, WHO expects that the number of people on ARVs in developing countries will grow from 300,000 to 935,000 by the end of 2005. The 3x5 campaign seeks to increase that number by 2 million, Dr. Teixeira noted, and will require at least \$5 bn in new money over the next two years. The search for those funds, he added, is only just beginning.

US programme is key

In a detailed survey of global HIV/AIDS funding sources, researcher Jennifer Cates, HIV policy director for the Henry J. Kaiser Family Foundation in the US, found that in 2003 about half of all funding for

HIV/AIDS programmes in poor countries came in the form of bilateral official development assistance. Developing countries raised another 25 per cent from domestic sources, with the balance coming from multilateral donors like the

"It will take a huge effort, an unprecedented effort, by all the stakeholders if we are to go from having 300,000 people in poor countries [on ARVs] to 3 million in just two years.... Our targets are difficult but they are possible."

— Dr. Paolo Teixeira, 3x5 campaign director



Africa Recovery / Michael Fishman

Global Fund and the World Bank, private donors and UN agencies (see table below). "Funding from all sources has been rising steadily in recent years and the trend appears set to continue," she noted. "But it remains well below the levels UNAIDS [the Joint UN Programme on HIV/AIDS] estimates is needed — and that was true even before the 3x5 campaign financing requirements are factored in."

Funding for treatment received a dramatic boost on 23 February, when the US government launched its President's Emergency Programme for AIDS Relief (PEPFAR) in Washington. The plan commits the US to a 5-year, \$15 bn effort to provide ARVs for 2 million people in 14 countries in Africa and the Caribbean. Botswana, Côte d'Ivoire, Ethiopia, Kenya,

Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia will participate, together with Haiti and Guyana in the Caribbean.

According to analysts, the US will spend about \$5 bn on existing bilateral HIV/AIDS programmes in about 100 countries over the next five years and has committed a minimum of \$200 mn annually to the Global Fund. PEPFAR therefore represents some \$9 bn in additional funding — an amount that the programme's head, Mr. Randall Tobias, has asserted is "more money than has ever been committed by any nation for any health care initiative." A third of the funding, \$5 bn, will be spent to promote sexual abstinence.

Mr. Tobias, a former chief executive of the Eli Lilly pharmaceutical company, also announced that the first installment of the new funding, \$335 mn, would underwrite ARV treatment for 137,000 people over the next 5 years. PEPFAR's \$2.4 bn budget for 2004 is nearly equal to total global spending on HIV/AIDS in developing countries in 2002.

Bilateral programmes, global needs

In theory, PEPFAR alone could meet the 3x5 target of 2 million additional people on treatment, although on a longer time frame. WHO officials welcome the initiative as a big step towards the campaign's goals. But many commentators, including the UN Secretary-General's Special Envoy on HIV/AIDS in Africa Stephen Lewis, question the effectiveness of bilateral responses to the global epidemic, calling instead for increased support for the Global Fund.

There is no question that funding for treatment and prevention programmes will continue to flow bilaterally, Mr. Lewis told *Africa Recovery*. "And every penny that does ... is welcome. But there are significant drawbacks to bilateral programmes. For one thing, donor countries pick and choose, so countries that desperately need funds are excluded." Under PEPFAR, he noted, some of the most heavily affected countries, including Swaziland, Lesotho, Malawi and

Sources of funding for global HIV/AIDS, 2003 (\$ mn)

US government, bilateral	852
Other governments, bilateral	1,163
Global Fund (HIV/AIDS only)	547
UN agencies	350
World Bank (grant equivalent)	120
NGOs/private donors	200
Affected country governments (domestic)	1,000
Total	4,232*

* Budgeted; actual spending totaled \$3,600 mn.

Source: Kaiser Family Foundation.

Zimbabwe, are excluded. "That's one of the problems with bilateral funding."

"Very often," he said, "the donor will dictate uses of their funds which are not consistent with the national AIDS policies of recipient governments.... The Global Fund speaks to a process which is rooted at the country level, and in which virtually every stakeholder has participated."

Another potential problem is coordination between PEPFAR and the 3x5 campaign on such fundamental issues as drug procurement. The primary ARV medication for the 3x5 campaign, the triple combination tablet, is currently available only from low-cost generic suppliers. Activists fear that the US, which resisted changes in World Trade Organization rules to make generics cheaper and more available, is planning to use only costly patented drugs from US companies.

US officials bristle at the suggestion, noting that PEPFAR guidelines specifically permit both patent holders and generics manufacturers to bid on supply tenders. Critics have responded, however, that language elsewhere in the PEPFAR plan could prohibit the purchase of generic drugs. They note that the US has continued to press for restrictive patent protections in regional and bilateral trade negotiations.

Some US drug manufacturers are also challenging the safety and quality of the triple combination tablet. Although WHO has approved the pill for use, some companies argue that it could speed up resistance to the current generation of anti-retroviral drugs and encourage counterfeiting. A meeting between senior US and WHO officials is set for later this year to coordinate policy.

Finding the resources

Even with PEPFAR, however, overall global spending on HIV/AIDS in developing countries will remain well short of requirements, and the need is rising. According to UNAIDS, a minimum of \$8.3 bn is needed for 2004, a number that will rise to \$10.7 bn in 2005 and nearly \$15 bn in 2007. Because ARV treatment must continue for life, drug access programmes like PEPFAR and the 3x5 campaign will increase demand.

The Global Fund is one potential source of additional resources. Launched

in 2001 as a multilateral funding agency to accelerate the international response to HIV/AIDS, malaria and tuberculosis, the Fund reports it has approved \$2.1 bn in multi-year grants in 121 countries to date, including about \$750 mn for HIV/AIDS programmes in Africa. Dr. Richard Feacham, executive director of the Global Fund, told reporters in September that the facility would be the "principal" funding vehicle for the 3x5 effort.

But the Fund has not succeeded in securing the multibillion-dollar pledges

But even the Bank's very low interest loans have to be repaid, and some indebted countries have been reluctant to borrow more for HIV/AIDS programmes. In its estimates of global spending, UNAIDS calculates the difference between the amount provided and the amount to be repaid to arrive at a "grant value equivalent" for such World Bank financing. The adjusted figures totalled \$95 mn in 2002 and \$120 mn in 2003.

Debt relief through the Heavily Indebted Poor Countries initiative has also

—
*Another
AIDS coffin:
Will there
be enough
funds to
stem the
epidemic's
deadly toll?*
—



Jake Price

needed for a rapid scale-up of treatment programmes. According to Ms. Cates, technical reasons have hampered the disbursement of funds, with just \$164 mn reaching approved projects as of December 2003.

Although 60 per cent of Global Fund grants have gone for HIV/AIDS programmes, only a portion of those funds are earmarked for treatment. Without significant increases in contributions, the Global Fund is only expected to underwrite ARV treatment for 240,000 people by the end of 2005 — about 8 per cent of the 3x5 goal.

The World Bank has also stepped up support for HIV/AIDS prevention and treatment. Since it first began lending for HIV/AIDS projects in 1986, the Bank reports that it has committed \$2.2 bn to combat the disease in more than 50 countries. That includes a \$1 bn fund for Africa, the Multi-country HIV/AIDS Programme, established in June 2001. To date, \$865 mn in concessionary loans and grants have been approved in 24 African countries.

released money. The Bank reports that 24 African countries have received some degree of debt relief, permitting some to increase spending on HIV/AIDS programmes. But one activist group, Jubilee USA Network, estimates that even after debt reduction, African governments spend an average of \$14 per person annually on debt payments, compared to \$5 for health care.

"What should be happening at this moment is that the treasuries of the Western world should be falling open and money should be pouring in," said Mr. Lewis. "But there is a huge gap — several billions of dollars — between what governments are prepared to spend and what the requirements really are. On those billions of dollars, millions of lives hang." Failure to mobilize the resources for the 3x5 campaign, he concluded, "would be an incomparable tragedy, a continuing astonishing delinquency on the part of the rich nations of the world." ■

Global AIDS treatment drive takes off

Rapid increase in number of people receiving ARV medicines

By Michael Fleshman

When a reporter first met seven-year-old Bongani in a hardscrabble shantytown near Johannesburg in 2003, it was evident the child was dying. He was too weak for school, stunted and racked by diarrhoea. There was little question that he, like his deceased parents, was infected with the human immunodeficiency virus

and a growing number of people living with HIV and AIDS in Africa — has resulted from access to anti-retroviral drugs (ARVs) that attack the virus and can dramatically reduce AIDS deaths. For years high costs severely limited their use in Africa. The Joint UN Programme on HIV/AIDS (UNAIDS) estimated that only about 50,000 of the 4 million Africans in urgent need of the drugs were able to obtain them in 2002. But with prices dropping in the face of demands for treatment access and competition from generic copies of the patented medications, the politics and economics of AIDS treatment have finally begun to shift.

In December 2003, the World Health Organization (WHO) announced an unprecedented drive to put 3 million people living with HIV/AIDS in developing countries on ARV treatment by the end of 2005, the “3x5” campaign. Two months later, the US launched an ambitious programme of its own, the President’s Emergency Plan for AIDS Relief (PEPFAR) — a 5-year, \$15 bn initiative to provide ARV therapy to 2 million people and prevent 7 million new infections by 2008 in 15 countries, including 12 in Africa.

experts, the rapid increase vindicates what some critics derided as WHO’s “irresponsible” and unrealistic 3x5 pledge.

The results also seem to belie predictions that the mix of multilateral and bilateral funding and treatment programmes would prove impossible to coordinate and only further burden overstretched health systems in the worst-affected countries. South Africa, Nigeria and India account for over 40 per cent of the total number of people still in need of ARV treatment, and experts say that a focus in those three countries could produce major gains for treatment access in a short time.

Speaking at a press conference at the World Economic Forum in Davos on 26 January, WHO Director-General Dr. Lee Jong-wook singled out developing countries for much of the credit. “We salute the countries that have now shown us that treatment is possible and can be scaled up even in the poorest settings,” he said. “AIDS treatment access is expanding every day thanks to the dedicated work of doctors, nurses, health workers and people living with HIV and AIDS, who are often working under difficult circumstances to turn the dream of universal treatment into a reality.” WHO officials assert that at current rates the world is on track to reach the 3x5 goal.

This upbeat assessment is tempered, however, by an estimated \$2 bn shortfall to reach the 3 million mark by the end of this year. That amount is part of the \$6 bn in additional resources UNAIDS says is needed in 2005 for the full range of HIV/AIDS programmes in developing regions. The treatment drive in many countries is hampered by severe shortages of trained medical personnel and facilities and by continuing controversies over drug prices and patents. “Unless these and other pressing issues are addressed urgently,” declared the non-governmental organization Médecins sans Frontières (MSF), “many of those living with HIV/AIDS in developing countries will never get access to life-saving treatment or may not be able to survive once on treatment over the long term.”



A couple receives ARV medications in Cape Town, South Africa.

that causes AIDS. It seemed equally certain that he would soon lie in a tiny grave next to theirs — joining the 370,000 South Africans who died from the disease that year.

