FOIA Number: 2007-1550-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21072

FolderID:

Folder Title:
AIDS Infothek

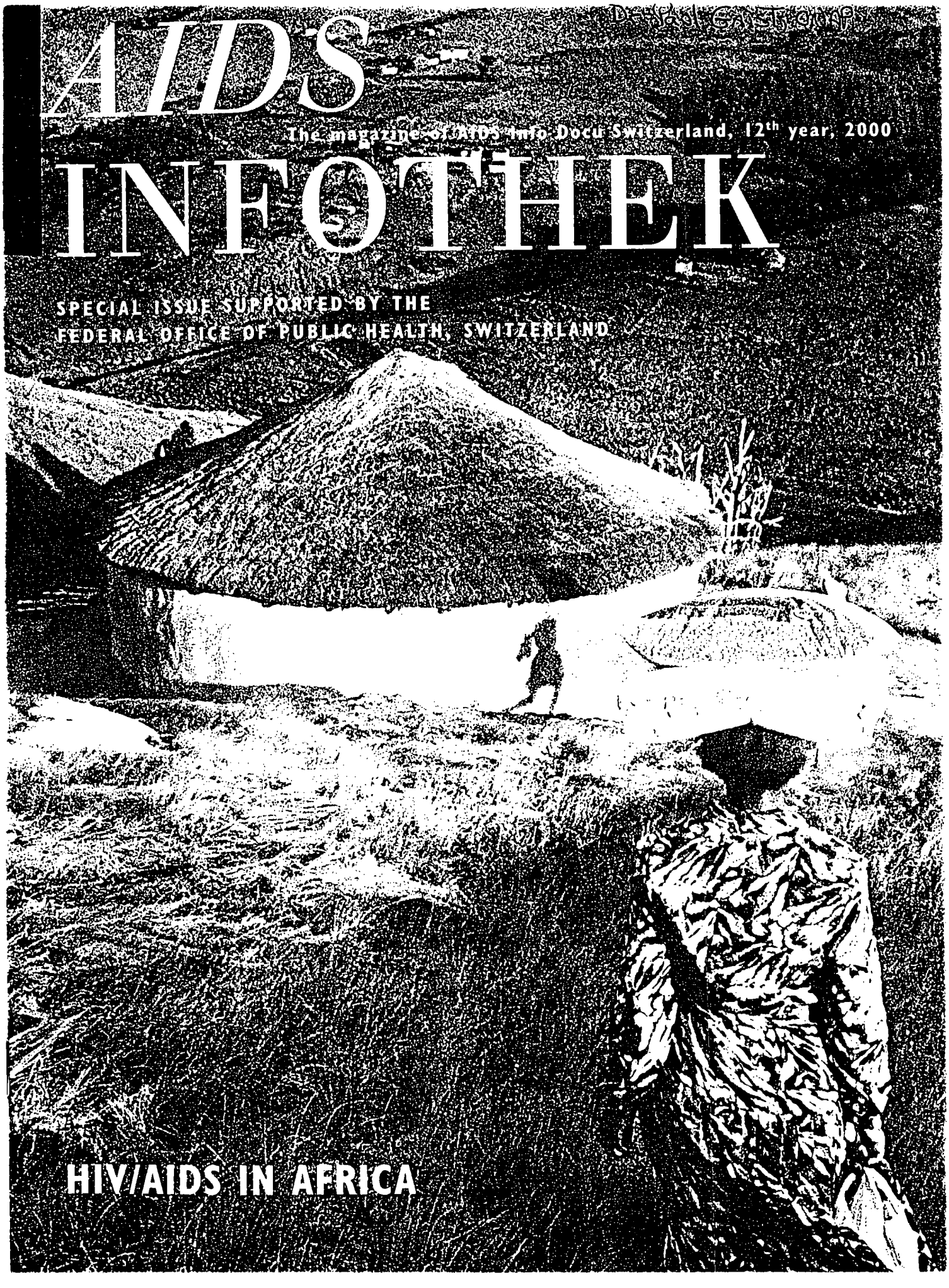
Stack:	Row:	Section:	Shelf:	Position:
S	67	1	1	3