But when the journalist, Mr. Martin Plaut of the BBC, returned a year later, he found a healthy, laughing Bongani poring over his lesson book. “The transformation,” Mr. Plaut wrote last December, “was remarkable.”

That transformation — and the difference between life and death for Bongani

‘Irresponsible’ goal now in sight

The early results are encouraging. In January 2005, WHO, joined by representatives of the US government, UNAIDS and the multilateral Global Fund to Fight AIDS, Tuberculosis and Malaria, announced that the number of people receiving ARV treatment in developing countries had increased by 75 per cent during 2004 to over 700,000 — including an estimated 325,000 in sub-Saharan Africa. In the view of many public health

Africa Photos / Eric Miller

MSF and other advocacy groups point out that the 700,000 people in ARV treatment represent only about 12 per cent of the nearly 6 million people in developing countries who need it. With the disease taking 8,000 lives daily, and new infections topping 5 million last year alone, MSF declared that “the global picture is bleak... WHO ... and other institutions should be sounding the alarm.”

‘A tremendous determination’

Whether one views the pill bottle as half empty or half full, the increased availability of anti-AIDS medicines in Africa is very good news. Although the percentage of Africans currently receiving the life-prolonging drugs remains a low 8 per cent of those requiring it — ARVs are prescribed only for those in the final stages of the disease — the continental average masks significant advances in some countries.

In Botswana, the country with the second-highest HIV-infection rate in the world, an estimated 50 per cent of those in need currently receive ARV drugs. This is due in large part to the government’s pioneering decision in 2002 to provide the medications free of charge through the public health system.

Uganda, whose AIDS prevention campaign is already considered a model for effective programmes, now provides ARV treatment to 40 per cent of the 114,000 people who require it. In Cameroon, reports WHO, strong political leadership combined with increased funding assistance and a sharp drop in drug prices has allowed some 12,000 people to begin ARV therapy. Cameroonian authorities say they will triple that number by the end of 2005.

Overall, notes WHO in its December 2004 *3x5 Campaign Report*, anti-retroviral medications are now available at more than 700 sites across the region. The study also found that African ARV patients are equally or more likely than patients in developed countries to maintain the drugs’ strict daily treatment schedule. This finding has

confounded critics who argued that poor adherence rates would accelerate the emergence of drug-resistant strains of the virus.

WHO also reported that men and women have roughly equal access to ARVs in Africa under the new treatment programmes. This means that women, who make up 57 per cent of Africans living with the virus, are under-represented in some countries; but the numbers have allayed, at least for now, fears that women would be excluded from national treatment strategies.

The early success of the treatment drive, says UN Special Envoy for HIV/AIDS in Africa Stephen Lewis, reflects the coming together of new resources from the Global Fund and the US government, the technical support and momentum of WHO’s 3x5 campaign and a new sense of urgency among African governments and civil society. Mr. Lewis, a former Canadian diplomat known for his criticism of responses to the pandemic by both donors and African governments, told *Africa Renewal* that in recent months “there has been a huge change for the better” among African political leaders and health officials. “It’s like night and day. There is tremendous determination to meet those 3x5 targets.”

The reason for the sudden change, he notes, is that in the hardest-hit countries, HIV/AIDS can no longer be ignored. For

some leaders “it was the fear that the country was falling apart, the sense that every indicator was being turned back, from life expectancy to levels of poverty to infant and maternal mortality. It made the political leadership say, ‘Oh my God, we’ve got to turn this around.’” In the worst affected regions, “the pervasiveness of death is almost unbelievable. They’re in a life-and-death battle, and now everybody sees it that way.”

In Botswana, the country with the second-highest HIV-infection rate in the world, an estimated 50 per cent of those in need currently receive ARV drugs.

Building capacity

Despite the progress, obstacles to treatment access remain stubbornly in place. Chief among them is the absence of the public health capacity — hospitals and clinics, diagnostic and laboratory facilities, trained medical personnel — to maintain millions of people on the powerful anti-retroviral medications. Although Mr. Lewis estimates that Africa already has the capacity to maintain double the current number of people now on treatment, “the need to increase capacity is huge, and there’s a kind of grim, gritted-teeth determination to get it built.”

Part of the problem, notes a recent study by WHO and other international health organizations, is the “fatal flow” of African health professionals to better-paying jobs overseas. The study notes that there are more Malawian doctors practicing in the UK city of Manchester than in Malawi itself, while Zambia, with one of the highest HIV-infection rates in the world, has lost to foreign employers 550 of the 600 doctors it has trained since independence.

Malawi and its development partners have responded to the desperate staffing shortage with a programme to improve salaries and working conditions for health professionals and to train a new cadre of health workers able to dispense ARVs and provide basic medical services.

Rebuilding Africa’s threadbare public health systems will

ARV treatment access in countries most affected					
Country	Adults with HIV ¹	Adult infection rate	Number needing treatment ²	Number getting treatment ³	% under treatment
Swaziland	190,000	38.8	36,500	5,750	16
Botswana	330,000	37.3	75,000	37,500	50
Lesotho	300,000	28.9	56,000	2,750	5
Zimbabwe	1,600,000	24.6	295,000	8,250	3
South Africa	5,100,000	21.5	837,000	55,000	7
Namibia	200,000	21.3	32,000	9250	28

¹ End 2003. ² End 2004. ³ End 2004, median between low and high estimates.
Source: UN Africa Renewal from UNAIDS, WHO data.

take time, however, and for millions of people in the last stages of AIDS, time is running out. "Almost everyone would agree that the largest challenge resides around capacity," says Dr. Mark Dybul, the assistant US global AIDS coordinator and chief medical officer for the PEPFAR programme. The US, the Global Fund and WHO programmes therefore focus on "supporting new people on therapy, but simultaneously building new capacity. I don't think it's correct to say that all [the recent increases] have been done using existing capacity."

One small PEPFAR-supported clinic in Namibia, he notes, had the resources to treat several hundred people. "Now they have the capacity to treat a couple of thousand people. They're taking people off the waiting list and putting them on the rolls, because they built new capacity at the same time they began treatment."

Funding support, technical assistance and drugs and equipment could come from outside, Dr. Dybul told *Africa Renewal*. But for the programme to expand, there also needs to be capacity within the country. "And that's got to begin with the national strategy commitment" of the governments and civil societies of affected countries. "What we do is support them.... We [all] need to do more, and we're not there yet... but capacity has been expanded over the past year with tremendous success."

The US programme alone added 155,000 people to the treatment rolls in just eight months in its 15 target countries: Botswana, Côte d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda, Zambia, Haiti, Guyana and Vietnam. Dr. Dybul says it is on track to reach the 500,000 mark by June 2006.

"I think there are a lot of misconceptions about [ARV] drugs," Dr. Dybul adds. "The cost of anti-retroviral therapy is not drugs.... The major costs are supporting and training personnel, laboratory capacity and supporting those laboratories."

Dr. Dybul puts the annual cost of ARV treatment in Africa at \$1,500–\$2,500 per person, with drugs accounting for just \$300–\$600 of the total. "Arguments about the cost of the drugs are for us a red herring," he explains. "That's not the problem right now."

Patent, pricing controversies

But controversies over the safety, supply and cost of anti-AIDS drugs have continued. In contrast to Dr. Dybul's assessment, WHO reported last December that "the high cost of ARV drugs remains a barrier to scaling up HIV treatment and care." Prices for the next generation of anti-AIDS drugs, which will be needed as the virus develops resistance to current medications, "remain prohibitively expensive throughout much of the world," the organization noted. It warned

that action is needed now to control future costs.

For more than a decade after the development of the first anti-retrovirals in the late 1980s, their high cost and the complexity of using them kept the life-prolonging medications out of the hands of all but a few very wealthy or very fortunate people in poor countries. At \$10,000–\$15,000 per year, ARV treatment was simply unaffordable. Efforts by UNAIDS to negotiate discounted prices for developing countries enjoyed only limited success, and the major Northern pharmaceutical companies generally resisted calls to licence inexpensive generic versions of their patented products.

In 2001, however, an Indian pharmaceutical firm, Cipla, introduced an innovative generic medication that combined three of the most effective anti-retroviral drugs into a single pill, known as the triple fixed dose combination tablet (FDC). Not only was the drug easier to administer than its patented competitors — two pills a day compared with six or more of some of the patented formulations — it was available initially for the unheard-of price of \$350 per year. After a two-year investigation by WHO's drug prequalification programme, the triple FDC was certified safe and medically equivalent to the patented originals, and went into wide use. With prices now as low as \$140 a year, the triple FDC has emerged as the pharmaceutical backbone of the 3x5 campaign and is credited with making it possible to expand ARV treatment.

But PEPFAR requires its grantees to use only drugs certified by the US Food and Drug Administration (FDA), a policy that, in practice, has meant the programme buys only patented products, mainly from US suppliers. PEPFAR officials say the policy is necessary to ensure the safety and quality of drugs and note that a number of generic ARVs have been removed from the WHO pre-approval list after problems were discovered in the certification documents. They also note that foreign generics producers are welcome to submit

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Growing public demands for access to AIDS treatment has helped speed up anti-retroviral therapy programmes.
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AP Photo / Themba Hadebe



tries on 1 January 2005, under the World Trade Organization's agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), has also set off alarm bells among advocates and health officials. The agreement makes it more difficult for India and other major exporters of generic drugs to continue to supply developing countries with low-cost ARVs and other vital medicines.

The current generation of frontline anti-AIDS drugs are exempt from the new patent rules, says Mr. Brook Baker, a

Making generic anti-AIDS medicines in South Africa. Will trade rules hamper generic producers?

their products for FDA approval under a special "fast track" procedure.

To date, however, none of the triple FDC drugs favoured in international treatment programmes has secured FDA approval. The result, reported the US government General Accounting Office, is that PEPFAR currently pays about twice as much for anti-retroviral medications as treatment schemes using generics. The agency estimates that the costs could potentially run into hundreds of millions of dollars over the five-year span of the PEPFAR initiative, reducing the number of people who can be treated for the same money.

In late January, the FDA approved its first generic ARV product, a two-pill package taken twice daily, and applications for other generic products, including triple FDCs, are under review. Treatment advocates welcome the development but charge that the failure of the US to adopt the preferred triple FDC tablet is forcing participating countries to manage different supply chains and treatment regimes — complicating the drive to expand treatment.

Trade rules threaten affordability

The extension of 20-year patent protections to all but the least developed coun-

professor at Northeastern University in the US and a member of the treatment advocacy group Health Gap. "The problem will be with the next generation of ARVs in the pipeline. TRIPS will prevent the kind of generic competition that has driven prices down in the past."

In August 2003, the WTO's TRIPS Council, under pressure particularly from African countries to create a public-health exemption to the new rules, reached an agreement to permit the export of generic drugs for public health emergencies. But the exemption is limited and procedurally complex. To date, no country has attempted to use it.

Mr. Baker also notes that US negotiators are seeking patent protections in excess of WTO requirements in regional and bilateral trade talks. These so-called "TRIPS plus" agreements, Global AIDS Fund head Richard Feacham said last year, have the effect of "either pushing [drug] prices up or preventing their fall," further limiting the availability of affordable medications.

Canada recently amended its patent laws to permit the pharmaceutical industry to use the WTO exemption, but according to Mr. Richard Elliot, the direc-

tor of legal research and policy at the Canadian HIV/AIDS Legal Network and a member of the government's Ministerial Council on AIDS, its provisions too are complex and restrictive. So far, he told *Africa Renewal*, no Canadian company has sought an export license under the new law.

Short on resources, long on needs

The rapid expansion of AIDS treatment programmes has brought with it equally dramatic demands for new resources. And while the 3x5 campaign and the US programme have short-term targets, they are creating long-term obligations to the millions of people entering treatment, since ARV therapy must continue for life. When UNAIDS was launched in 1996, the organization noted recently, global spending on the full range of HIV/AIDS initiatives in low- and moderate-income countries was \$300 mn. Last year, reports the Washington-based Kaiser Family Foundation, spending topped \$6 bn.

But even that impressive figure, notes the UN's Mr. Lewis, is just half the \$12 bn UNAIDS estimates is needed this year to continue expanding treatment programmes and meet education, prevention, counselling and research needs. The Global Fund needs \$1 bn this year to cover its commitments, he says. "WHO is short \$60 mn for the final vital push on 3x5 and they still don't have it. I don't understand this grudging incrementalism by Western countries. We're losing incredible numbers of lives every day."

UNAIDS estimates that by 2007 \$20 bn will be needed for the fight against AIDS, and Mr. Lewis calls on wealthy governments to make major new commitments at the upcoming meeting of the Group of Eight industrialized countries. "We have more money now, but in a few years we'll be fighting desperately for dollars again. Prices for the next generation of drugs are very, very high. They will have to be negotiated down and ways found to make generics."

"Everywhere we turn we have impediments," he acknowledges. "But we also have a momentum that is unstoppable. I see the focus everywhere in Africa. Now the commitment is tremendous." ■

Botswana's high-stakes assault on AIDS

An African test case for wide distribution of life-prolonging medicines

By Roman Rollnick

Gaborone

The gleaming floors, white-frosted technicians and humming electronic equipment of the Botswana-Harvard HIV Reference Laboratory here in Botswana's capital are distant in more ways than geography from the dusty villages and crowded mining compounds on the frontline of Botswana's desperate struggle against HIV/AIDS. But closing the gap between the resources available at this modern new facility, and the nearly 40 per cent of the adult population infected with the deadly virus, is at the heart of Botswana's high-stakes effort to provide comprehensive HIV/AIDS treatment to all of its citizens. In January, Botswana became the first country in Africa to offer expensive, but life-saving, anti-retroviral drugs (ARVs) and other medications to all who need them through the public health system.

It is a costly and ambitious undertaking, one that many health care experts say cannot be done in Africa. But for the 330,000 Botswanan adults estimated to be HIV-

from AIDS-related illnesses last year alone. "We are threatened with extinction," President Festus Mogae told the UN General Assembly last year. "People are dying in chillingly high numbers. It is a crisis of the first magnitude."

More than Botswanan lives may be at stake, however. For years, some international health experts, backed by many donor governments and agencies and the powerful pharmaceutical industry, have argued that poverty and the absence of infrastructure make it impossible to successfully treat large numbers of HIV-positive people in developing countries with AIDS medications. Rather than waste resources on a failed effort to treat those already ill, they assert, scarce funds should be spent preventing new infections through education and prevention programmes.

Activists counter that pilot projects have demonstrated the feasibility of treatment programmes in developing countries, and that only a combination of treatment and prevention can turn the tide against the disease. Many advocates charge that opposition to large-scale treatment programmes is fueled more by concerns for patent rights and profits than genuine doubts about practicability.

Botswana is the first African test case. Success in treating large numbers of patients will buttress the argument for greatly expanded treatment efforts in the rest of Africa and other developing regions. Failure will badly undermine the call for greater treatment access for the world's poor. Although the Joint UN Programme on HIV/AIDS (UNAIDS) has long maintained that both prevention and treatment are necessary in the campaign against AIDS, fewer than 30,000 of the almost 29 million Africans infected with the virus have access to the ARV drugs that have dramatically reduced death rates in rich countries.

Slow but steady progress

If any country in sub-Saharan Africa can implement a comprehensive HIV/AIDS prevention care and treatment programme, observers say, it is Botswana. Unlike many of its neighbours, the country has enjoyed an

unbroken period of peace and comparative prosperity since independence in 1966. Its government is widely regarded as among the most efficient and capable on the continent, and its annual per capita income of \$3,300 is among the highest.

Success in treating large numbers of patients will buttress the argument for greatly expanded treatment efforts in the rest of Africa and other developing regions.

Still, the obstacles are formidable. Many Botswanans are migrant workers, employed in neighbouring South Africa for much of the year, but maintaining farms and families back home. Migrants are at particular risk of infection because of the increased likelihood of contact with prostitutes and other

casual sex partners while away from home. Often unaware that they have become HIV-positive, and unwilling to seek out testing and counselling because of the stigma associated with the disease, migrants are thought to be an important factor in the spread of the virus.

For those who do seek medical help, there is the problem of locating it. For HIV patients outside the private sector, there are only two government referral hospitals, one in Gaborone and another in the north, in Francistown. There are two smaller, district hospitals in the country, but most public health care is delivered through local clinics offering only basic services.

The National AIDS Coordinating Agency (NACA) formally embarked on the national treatment programme in January this year. Dr. Banu Khan, NACA's national AIDS coordinator, told *Africa Recovery* that the government set a target of 19,000 people for enrolment in their first year of ARV treatment under a \$27.5 mn programme in which people who require the drugs will get them for life. The ministry of health has calculated the cost of medications, testing and counselling at about \$600 per person, per year. Over the first five years of the programme, the Gates Foundation will provide \$50 mn to help Botswana strengthen its primary health care system, while the giant US drug manufacturer Merck will match that contribution with anti-retroviral medicines. The other half of the cost, some \$100 mn, will be met by the government.

"As of June this year, we had an estimated 1,000 people enrolled," Dr. Khan noted. "We have 500 undergoing the treatment, while the

Botswana's AIDS epidemic, 2001

Population	1.6 million
Adult population (15-49)	762,000
Total adults with HIV	300,000
Adult infection rate	38.8 per cent
Adult women with HIV	170,000
Adult men with HIV	130,000
Children with HIV (0-14)	28,000
Older adults with HIV (50+)	2,000
Total deaths (2001)	26,000
AIDS orphans (0-14)	69,000
Life expectancy (1987)	63
Projected life expectancy (2005)	37

Source: UN Africa Recovery from UNAIDS, World Bank data

positive, access to ARVs and to ongoing care, counselling and testing, is a matter of life or death. The vast but sparsely-populated territory has the highest HIV infection rate in the world (see table, above). Some 26,000 people in this country of less than 1.6 million died

remainder are still being screened to ascertain their precise treatment requirements.” She termed that number “disappointingly” low, but said that more people are steadily coming forward. NACA says the volunteer patients include a “good mix” of educated and poorer rural people, some from the remote regions of the arid Kalahari in the west and northwest of the country.

Significantly, NACA officials say, initial indications are that very few patients have difficulty adhering to the complex ARV drug treatment regimes. The ability of poor and poorly

is especially concerned at the low intake of mothers in a programme intended to cut mother-to-child transmission of the HIV virus and keep infected mothers alive. Since the pilot project began, she said, only 2,000 women are currently undergoing treatment for AIDS-related illnesses. “We only opened up pilot sites two years ago. The percentage of mothers enrolled, however, is not desirable. It is low and must be increased. We have problems here, especially the one of stigma.” Health officials said enrolment by pregnant mothers had only been in the 11-20 per cent range.

“Another problem is the status of women in relation to men,” Dr. Khan added. Many women lack the power to control decisions about sexuality and remain under the authority of husbands, parents and in-laws all their lives. “How do you test someone if they do not get permission?”, Dr. Khan asked.

“Then, with those who do enrol, they go home to a remote village with formula milk for their baby and are branded as suspect because they are not breastfeeding... Mothers also worry about who will look after their baby if they die. But ARV therapy is now available in Botswana for these mothers and their babies, and I am hoping [enrolment] will increase now.”

Child AIDS patient in Botswana's Princess Marina hospital, which has the most advanced AIDS research laboratory in Africa.



© Don McCullin / Contact Press Images

educated patients to stick to strict medication schedules over a lifetime has been a major concern of health specialists and is an important aspect of Botswana's treatment initiative. Like Alcoholics Anonymous, NACA operates a “buddy system” whereby each patient is encouraged to form a special bond with someone close, who makes sure they remain on their medication schedule. The patients, in turn, counsel others who feel they may need help, to come forward.

Targeting mothers

Enrolling women in the programme is a key priority because they make up more than half of all infected adults. Dr. Khan said that NACA

The country currently has 16 voluntary counselling and testing centres specifically for mothers, one in every district. These are stand-alone centres where one can discuss medical problems in privacy. “For example, in the latter part of last year, we had a conference for people living with HIV/AIDS and it drew 500 sufferers,” Dr. Khan noted. “They went back to their homes and formed support groups to reduce stigma.”

Dr. Khan said that NACA urgently needs more trained staff. “We have found that if you have a trained nurse dealing with many people in a rural clinic, for example, she does not have the time to counsel every HIV patient. So we are building a system of lay counselors, like social

workers. For this, we do not necessarily need nurses and we have a programme to employ 500 such lay counselors. We are hoping they will also play a key role in reducing stigma.”

She said that people living with AIDS, both from the educated urban classes and rural communities, are increasingly aware that the government is providing free lifelong treatment. “These people are with us on a voluntary basis. No one is coerced. We counsel them on positive living, about prevention, about the importance of remaining on the treatment even if they feel better. And they usually go home and spread this positive message.”

Staff shortages severe

At present, NACA employs 10 doctors working full time on HIV/AIDS at the Princess Marina Hospital in Gaborone, and five at each of the other hospitals. Patients are also seen at the smaller health facilities, some of them mobile clinics, around the country. Uniquely for an African country, NACA says, almost no one is more than 8 km away from a clinic where they can seek medical help. Even in the remotest areas of the Kalahari, most people are just 15 km away. These clinics decide what sort of treatment people need, and either refer them to a hospital or provide them with ambulance transport if required.

Ms. Catherine Sozi, a British-trained Ugandan doctor based at the UNAIDS office in Pretoria, South Africa, said Botswana can sustain its national health scheme for AIDS patients even though the drugs are required for life. “However, there is an acute, absolute shortage of doctors, nurses and counselors in Botswana's health care system,” she said, citing a recent UNAIDS assessment. “Although we did not have time to calculate the number of extra health workers needed for the ARV programme, the numbers are substantial. If a first recruitment for ARV treatment would cost one hour of a doctor's time, recruiting 10,000 new patients in three months, for example, would require at least 20 fulltime doctors doing nothing else but supervising these patients.”