AIDS

The magazine of AIDS-Info-Docu Switzerland, 12th year, 2000

INFOTHEK

SPECIAL ISSUE SUPPORTED BY THE
FEDERAL OFFICE OF PUBLIC HEALTH, SWITZERLAND



HIV/AIDS IN AFRICA

Publisher:
AIDS Info Docu Switzerland
P.O. Box 5064
CH-3001 Bern
Tel. +41 31 312 12 66
E-mail: info@aid.ch

Responsible:
Christa Brunswicker (CB)
Executive Director

Advisers:
Prof. B. Hirschel
S. Schifferer

Collaborators:
Raphael Baltes
Mathis Brauchbar (MAB)
Roger Charbonney (RCh)
Katja Delang (kd)
David Haerry (DH)

Translator:
Michael T. Wright
Berlin, Germany

Editor:
Wolfgang Wettstein
Kommunikationsberatung und Medienarbeit
CH-8008 Zurich
E-mail: wwettstein@access.ch

Layout:
Helm AG, Yvonne Helm
CH-8008 Zurich

Print:
Rickli + Wyss AG
CH-3027 Bern

Photographer:
Gideon Mendel, South Africa (Network Photographers Ltd. London; Lookat Fotografenagentur, Zürich)

AIDS INFOTHEK
The bi-monthly magazine of AIDS Info Docu Switzerland.
Special edition: April 2000
This special edtion is also available in French and German.
Circulation: 10 000
ISSN 1021-321X

Subscriptions:
Phone +41 31 740 97 65
Fax +41 31 740 97 70
Yearly subscription: CHF 41.–

Table of contents

Greetings

This special issue of AIDS INFOTHEK applies itself to important issues on HIV/AIDS in Africa, and its release is timed to coincide with the period leading up to the XIIIth International AIDS conference which is to be held in Durban, South Africa, between 9th and 14th July 2000.

The articles provide useful information on the populations most seriously and widely affected by this pandemic and anticipate some of the key topics to be highlighted at the Conference. A careful reading of the main ideas put forward by the contributors to this volume, each experienced and knowledgeable about AIDS in Africa, can help explaining some of the complex problems arising from this disease and draw attention to programmes which are likely to work.

The emphasis throughout is on prevention of HIV. The subjects covered include identification and targetting of specific groups which are at high-risk for contracting HIV, the response of international funding and development agencies to the epidemic in Africa, the appropriateness of health care systems for dealing with HIV/AIDS, and selected examples of impact of the disease on health and development.

I hope that through the contribution of AIDS Info Docu Switzerland people in Europe will become increasingly aware of the grave problems facing Africa, and that our collective action will, in the end, lead to success.

Professor Hoosen M. Coovadia
Conference Chair of the XIII International AIDS Conference
Durban, South Africa

Doing Our Part

Dear Readers,

In preparation for this special issue we asked African authors and international experts on Africa to contribute. Their readiness to participate was overwhelming. In spite of all the difficult work in preparation for the conference and their various other commitments, the authors immediately agreed to submit material in order to focus public attention on the problems in Africa. Here we would like to thank all of the authors most sincerely for their contributions.

We hope that through this special issue we have contributed to the success of the conference in Durban, a success with a lasting influence, creating a new sensibility which will turn words into deeds.

Christa Brunswicker
Executive Director
AIDS Info Docu Switzerland

Wolfgang Wettstein
Editor
AIDS INFOTHEK

The Economic Impact of H V

Professor Alan Whiteside, Director, Health Economics and HIV/AIDS Research Division, University of Natal, South Africa
Mary O'Grady, Associate Director, Information Programs, IMPACT/ HIV/AIDS Prevention and Care Department, Family Health International, Arlington, USA, with input from Dr Anita Alban, Senior Economist, UNAIDS, Geneva, Switzerland

Useful Resources
AIDS Briefs
www.info.usaid.gov/gov/regions/afr/hhraa/docs.htm.

UNAIDS
www.unaids.org

Alan Whiteside: whitesid@shep.und.ac.za

Southern Africa is currently experiencing the worst HIV epidemic in the world. HIV prevalence has risen to levels that seemed impossible a few years ago. Even more worrying, the spread is far more uniform between rural and urban areas than was the case in East African countries, which previously had the highest rates of infection.