The shortage of doctors, pharmacists, nurses and counselors is compounded by the fact that over 90 per cent of doctors in Botswana are foreigners who do not speak Setswana. Counselors too are recruited from abroad and need to spend time becoming familiar with the local culture. Many spend only a brief period in the country, thus exacerbating the need for frequent training and supervision to ensure proper medical care. There also is concern that

many nurses, once trained and registered, emigrate to better-paid jobs abroad.

The government is seeking to recruit up to 200 new doctors from South Africa, Cuba and other nations to administer the drug programme. "In return for their travel and accommodation expenses, many are coming to give their time free of charge," Dr. Khan explained. "They know the government is serious in addressing this epidemic."

The shortage of pharmacists outside the major hospitals is another problem. UNAIDS found that Botswana's few pharmacy technicians already have to manage drug supplies and distribution in the hospital and surrounding clinics. "They need support if they are to handle sensitive drugs like ARVs," Dr. Sozi said. Because Botswana will have to rely for some years to come on foreign health professionals, she noted, UNAIDS is recommending appropriate courses for them about local culture, health policies and protocols. Many current staff will require crash courses on ARV treatment issues.

Botswana is supporting the new drug treatment policy with an expanded and more aggressive education campaign, modeled in part after Uganda.

development of new medicines, including a vaccine. "The virus strain in Botswana is clearly different from those we see in the West," said Dr. Max Essex, Chair of the Harvard AIDS Institute. "Nobody knows if a vaccine [being developed] against HIV-1B, the strain most common in Europe and the US, will work as well against HIV-1C." Scientists at the institute said they are concerned that strains like HIV-1C would become even more drug resistant without effective monitoring of patients taking ARVs. This is why, Dr. Khan said, the "buddy" system to ensure adherence is as important a component in the battle as further funds for training new medical teams.

Combining treatment and prevention

Botswana is supporting the new drug treatment policy with an expanded and more aggressive education campaign, modeled in part after Uganda, which has successfully reduced new HIV infections through sustained public education. President Mogae is determined to make

on the country as a whole. People are scared."

"For a decade," he continued, "until the end of the 1990s, we were in a state of denial, blaming the crisis on foreigners. Then, as we realized its extent, we started acting. Today, I would say the government is very transparent, pro-active and accountable. We are the most advanced African nation in this struggle — and believe me, I would not have said that just three years ago."

Employers get involved

Botswana's private sector has also become involved. Three years ago, the country's biggest employer, the Debswana diamond mining company, realized after testing its 6,000-strong workforce that fully a third of workers aged between 24 and 40 were HIV-positive. With revenues of some \$1.8 bn dollars a year, and skilled miners scarce, the company set up its own HIV/AIDS scheme.

"We realized we had to do something fast because diamonds are the foundation of our economy," said Ms. Tsetsele Fantan, director of the company's programme. She said Debswana agreed to provide free treatment for each infected employee and one legal spouse, while the government would provide treatment for other partners and their children. The government has also urged major banks, transport companies and even petrol stations to provide better levels of health care and make HIV counselling and treatment available to their employees.

The Harvard-Botswana lab is another example of the public-private partnerships the Botswana government is seeking to build. The government provided \$3 mn, while additional funding was contributed by the Gates and Merck Foundations, the Bristol-Myers Squibb drug company, the Harvard AIDS Institute and others.

"This collaborative programme is designed to demonstrate the benefits of a comprehensive, multi-sectoral approach to improving the care of people living with HIV in a country with limited resources," said Dr. Clement Chela, of the Botswana Comprehensive HIV/AIDS Partnership. The fact that ARVs are now freely available, he added, has become a motivating factor for people to come forward. "The programme we have put in place here can work in other countries in Africa, and with international financial help, it can be sustained." ■

Young Botswanan activists have been key in public AIDS education and prevention programmes.



UNAIDS / G. Pirozzi

Testing, monitoring and surveillance of the Botswana AIDS plague, as many now call it, is carried out by the new Botswana-Harvard laboratory at the Princess Marina Hospital. The first of its kind anywhere in Africa, the laboratory, with a staff of 50, is equipped with gene sequencers and blood cell sorters, enabling scientists to keep track of the spread of HIV, especially the HIV-1C strain prevalent in Africa.

The lab will also conduct research for the

sure that the message of free treatment gets out — through radio, billboard campaigns and by word of mouth.

Mr. Edmund Dladla, national coordinator of the Botswana Network of People Living With HIV/AIDS, welcomed the president's leadership. "Any person who is of working age, who has a job and some education talks about it. And everyone wonders about the impact AIDS is having, not only on those close to them, but also

Senegal's recipe for success

Early mobilization and political commitment keep HIV infections low

By **Mamadou Mika Lom**

Dakar

Senegal is one of the countries cited as an example in the struggle against AIDS in Africa. Since its first confirmed case in 1986, the prevalence rate of HIV infections among adults has been kept at between 1.77 and 1.74 per cent. Around 80,000 adults and children are infected, out of a total population of 9 million.

The reasons for this success against the spread of the virus lie in Senegal's early response to the disease, vigorous preventive action, care of AIDS patients and the mobilization of people at all levels, including teachers, soldiers, women, religious leaders and non-governmental organizations (NGOs). Senegal's long experience with democracy and its freedom of the press also made it possible to openly discuss the problem and easily get out information about the disease.

In 1970, well before the discovery of the first AIDS case, the government already had initiated a policy for managing blood transfusions. It was strengthened after 1986 through the systematic screening of donated blood. And to better keep the disease from spreading among prostitutes, the health authorities very early established a system for addressing their health needs, as well as a programme against sexually transmitted diseases.

Bonds of trust were forged early on between medical experts and government officials, who

were convinced of the stakes involved, and allocated budgetary resources to fight the disease. They launched a national committee to combat AIDS in October 1986.

Aware that all these initiatives would have only a limited impact if they were not accompanied by other measures, health officials in 1988 launched a national campaign aimed at women and young people, particularly students. Teaching modules on the links between AIDS and other sexually transmitted diseases were made part of school curricula. These target groups in turn helped to raise the awareness of other especially vulnerable and high-risk groups of the population, such as prostitutes and migrant workers.

Senegal was also among the first countries in Africa to take advantage of the new opportunities to gain access to anti-retroviral medicines, to care for those who have become infected. The average cost of basic medicines for treating AIDS-related diseases has been reduced by 90 per cent. In addition, President Abdoulaye Wade has committed the government to doubling the amount needed for anti-retrovirals, from CFA 250 mn to CFA 500 mn (about \$700,000) per year.

Profile: AIDS in Senegal

People living with HIV/AIDS (1999)	79,000
of which:	
women (15-49 years old)	40,000
men (15-49)	35,700
children	3,300
Adult HIV prevalence rate (%)	1.8
Estimated AIDS deaths to 1999	7,800
Children who have lost one or both parents	42,000

Source: UNAIDS, UN Economic Commission for Africa, AIDS in Africa: Country by Country, 2000.

Peer education

In support of these programmes, the interventions were decentralized at all levels by establishing numerous awareness-raising projects among community organizations, especially cultural and sports associations and women's groups. Centres for young people were set up in different regions, to promote the use of condoms and "peer education," in which young people knowledgeable about AIDS talk primarily to other young people.

"This method has the advantage of getting around the obstacle of sexual taboos" and the reluctance of youth to talk about sex in front of adults, says Ms. Ami Seck, a high school student belonging to the sports and cultural association in Louga. "Among themselves, young people are able to say everything, looking each other in the eyes, without any qualms."

The overall formula in the schools, notes Ms. Seck, is that "the teachers speak to the students, and then they in turn talk to people their own age and to members of their neighbourhood associations." A similar system is used with women's associations.

Religious leaders in the forefront

About 95 per cent of Senegal's population is Muslim and 4 per cent Christian. Religious authorities, both Muslim and Christian, have been very actively engaged in the battle against AIDS. They have organized workshops and conferences, of which the most important was

Health minister and AIDS specialist

Dr. Awa Marie Coll Seck, a specialist in HIV/AIDS and other infectious diseases, was named Senegal's new minister of health and prevention on 12 May. She has long been active in AIDS education and prevention activities, working with Senegal's national committee against AIDS since its formation in 1986. Three years later she launched a non-governmental organization dedicated to highlighting women's particular vulnerability to AIDS, and directed the group until 1996. She subsequently joined the staff of the Joint UN Programme on AIDS (UNAIDS) in Geneva, before taking on her new duties as minister.

Dr. Seck's appointment is noteworthy in several respects. Until recently, it has been rare for health professionals to actually attain ministerial office, a rank usually reserved for influential political figures. Like a number of other "civil society" ministers in the new government, which was formed in the wake of the 29 April legislative elections, she does not belong to any party. She also is one of a record number of six women in the cabinet, including Prime Minister Mame Madior Boye.

an international colloquium on “Religion and AIDS” held in Dakar in 1997, with the participation of representatives of Islamic, Christian, Buddhist and other religious communities from around the world.

From the outset, the Muslim leaders have refused to talk about condoms, preferring instead to emphasize in their sermons fidelity and abstinence as the best means for preventing the disease. They do not, however, exclude the possibility of a couple using condoms if one of them is infected. They also have done successful work in countering discrimination against infected people, some of whom previously had been rejected by their close families and communities.

Changing the behaviour of people is most important, stresses Mr. Bamar Guèye, coordinator of the Islamic NGO Jamra (Arabic for “embers”). “We have always insisted on the moral quality of the individual in our messages,” he says. It was Jamra that succeeded in mobilizing the khalifs (spiritual leaders) of the main Islamic brotherhoods of Senegal to openly discuss the problem of AIDS.

Sida Service, a Christian NGO, also is heavily involved in the fight against AIDS. It is the only NGO to operate a centre that conducts free and anonymous screening for AIDS. Executive Secretary Paul Sagna acknowledges that his group does not reject the use of condoms, but most often advises “abstinence and fidelity.”

Risky cultural practices

According to Ms. Bineta Bocoum, an official of the health education office in the Louga region (which has a high concentration of people who are HIV-positive), it is very difficult at the moment “to say who, among men and women, are the most infected with the disease in Senegal.” Ms. Bocoum, who also is an active member of the Society for Women Against AIDS in Africa, adds that it is particularly risky to specify infection rates among prostitutes. While “official” prostitutes are well monitored and well educated about the disease, others practice the trade more clandestinely. Nevertheless, she is encouraged by the fact that information about the disease has been widely disseminated by NGOs and women’s, youth and religious associations.

One problem, however, is that many of the cultural practices that are prevalent in Senegal may serve to propagate the spread of the disease.

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Women’s
coopera-
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Senegal:
community
groups
have been
key in
spreading
information
about
AIDS.
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World Bank / Curt Carmichael

These include the *levirate*, in which a man is obligated to take as his wife the widow of a deceased brother, or the *sororat*, in which a woman marries the spouse of her late sister. Polygamy and excision (female genital mutilation) also are widely practiced. Fortunately, the involvement of religious leaders in raising awareness about AIDS has contributed to reducing such practices. As some of these authorities now emphasize, no one should be obliged to marry if it “runs the risk of losing your life.”

Soldiers well-equipped

Army soldiers are regarded as the biggest consumers of condoms in Senegal. This is because special steps have been taken to raise the awareness of troops, in order to prevent the spread of AIDS. The success at this level lies with the fact that Dr. Souleymane Mboup, a colonel in the army’s medical corps, has himself been deeply involved in research on the disease. He was part of the effort to isolate HIV-2, a particular strain of the malady discovered in Senegal, and he has received numerous distinctions for his research.

Generals in the Senegalese army often receive training about AIDS from military doctors, and in turn are expected to raise the awareness of their troops and the troops’ families. During every peacekeeping mission involving Senegalese contingents, explained a military doctor, “the troops are well-educated about the disease and given sufficient numbers of condoms.” While on mission, these troops also regularly undergo examinations and screening, the same source indicated.

Among private businesses, the emphasis is

on preventive action. This is especially the case in the country’s big enterprises, such as the Industries chimiques du Sénégal, a phosphate mining and processing complex in Thiès, and the Compagnie sucrière sénégalaise, a sugar plantation and milling enterprise in Saint-Louis. According to Mr. Papa Nalla Fall, a leading employers’ representative, “everything is being done to safeguard workers from the disease.”

“Since businesses are not isolated from society,” says Mr. Fall, “it is therefore necessary to be concerned with the employee’s immediate environment, and beyond that, with the entire community to which he belongs, to avoid eventual losses of time and money for the enterprise.”

Mr. Fall took part in the December 2000 African Development Forum organized by the UN Economic Commission for Africa, which focused on the AIDS crisis. At the forum, he urged the reduction of developing countries’ debts, so that they can devote more resources to the fight against AIDS. Upon his return to Senegal, he and other private employers initiated a series of seminars to stress the importance of disseminating information on AIDS within businesses.

A stable infection rate

In the 17 years since Senegal’s first AIDS case was diagnosed, the HIV infection rate has been kept stable. Of the 80,000 or so Senegalese living with the virus, about 3,000 are children. Initially, there were about four infected men to every infected woman, but now the ratio is about equal.

According to medical experts, prostitutes, or

turn to page 31

Uganda beating back AIDS

Leadership, education and openness are keys to progress

By **Fred Kirungi**

Kampala

Uganda has recorded declining rates of HIV infection since 1993. Although HIV prevalence among pregnant women rose from 24 per cent in 1989 to 30 per cent in 1992, by 1999 it had dropped to 10 per cent, according to the latest figures from the AIDS Control Programme (ACP) in the Ministry of Health. Among patients suffering from sexually transmitted diseases at Uganda's leading hospital, Mulago, HIV infection rates fell from 44.2 per cent in 1989 to 23 per cent in 1999.

This achievement can be attributed to four factors, according to Dr. Joshua Musinguzi, the

transmission of HIV, create mechanisms to care for the infected and their families and create the capacity to contain the epidemic. "The backbone of our programme was information, education and communication. We had to make people aware of the problem and translate this awareness into behavioural change," said Dr. Musinguzi.

The core of ACP's anti-AIDS message was abstinence from sex, faithfulness to one's partner and use of condoms. "More people are now using condoms and there has been a decline in casual sex," said Dr. Musinguzi.

The ACP alone distributed 80 mn condoms last year, and the number is expected to rise to

put up billboards across the country. However, because of the limited reach of these, especially in the rural areas, the programme also used existing administrative and social institutions.

"We especially used the LC [Local Council] system not only to get our message to every village but also ensure that anti-AIDS activities were initiated and implemented at the lowest level," he said.

The LC system is a hierarchical administrative structure from the village to the district level. At each level, there is a governing committee composed of nine elected members, including secretaries for health, women and youth. The ACP trained LC officials at the district and in some cases, sub-county levels, and they, in turn, trained their counterparts at the lower levels on AIDS-related issues. "Our approach was to encourage them to design and implement their own strategies to cope with the problem," said Dr. Musinguzi.

Although there was no direct funding from the government for AIDS-related activities in the villages, LC committees were given assistance in the form of information leaflets, condoms and, in some cases, HIV testing services. Since 1996 when the government adopted the policy of decentralization, 65 per cent of tax revenues remains at the sub-county level and some of it is committed to AIDS activities.

In addition, the ACP used drama groups, schools, churches, mosques and community-based organizations to help spread the word on AIDS. "Because of our openness about it, the challenge of AIDS became the concern of everybody. Churches, mosques, schools, the army, and even private companies initiated their own programmes to handle the problem," he said.

Combating stigma

Dr. Musinguzi said that openness about AIDS also helped remove the stigma associated with the scourge and encouraged people infected with HIV to join in the fight. One such group is the Buwolomera Development Association (BUDEA), set up in October 2000 in Iganga district, some 120 km east of the capital, Kampala. All 55 members of the group are



— Mobile team with a young AIDS sufferer in Kampala: Many sectors of Ugandan society are active in anti-AIDS activities. —

acting programme manager of ACP: the high level of political commitment to the fight against HIV/AIDS, openness about the epidemic, involvement of all sections of society and the government policy of decentralization. Even President Yoweri Museveni "got engaged in the fight early and encouraged other political leaders to do so," Dr Musinguzi told *Africa Recovery*.

A strong start

In 1986, the same year Mr. Museveni came to power, the government launched the ACP to spearhead the struggle against HIV/AIDS. The programme's objectives, according to Dr. Musinguzi, were to prevent further

120 mn this year, compared to only 4 mn in 1990. A June 2000 report shows an increase in condom use across the country. In Kampala, 51 per cent of those surveyed used condoms in 1998 compared to 42 per cent in 1995. The report also records a slight decline in non-regular sex partners from 14.1 per cent in 1995 to 13.7 per cent in 1998. However, condom use with non-regular partners increased significantly, from 58 per cent to 76 per cent.

Local councils

Dr Musinguzi said the ACP conducted information campaigns on radio, television and in newspapers, distributed leaflets and posters and

Sean Sprague



infected with HIV, and 43 of them are women.

Ms. Florence Kumunhyu said they formed the association not only to support each other, but also to help others in the community avoid their fate. "We visit and give each other material and emotional support. Since we are all infected, we appreciate each other's problems and the dangers of this scourge more than anybody else," says Ms. Kumunhyu.

Members of BUDEA visit schools, churches and mosques to preach against the epidemic. They also carry out door-to-door campaigns. "People take an infected person more seriously. Our status is an advantage rather than a weakness in the struggle against the spread of HIV," Ms. Kumunhyu says.

BUDEA receives no external funding, relying solely on the efforts of its members to finance its education and home care activities. "We rear chickens, grow crops and make handicrafts to raise money," explains Ms. Kumunhyu.

Society-wide coordination

The members of BUDEA initially belonged to a larger non-governmental organization, Integrated Development Activities and AIDS Concern (IDAAC). Formed 10 years ago, the NGO operates in the three districts of Eastern Uganda.

"We went to the villages encouraging people to come for HIV testing. We provided our members with home care support and counselling," said Rev. Jackson Muteeba, IDAAC's programme manager. As the numbers grew, however, IDAAC found it difficult to provide these services. "We encouraged them to form local associations so that they could support each other. Intervention

measures are more effective and sustainable if they are applied from the lowest level, right from the home," Rev. Muteeba said. The group, with over 4,500 registered HIV patients, provides its member associations with training and advisory services. There now are over 1,500 NGOs and community-based organizations involved in HIV activities in the country.

Dr. Musinguzi noted that it was the involvement of different sectors of society that originally led to the formation of the Uganda AIDS

Commission (UAC) in 1992 to coordinate all AIDS activities. The UAC's director of AIDS research and policy development, Dr. John Rwomushana, explained that under the multi-sectoral approach the commission adopted in 1993, the struggle against AIDS was broadened to include fighting poverty, illiteracy, child abuse and cultural practices like polygamy and wife inheritance, all of which make individuals more vulnerable to HIV infection.

Overall, AIDS-related activities are expected to cost \$181 mn over the next five years, according to the UAC. The government will contribute \$60-88 mn, with the shortfall expected to be taken up by NGOs and donor agencies.

Cultural sensitivities

"Our education campaigns not only addressed AIDS and health-related issues," said Dr. Rwomushana, "but also risky cultural practices. HIV control was made an integral part of the country's national education and poverty eradication policies."

One of the biggest challenges, according to Dr. Rwomushana, was how to campaign against AIDS and risky behaviour without upsetting cultural and religious sensibilities. "We adopted a policy of inclusiveness that avoids confrontation with the different social and religious groups," he said. "The fact that the chairman of the Uganda AIDS Commission, Halem Imana, is a retired Catholic bishop is a demonstration of this."

One policy that posed particular problems was the promotion and distribution of condoms. Many religious groups were opposed to them, prompting the ACP and UAC to not be very forceful in promoting them in the beginning. That obstacle has now been overcome, according to Dr. Rwomushana.

"We encourage groups that preach morality to promote means of HIV avoidance they are comfortable with, without, however, undermining other agencies that may be promoting

Profile: AIDS in Uganda

People living with HIV/AIDS (1999)	823,000
of which:	
women (15-49 years old)	420,000
men (15-49)	350,000
children	53,000
Adult HIV prevalence rate (%)	8.3
Estimated AIDS deaths to 1999	110,000
Children who have lost one or both parents	1,700,000

Source: UNAIDS, UN Economic Commission for Africa, AIDS in Africa: Country by Country, 2000.

methods less acceptable to them," he said.

Big challenges

Despite all these achievements, there are serious challenges to be faced, not least the growing number of AIDS orphans. According to UAC, there are 1.9 million Ugandan children who have lost one or both parents to AIDS. "The challenge is to provide them with housing, food and education," says Dr. Rwomushana, who is in charge of formulating a national strategy to address the problem of orphans.

Another big challenge, according to Dr. Musinguzi, is reducing the comparatively high prevalence of HIV among girls aged 15-19 years. A March 2001 UAC report noted that girls are six times more likely to be infected with HIV than boys the same age. Dr. Musinguzi attributes this to the "sugar daddy" syndrome, referring to older, relatively wealthy men who engage adolescents in sexual relationships. "A broad approach that involves enrolling and keeping girls in school and equipping them with skills to resist such men is needed," he says.

Ms. Anne Akia Sydler, editor of *Straight Talk*, a free monthly magazine that targets adolescents, agrees. "Girls fall easy prey to sugar daddies because they have no bargaining power. *Straight Talk* is trying to equip these girls with bargaining and communication skills," she says.

Daunting as these challenges are, Dr. Rwomushana has no doubt that they will be surmounted. "With the involvement of everybody, we have managed to bring the infection rates down. There will be no complacency, and the situation can only improve," he says. ■

"Intervention measures are more effective and sustainable if they are applied from the lowest level, right from the home."