It is estimated that 12 % of the adult population of Southern African Development Community (SADC) countries is infected, and although there is great variation (from 0.08 in Mauritius to 25.84 in Zimbabwe), eight of the 14 countries have adult prevalence above 10 %. SADC is home to one third of the global population of people living with HI The 1998 surveys of pregnant women showed th in South Africa an estimated 22.8 % were infecte in Swaziland 31.6, and in Botswana 38.8.

The consequence of HIV infection is that peopl will fall ill and die. The impact is most prominentl seen in terms of decreased life expectancy, in creased orphaning, and higher rates of infant an child mortality. Although children born to infecte women have only about a 30 % chance of being in fected, they have virtually 100 % chance of bein orphaned. It is estimated that by 1998 there wer 2 214 000 AIDS orphans in the region.

and A)S 'n Southern A r'ca

There are two published sources on the impact of AIDS on life expectancy: the annual Human Development Report produced by the United Nations Development Programme; and the US Bureau of the Census.[1]

AIDS and Business

Because it strikes adults during their most economically productive years, HIV/AIDS will have greater social and economic impacts than other diseases in sub-Saharan Africa. It has huge impact at the level of individuals and households, and the communities in which they live. At the other extreme, according to the World Bank, the HIV/AIDS pandemic appears to be the major reason why per capita growth is slowing in ten sub-Saharan African countries. Poverty is expected to increase and development to falter because of the pandemic's effects on households, governments, businesses and national economies. The epidemic has the potential to undermine not only the economic and development gains but the social fabric and attempts at nation building. Clearly the disease will have a marked effect on business but published evidence is meagre.

Costs to Companies

The major concerns to businesses in areas where HIV prevalence is high are reduced productivity and increased costs. Productivity will fall and costs rise because of:

- Increased absenteeism. This will not only be because of the ill health experienced by the employees, but also because they (particularly women) may take time off to care for their families (especially the women) and for funerals.
- Workers will be less productive at work and not able to carry out more demanding physical jobs.
- Employees who die or retire on medical grounds have to be replaced and their replacements may be less skilled and experienced and require training.
- Employers may increase the size of the workforce to provide for absenteeism.
- As skilled workers become scarcer wages may increase.

It is probable that the highest HIV/AIDS cost to companies is absenteeism. A study of a bus company in Zimbabwe demonstrated that AIDS-related absenteeism accounted for 54 % of AIDS costs. This was followed by absenteeism due to HIV-related symptomatic illness at 35 %. Zambia's largest cement company reported that absenteeism for funerals increased 15-fold between 1992 and 1995. As a result, the company has restricted employee absenteeism for funerals to only those for a spouse, parent or child. Indeed, even five years ago some companies, such as the Uganda Railway Corporation, were reporting steep increases in absenteeism and turnover among workers. By the mid-1990s, the railway corporation had an annual employee turnover rate of 15 %, with more than 10 % of its workforce dead from AIDS-related illness. In

Zambia, Barclays Bank has been losing 36 of its 1,600 employees each year, ten times the death rate at most U.S. companies. In Kenya, 43 of the 50 employees of the Kenya Revenue Authority who died in 1998, or 86 %, died from AIDS.

The second highest area of costs to companies relates to employee benefits. These will depend on the conditions of employment, the level of staff, and on what benefits are provided. It is possible that the more advanced African economies will be more adversely affected.

Projections for costs related to HIV/AIDS for companies in Kenya by 2005 range from an increase of 4 to 8 %, depending upon the industry. However, one Kenyan transportation company was projected to lose nearly 15 % of its annual profits by 2005 (AIDSCAP, 1996). The impact will depend on the type of business, the skill levels, and replaceability of employees. The most seriously affected businesses might be those in labour-intensive industries, such as transportation, and those depending on migrant workers, such as mining.