— Rev. Jackson Muteeba

AIDS orphans: facing Africa's 'silent crisis'



World Bank

By Michael Fleshman

To the tragedy of the 17 million people who have lost their lives to AIDS in Africa, add the 12 million orphaned children left behind. Traumatized by the death of parents, stigmatized through association with the disease and often thrown into desperate poverty by the loss of bread-winners, this growing army of orphans — defined as children who have lost one or both parents — is straining the traditional extended family and overwhelming national health and education systems in the most severely affected countries. The problem is particularly severe in Zambia, where, according to the US Agency for International Development (USAID), the number of orphans topped 1.2 million in 2000 — 1 in every 4 Zambian children. Of these an estimated 930,000 have lost at least one parent to AIDS.

Housing, feeding, educating and nurturing these children is both a moral imperative and essential to Africa's development prospects, Mr. Stephen Lewis, UN special envoy for HIV/AIDS in Africa, told *Africa Recovery*. "There has to be an Herculean effort made for these kids so we don't lose them." Otherwise, he cautioned, "you reap the whirlwind.... You

have a society where kids haven't been to school and therefore can't fulfill even basic jobs ... a society where a large proportion can have anti-social instincts because their lives will have been so hard. You have a generation of children who will be more vulnerable to exploitation and to disease because they won't have the same sense of self-worth."

The needs of AIDS orphans are as immediate as their next meal and as extended as access to education, guidance and care until the end of their adolescent years. Speaking to leaders of industrialized countries at the July 2001 Group of Eight meeting in Genoa, UN Secretary-General Kofi Annan appealed for the resources "to care for all

whose lives have been devastated by AIDS, particularly the orphans." The number of AIDS orphans exceeded 13 million globally, he noted, "and their numbers are growing."

Strengthening the family

In Zambia and other countries hit hardest by the pandemic, however, the traditional mechanism for the care of vulnerable children, the extended family, has started to break down under the twin pressures of poverty and disease.

Reinforcing the family, UN Children's Fund (UNICEF) Executive Director Carol Bellamy told *Africa Recovery*, is the only practical response to the crisis. "There are not enough orphanages in this world to take care of these kids," she noted. "We've got to strengthen the extended family." But a comprehensive 1999 study of what one researcher termed Zambia's "silent crisis" of orphans revealed just how difficult that can be in practice.

Part of the problem is financial. The pandemic has been both a cause and an effect of the country's deepening poverty and rising external debt, problems that have pushed many families to the very edge of survival and limited the government's ability to respond to the orphan cri-

sis. Per capita income, just \$490 in 1990, slumped to \$330 by the end of the decade, while debt service payments consumed a larger share of the national budget last year than did health and education spending combined.

For many children, the loss of parents brings destitution, an end to schooling and stigmatization by family and neighbours. Despite the mounting death toll, nearly half of Zambia's orphans live in a household with one surviving parent, usually their mother. The high incidence of HIV infection within marriage, however, means that many children soon lose both parents, and become the responsibility of the extended family. About 40 per cent of these children are raised by grandparents, while about 30 per cent are reared by aunts and uncles.

The consequences for the family, however, can be devastating. One 70-year-old woman raising her 4 grandchildren told researchers that "ever since these children were brought to me I have been suffering. I am too old to look after them properly. I cannot cultivate ... and the food does not last the whole year."

"It is an unbelievable act of self-sacrifice on the part of the families because frequently it pushes them over the edge," acknowledged Mr. Lewis. "They have just enough for themselves and suddenly they take [in] two kids.... I don't think anybody imagined the unprecedented assault on the extended family system which has occurred in grievously affected countries. This is just a huge challenge."

Child-headed households, once a rarity in Zambia, are now increasingly common, but formal and traditional inheritance, land ownership, and health and education policies have not kept pace with their needs. "Our parents both died in 1995," one young Zambian woman told UNICEF researchers. "When this happened, our relatives ran away from us. This surprised us because, being our relatives, we thought they would care for us.... Our parents had a big farm, but it was taken from us so we had nowhere to grow food. My young brothers and sisters became beggars; they would walk from house to house asking for food."

Other children are taken in by neighbours, or find a bed in one of Zambia's very few orphanages or residential facilities. For the rest, there

are only the streets of Zambia's cities, where children, lacking adult supervision and a stable home, survive by begging and petty crime.

Orphans or vulnerable children?

In Zambia, supporting the family's ability to raise orphans and other vulnerable children has been primarily a community effort. Over the nearly 20 years that the HIV/AIDS pandemic has spread through the country, hundreds of religious and community-based children's committees and homecare projects have been established to care for the sick and provide counseling and support for orphans and their families. The programmes are as diverse as the communities they serve. But in their various ways, virtually all attempt to help families meet two fundamental needs — food and education.

lived below the poverty line, so did 73 per cent of children with parents.

In one community, an external donor provided school fees and new uniforms for the children. The other students, however, could not afford new clothes. The resulting resentment isolated the orphans from their peers and raised tensions within the community. The same can occur within the extended family itself, where orphans under the care of an uncle may have access to benefits not available to the guardian's own children.

"When it comes to practical interventions," the study noted, "there is no useful purpose served by separating orphans from other vulnerable children. In fact, there are significant risks in so doing." Part of the challenge facing donors, researchers note, is that many pro-

usually allowed households headed by women and children to remain on their land, and the project initially supplied seeds, fertilizer and tools. When it became clear that families lacked the skills necessary to increase food production, the project hired a trained agronomist to improve agricultural techniques and yields. Originally conceived as a nutrition programme, KOP's farm project also became an important source of family income, allowing children to pay school fees, thereby reducing the financial burden on the community.

Nutrition projects in other parts of the country, however, have not fared as well. In Kitwe, the local Children in Distress committee (CINDI) established communally tended "orphan gardens" to generate income for vulnerable families and improve nutrition. But the gardens routinely produced less than gardens worked for personal benefit and failed to reduce dependence on donated food rations and other external relief programmes. In the view of UNICEF and other researchers, the community's inability to hire professional staff, coupled with awareness that relief supplies would make up for low yields in the gardens, contributed to the problem.

The experiences of the Kanyanga and Kitwe nutrition projects reflect strengths and weaknesses in locally based responses to the needs of orphaned and vulnerable children. In both cases, communities identified a need and moved quickly to improvise a solution, drawing on local skills and available resources. But the differences in the outcomes in the two communities point to the need for greater access to outside skills and financial and technical support, and highlight the difficulty of replicating local successes on a wider scale.

Orphans and education

The Zambian government and civil society groups are finding similar challenges in trying to meet the educational needs of orphans and other vulnerable children. Although communities, parents and children themselves identify education as critical, the study noted in 1999, "It is perhaps in the area of education that government, donors and the development community have failed the Zambian child the most." Zambia's financial difficulties do not allow the government to provide free education. The government pays teachers' salaries, but local school management committees must cover operating



AIDS orphans and other children drinking from a UNICEF-financed handpump in Chipata, Zambia.

One of the first challenges communities face is determining what constitutes an orphan and which children should receive extra help. The 1999 study, supported by UNICEF and other donor groups, found that many Zambians consider children orphaned only if they do not live with an adult relative. In some communities children who have lost both parents but are under the care of some other relative may not be presumed to require special assistance unless they also are very poor. Many Zambians prefer the term "vulnerable children" to "orphan" because children with parents are often little better off in material terms than those whose parents have died, and are considered equally deserving of aid. The study found that while 75 per cent of orphaned children

grammes earmark benefits exclusively for orphans — entrenching these "significant risks" in the eligibility requirements.

Land and food

In rural areas, the government, religious and community organizations have worked with traditional leaders to keep vulnerable families on their land, and, where families are no longer able to provide for themselves, create sustainable nutrition programmes with local resources. In rural eastern Zambia, the Kanyanga Orphan Project (KOP) — originally established as an AIDS homecare programme — recognized an urgent need to improve the farming skills and nutrition of families with vulnerable children.

Traditional inheritance customs in the area

costs by charging enrolment fees and setting requirements for uniforms. As a result, an end to education is often an early consequence of orphanhood and the loss of family income.

Children from poor families are most vulnerable. "Our records show most of the orphan children stopping school are those coming from poor families," noted a school headmaster in Katongo, Isoka.

In an effort to keep children in school, communities have developed three types of responses. The first is to lobby local school management committees to waive fees for the most vulnerable children. These efforts are often successful, but inevitably undermine the financial base of the school. At the Chimwemwe school in Kitwe, for example, fees were waived for 400 of the school's 1,500 students, reducing the operating budget by nearly a third.

A second community strategy is to raise money for orphans' school fees. Bursaries have the advantage of keeping schools solvent, but usually compel local committees to design and manage successful income-generating projects. With notable exceptions, however, communities often find they lack the management skills, start-up capital and marketing opportunities to run projects profitably. In many cases, community-initiated income projects lose money and drain volunteer committees of limited time and energy. Zambian government, donor and NGO advocates agree that improving communities'

ability to generate operating revenue is vital, but it remains a long-term goal.

A third approach is the Open Community Schools programme — community-run schools without fees or dress codes created for vulnerable children using volunteer teachers, donated space and a curriculum that compresses the first six years into just three. Initially launched as an innovative government-community partnership to provide education to orphans and other vulnerable children, the schools were intended as adjuncts to the public school system rather than alternatives. Students were expected to return to the state system at year seven.

The success of the open schools triggered a rapid increase in their numbers, but often at the cost of educational quality. The reliance on volunteer staff meant that teachers were often absent, and left the school entirely when paid employment became available. As important as such stopgap measures are, educators argue, only a national system of free and compulsory public education can equip the next generation with the skills needed for development.

Institutionalizing responses, not kids

The Kaoma Cheshire Home serves an area with

the largest number of orphans in the country and is among the few programmes to provide institutional care for infants orphaned by AIDS. Yet it too aims to return the children to their communities as soon as circumstances permit, usually between the ages of two and three.

Child-headed households, once a rarity in Zambia, are now increasingly common, but formal and traditional inheritance, land ownership, and health and education policies have not kept pace with their needs.

If there is consensus among advocates and service providers about the dangers of institutionalizing orphans and other vulnerable children, there is equally broad recognition of the need to systematize and coordinate international, national and local responses. This role is increasingly being assumed by the Zambian government, with support

from UNICEF and UNAIDS. At the national level, the Department of Public Welfare coordinates a steering committee of NGOs, civil society organizations and community-based providers to identify needs, direct technical and material resources where they are most needed and develop a policy framework that responds to the complex needs of orphans and vulnerable children.

There are also efforts under way to better use the resources of Zambian civil society groups, which have long grappled with the orphan crisis and accumulated valuable experience in mobilizing people throughout the country to become involved. But unless a major increase in financial, technical and human resources occurs, said Mr. Lewis, the future of Africa's orphaned children is bleak.

"So many of the kids have gone through the desperate, traumatic ordeal of looking after a mother who literally dies in the child's arms," he observed. "They feel so abandoned. The little ones, the 4 and 5 and 6-year-olds, with these great big eyes, their little voices engaging you in this quiet whispered conversation — and you're trying to figure out what can be done for this seemingly endless roll-call of children. Communities try to make arrangements where kids can spend some time together, to have one meal if they can manage. But it's all very fragile... Communities are so [besieged] by the dying and the death and the poverty," he noted, "that there just isn't enough time and concern focused on orphans, and there must be." Sometimes, he concluded, "it can be emotionally overwhelming."

Senegal's recipe for success

from page 23

"sex workers," are the group most exposed to the disease.

Their prevalence rate is between 12 and 15 per cent. Dr. Ibra Ndoye, director of the National Programme Against AIDS and head of a major AIDS treatment and research centre at Fann Hospital in Dakar, notes that this rate compares favourably with the average for prostitutes in Africa, about 50 per cent of whom are believed to be infected. "The rate of infection of prostitutes is not alarming in Senegal," he maintains, adding that since 1988 the rate of new infections among Senegalese prostitutes has not changed. He attributes this to effective work on monitoring the population in general, and sex workers in particular.

The overall infection rate may climb somewhat over the next few years, but according to Dr. Ndoye, the goal is to not exceed 3 per cent between now and 2005.

"The greatest difficulty that we are now confronting," says Dr. Ndoye, "is the problem of access to medicines, whose prices still are too high for those who are sick." Another difficulty is the lack of information among doctors responsible for dealing with the disease. "AIDS is a new illness that requires a new approach among specialists involved in treating it," he says. Therefore better training and more medical personnel are needed to mount an even more effective response against the spread of the virus. ■

AIDS takes an economic and social toll

Impact on households and economic growth most severe in Southern Africa

By **Belinda Beresford**

Johannesburg

In Southern Africa, as elsewhere in the continent, the AIDS epidemic is not just a health crisis. It is also “a major threat to development and to human society,” as Executive Director Peter Piot of the Joint United Nations Programme on AIDS (UNAIDS) put it at a conference in Nairobi in April. While wreaking havoc on the present generation, the disease jeopardizes the future as well, undermining African economies and societies in ways that often are not immediately apparent.

Taking a narrow economic approach, however, some have argued that AIDS is unlikely to inflict severe damage on national economies because those infected are, in their great majority, the poor and unskilled, who contribute little in pure economic terms. This view ignores not only the human dimension, but also the broader social and economic

it begins by killing those parts responsible for building society, the women and breadwinners who sustain and safeguard the community as a whole. Ultimately, AIDS undercuts economic growth and harms development, but its impact is felt first at the “cellular” level, among African households.

Of all parts of Africa, the Southern African region has the highest infection rates (see map, page 36). In South Africa and Botswana, 15-year-olds currently have a one-in-two chance of dying of HIV/AIDS. The US Census Bureau last year forecast that Botswana, Zimbabwe and South Africa would experience negative population growth as a result of HIV. Slowly won development gains, such as life expectancy, education and

estimated number of infected people may rise from 5.2 million to 8.2 million, or nearly 17 per cent of the total population. Such projections, of course, do not take into account new medical breakthroughs or changes in people’s behaviours, which could impede the disease’s progression.

HIV/AIDS damages society just as it does the human body: it begins by killing those parts responsible for building society, the women and breadwinners who sustain and safeguard the community as a whole.

Families hit hard

Among households, the direct costs of HIV/AIDS can be measured in the lost income of those who die or who lose their jobs because of their illness. Household savings fall, consumption on items other than health and funerals

declines and expenditure patterns are distorted as families struggle to cope with the demands of the sick and dying.

Mr. Robert Greener of the Botswana Institute of Policy Analysis told *Africa Recovery* that while government revenue from its diamond industry has been relatively unaffected by the AIDS crisis, that of households has been hit hard. Overall poverty rates will not necessarily get worse, “but the rate of improvement will not be what it was. We found that HIV will have a major effect on how [people] can invest in their own future.” He estimates that between 17 and 25 per cent of households will lose an income earner in the next 10 years, with total income falling by 15 per cent in the poorest homes. A government AIDS-impact study estimated that overall household per capita income will fall by 8 per cent, and as much as 13 per cent for the poorest quarter.

Households which otherwise might have remained above the poverty line are pushed below it. This in turn can feed the epidemic. As the UN programme, UNAIDS, has pointed out, at least two of the behavioural responses to poverty can exacerbate the epidemic: migration in search of work and employment in the sex trade. When people are mired in poverty, “taking care to avoid HIV/AIDS may seem a less immediate concern for many people than simple survival.” Combating poverty, in turn,

Farmers in Zambia: Loss of a family member to AIDS can push households deeper into poverty.



Das Fotoarchiv / Henning Christoph

aspects of development. It likewise ignores the existing evidence of the many insidious ways in which AIDS already is harming key sectors in those countries most seriously affected by the epidemic.

Harvard University economist Jeffrey Sachs pointed out at an international AIDS conference in South Africa last year that HIV/AIDS damages society just as it does the human body:

literacy, are being eroded. In Botswana, it has been forecast that HIV will cut in half life expectancy at birth.

South Africa, once seen as the economic powerhouse for the region, is thought to have the greatest number of infections in the world — an estimated one in nine of the population has HIV. The spread of the virus is not expected to peak for another five years, when the

can help make people less vulnerable to AIDS. A study in Bushbuckridge, South Africa, found that providing micro-loans to groups of women gave the women some financial autonomy, enabling them to better negotiate safer sex.

On a wider scale and over time, the erosion of household incomes and opportunities can damage the fibre of entire communities and societies. Extended family networks, which can cope with the normal traumas of life in poor countries, often begin to fray when multiple orphans are dumped on them and when the breadwinners can no longer support themselves, let alone anyone else. The transfer of knowledge across generations is lost, and socialization is reduced.

Health facilities under strain

Not only do overall household incomes fall, but also what money remains tends to be diverted to meet the needs of the sick. Family expenditure on healthcare rises, eventually consuming savings and other resources in an attempt to keep death at bay, and to pay for funerals when the battle is lost.

On a grander scale, countries' health systems themselves become overburdened. Already understaffed and underfunded, Africa's health infrastructure is struggling to cope with the enormous demands placed on it. Public health facilities in particular come under strain, as many private clinics and doctors choose not to offer treatment for HIV/AIDS. The lack of supplies can put healthcare workers at risk of becoming infected themselves.

AIDS distorts health-spending priorities. According to UNAIDS, up to 80 per cent of hospital beds in Zambia and Zimbabwe (as well as Côte d'Ivoire) are occupied by HIV-positive patients. For governments, the epidemic poses a number of dilemmas: to spend limited resources on trying to prevent further infections, helping those already infected, or combating other serious health problems, such as tuberculosis, malaria and cholera.

Empty schools

Many poor households affected by AIDS may not be able to afford to send their children to

school. Even in countries where schooling is free, there are other costs such as uniforms and books. Specifically to address this problem, the World Food Programme has proposed that "take-home rations" should be added to school feeding projects to give families an incentive to send their children to school.

Studies in Zimbabwe have found that of the AIDS orphans on commercial farms, not one was attending secondary school and almost half the primary school pupils had dropped out by the time their parents had died.

Such a programme could particularly help female children, since cultural conditioning means that girls are more likely to be kept out of school to become caregivers. Where HIV infection rates are lower, school attendance, especially of girls, tends to be higher.

Moreover, children may be the only able-bodied members of a household if the adults are sick — or dead — and are likely to concentrate more on survival and raising their siblings than on education. Studies in Zimbabwe have found that of the AIDS orphans on commercial farms, not one was attending secondary school and almost half the primary school pupils had dropped out by the time their parents had died. According to estimates, more than 7 per cent of Zambia's 1.9 million households are now

headed by children aged 14 or less.

In some cases, students also may be subject to disproportionately high infection rates. At one South African university, it has been estimated that two-thirds of students will be HIV-positive by the time they graduate. As such students and pupils die, not only do Africa's economies lose potential skilled workers, but the governments' educational investment in them also is wasted. Similarly, families' expenditures on their schooling have been in vain, and they lose not just a loved one, but a possible source of future revenue.

Infection rates among teachers also are high. According to South African economists Peter Badcock-Walters and Alan Whiteside, in 1998 the mortality rate among educators was 39 per 1,000, or 70 per cent higher than in the 15-49 year age segment of the population. In Zambia, during the first ten months of last year, 1,300 teachers died of AIDS — two-thirds of the annual number of newly qualified teachers.

Macroeconomic impact

In many different ways, the devastation of AIDS among individuals and families ultimately affects a country's overall economic performance. The loss of experienced workers and skilled professionals saps production in



UNDP / Ruth Massey

key sectors. More insidiously, AIDS can erode the people's morale, weakening their confidence in the future, further harming productivity and undermining their willingness to save and invest.

Foreign investors also are becoming increasingly concerned about the implications of the HIV/AIDS epidemic, at a time when Africa is seeking to attract more international investment. For foreign investors, notes Mr. Gordon Smith, chief economist of Deutsche Bank in South Africa, "uncertainty means sell rather than hold," much less invest more money.

According to some estimates, annual per capita economic growth in Africa is 0.7 per cent less because of the cumulative impact of AIDS. Such estimates are seriously unreliable, however. There is a paucity of accurate data both on AIDS itself — precisely who is infected, in which economic sectors — and on how the illness actually affects different economic activities. Nor can the impact of AIDS be easily separated from other factors. "AIDS is part of a whole. It will have a macro-economic impact," admitted Mr. Whiteside, the South African economist. "But you cannot disimpact AIDS from labour legislation, for example."

Nevertheless, numerous studies agree that AIDS can seriously slow down economic growth, to varying degrees. UNAIDS has estimated that when HIV prevalence rates rise to more than 20 per cent, gross domestic product

Former mineworkers in Lesotho, some of whom have AIDS, produce AIDS educational materials.



Das Fotoarchiv / Ludger Schindler

(GDP) in those countries can be lowered by as much as 2 per cent a year. In South Africa, the investment bank ING Barings has projected that HIV/AIDS could drag down GDP by 0.3-0.4 per cent a year. Another study has indicated that by the end of the decade, AIDS could have knocked South Africa's GDP by 17 per cent, or \$22 bn.

The UN Development Programme (UNDP), in its Botswana Human Development reports, cites government studies that HIV/AIDS will result in GDP being between 24 per cent and 38 per cent lower by 2021. Mr. Greener says that 2 per cent of the workforce in that country is showing clinical signs of AIDS. He predicts that over 25 years, GDP could be 40 per cent lower than without HIV/AIDS. "There will be an increased cost of skills," he says. "There is a need to put in place practices to maintain productivity and prevent a skills-related bottleneck."

Farm output erodes

The agricultural sector is one of the hardest hit in sub-Saharan Africa, where it is often the largest contributor to the economy. As people sicken, the areas they cultivate may shrink, and yields decline as physical weakness reduces farmers' effectiveness. Food security is jeopardized, as labour, time and money is diverted to deal with the illness. Agricultural households may revert to subsistence rather than cash crop farming, and the quality and quantity of food may decline.

In Malawi, death rates among employees of

the Ministry of Agriculture and Irrigation have doubled, almost all because of HIV/AIDS. In Namibia, studies indicate that agricultural extension workers spend a tenth of their time attending funerals.

"The effect of AIDS on food production is both immediate and long-term," Dr. Piot of UNAIDS has pointed out. This has been confirmed concretely by a study from Zimbabwe, which looked at the impact of an adult death on the household's ability to produce different foods. It estimated reductions of 61 per cent for maize, 49 per cent for vegetables and 37 per cent for groundnuts (see graph, next page). But AIDS also hits long-term agricultural capacity. Livestock is often sold to pay funeral expenses, and orphaned children often lack the skills to farm or look after livestock in their care.

High infection among miners

The mining industry is notorious for its high rates of HIV infection, particularly where there are single-sex hostels and attendant male-to-male sexuality and commercial sex. Migrant labour adds to the problem, with workers carrying infection to and from their employment on trips home, including in other countries. Areas of Lesotho are now being devastated by HIV as sick workers return from South African mines, a situation exacerbated by the economic reliance of the small country on their remittances.

Although there have been anecdotal reports of infection rates as high as 60 per cent, some mining companies say this is exaggerated and

Southern Africa: labour force losses due to HIV/AIDS (%)

	by 2005	by 2020
Botswana	-17.2	-30.8
Lesotho	-4.8	-10.6
Malawi	-10.7	-16.0
Mozambique	-9.0	-24.9
Namibia	-12.8	-35.1
South Africa	-10.8	-24.9
Tanzania	-9.1	-14.6
Zimbabwe	-19.7	-29.4

Source: UN Africa Recovery from ILO and UN Population Division data.

claim rates among their employees are close to the national average. The mining companies in South Africa are regarded as being at the forefront of businesses taking action on HIV/AIDS.

In Botswana, the highly mechanized diamond sector, which uses a smaller and more stable workforce, is likely to be relatively unaffected by HIV, unlike the gold mines in neighbouring South Africa. Few families realize direct earnings from diamonds and most of the revenue from the sector goes to the government. It therefore filters into the rest of the economy only through government expenditure. Thus, to an even greater extent than in many other countries, GDP, in per capita terms, does not reflect personal incomes. "Government is shielded, but people are not," observes Mr. Greener. "So that impact falls on the household."

Companies bear the costs ...

According to a Deutsche Bank study, while the HIV infection rate among unskilled and semi-skilled workers in South Africa is expected to peak at just under 33 per cent by 2005, for highly skilled workers it is expected to be around 13 per cent. Nevertheless, such skills are scarce, and the impact of AIDS will be disproportionate. One study found that highly skilled workers are on average about three times as productive as unskilled workers, and productivity losses could account for about 54 per cent of total economic costs.

Employers will face other costs as well, for example through increased medical claims and insurance payouts. South Africa's Metropolitan Life insurance company has calculated that by the end of this decade payroll expenses could be 30 per cent higher as a result of HIV/AIDS related costs, including pension and sick leave payouts. Absenteeism rises as employees take time to nurse the sick or attend funerals.

"There will be a decline in workers' morale as they become gripped with fear and uncertainty as they see people around them dying," said Ms. Tsetsele Fantan, head of the HIV/AIDS programme at the Botswana diamond company Debswana. "There will be accidents as they start to lose concentration.

Management resources will be eaten away by problem solving."

Skills shortages have been a perennial problem for businesses in Africa, a situation that HIV is making worse as more skilled workers

Many firms have introduced AIDS awareness programmes, in conjunction with health checkups and free treatment of sexually transmitted diseases.

die. Difficult or expensive to replace, the result can be a vicious circle as public and private infrastructure starts to decay. There have been reports of power failures in Zambia because there were not enough engineers to maintain the facilities. As HIV takes its toll, financial resources for training are being spread to cover more people, to ensure that enough will be available. Anecdotal reports suggest that some companies train several workers for every one they need — they assume natural attrition in the form of HIV will remove the extra hires.

... and take AIDS prevention seriously

Many large companies began planning responses to HIV/AIDS years ago, including researching the likely impact on their workforce. Although there are sometimes legal concerns about employee testing, companies often do surveillance studies using saliva samples as part of other health checks. The South African mining firm AngloGold, for example, conducts anonymous tests on its miners, with their consent, during their checkups for tuberculosis. According to a manager at South African Breweries, 40 per cent of the company's workforce in KwaZulu Natal is HIV positive.

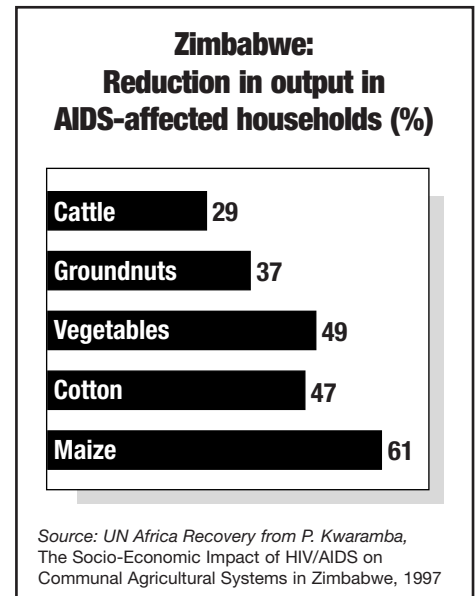
By planning ahead, the private sector has been able to shield itself to an extent. Some companies have sought to divest themselves of risk by outsourcing activities such as long distance transport, where workers tend to have high rates of HIV. One study by the Medical Research Council of South Africa found that approximately 90 per cent of truck drivers at one particular rest stop were HIV positive.

Some companies have concluded that the costs of introducing prevention and treatment measures could be lower than not doing so. The Anglo-American Corporation is just one organization looking at providing anti-retroviral drugs to its infected workers, especially if drug prices continue to fall. In Botswana, Debswana has announced plans to provide anti-retroviral

therapy to each HIV-positive employee and one dependent, a move that is also being considered by one of its parent companies, De Beers.

Many firms have introduced AIDS awareness programmes, in conjunction with health checkups and free treatment of sexually transmitted diseases (STDs). AngloGold's research centre, Aurum, calculated that the company was saving money by treating STDs, in that it contributed to lower infection rates.

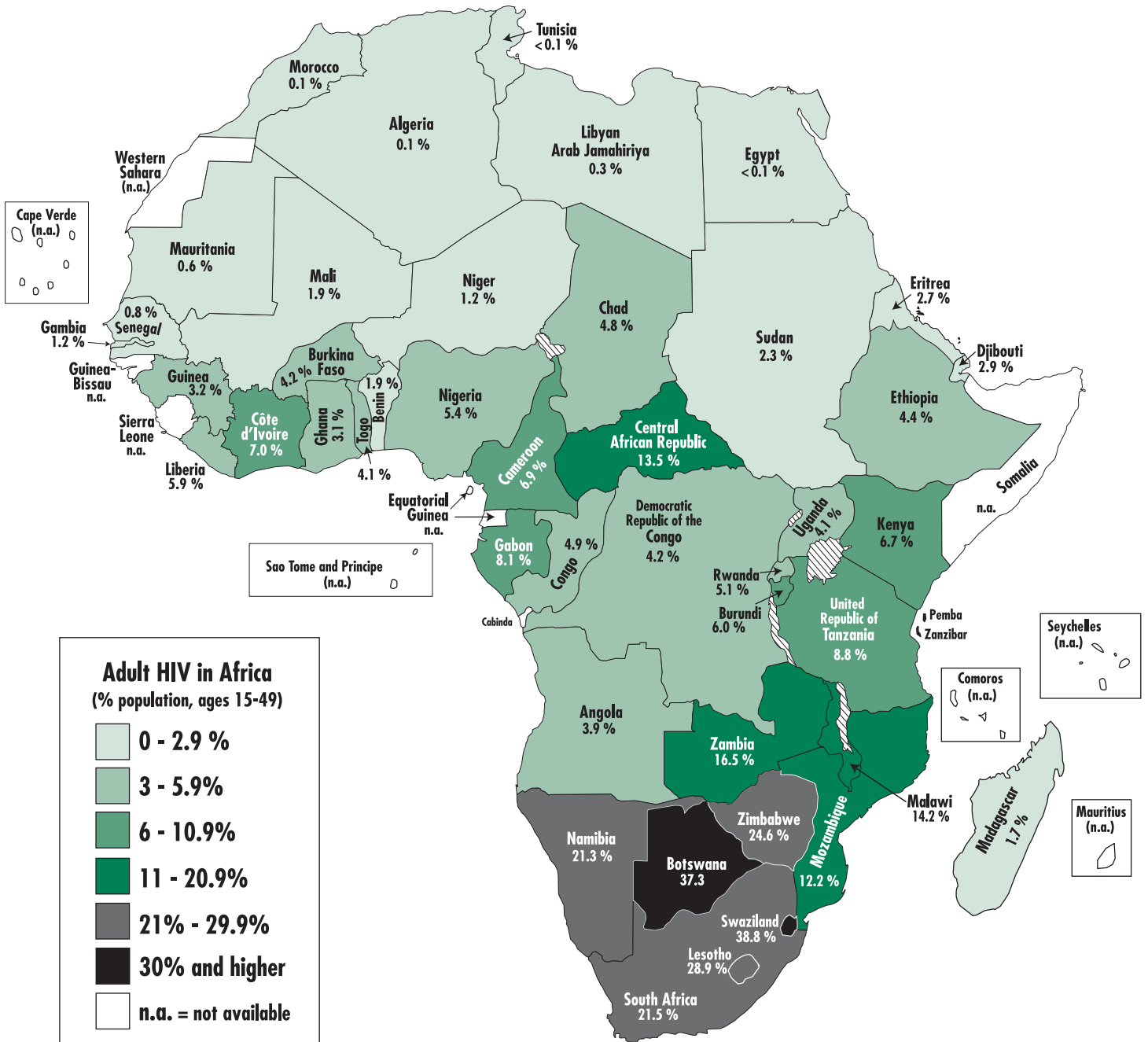
The South African power parastatal, Eskom, has been running HIV/AIDS programmes to educate staff and help those infected to remain healthy. The company, which employs approximately 32,000 people, claims to have infection rates "substantially less" than the national rate. Mr. Baningi Mkhize, the occupational medical services manager, says the company was inundated with employees wanting to take advantage of a voluntary counselling and testing programme. Staff who develop full-blown



AIDS can join Aid for AIDS, a managed care programme that concentrates on the disease. Eskom itself earmarks R125 (\$17) per employee for its HIV/AIDS programme, projecting to spend R150 per person the next financial year.

In their efforts, employers are increasingly being helped — and prodded — by their trade unions. The Congress of South African Trade Unions, the largest union federation in the country, is planning to launch a campaign to get employers to pay for anti-retroviral drugs for infected workers. ■

Adult HIV rates in Africa*



Source: UN Africa Recovery from UNAIDS data.

* These figures for 2003, the most recent available, reflect the midpoint between high and low estimates.