In Zimbabwe, a study of the main concerns that businesses expressed about the impact of HIV/AIDS found that 33 % were most concerned with the loss of skilled labour, 24 % with the loss of labour generally, an equal percentage with reduced future productivity, 13 % with increased insurance and pension costs, and 12 % with other associated economic costs. Their short-term concerns focused on the labour impacts, including recruitment, training and development and employee benefits; and, their long-term concerns focused on markets.

AIDS and Agriculture

Agriculture is one of the most important sectors in sub-Saharan Africa when measured by the percentage of the population it supports. Even if agriculture constitutes only 20 % of a country's total GNP, it can provide the survival base for as much as 80 % of the population. Furthermore there is a tendency for people who work in the urban areas to return to the rural areas for care, placing additional burdens on already impoverished households. In Malawi, where about 15 % of the adult population is HIV-positive, child labour is becoming common and many orphans have left school. A 1996 study for the Makandi Tea Estate in Malawi showed a sixfold increase in mortality from 1991 to 1995 from 4 per thousand workers to 23 per thousand. The annual cost of HIV/AIDS was 6 % of the company's operating profit.

Impact on Markets

HIV/AIDS could reduce the absolute number of potential customers, making markets that are relatively saturated and which depend critically on population size the most vulnerable. The impact of the epidemic on specific markets will depend on the demographic profile (age, sex, geographic location) of consumers. Because of the demographics of HIV/AIDS, consumers in the 25-49 age group are likely to be affected, especially those in disadvantaged communities, which currently present the largest opportunities for market growth. In countries where demand for goods is far from saturated, many of the consumers who die or have their disposable income reduced by HIV/AIDS will be replaced by new earners and con-

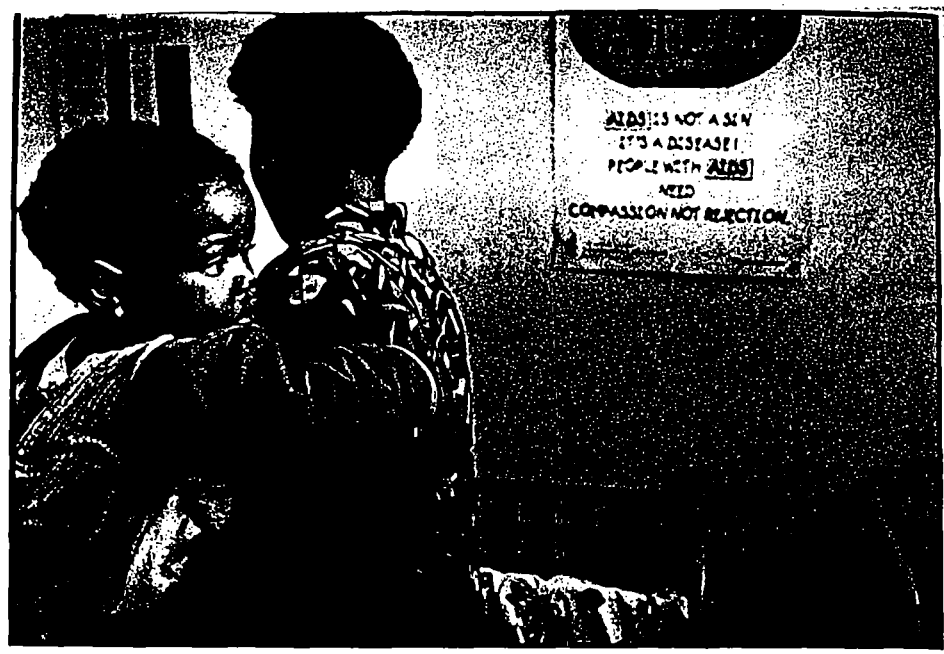
sumers, but only if overall GDP and consumption expenditure remain unaffected by the pandemic.

Macro Level and Business Environment

The impact on development as measured by life expectancy and the Human Development Index has been discussed. The question is what impact AIDS will have on the macro-economies. There are projections that economic growth can slow as a result of AIDS, but there is little hard evidence. There have been attempts to model the macroeconomic impact, but this is fraught with difficulty. Overviews[2] identify the mechanisms through which the epidemic may affect macroeconomies as a result of the illness and death of productive members, and the diversion of resources from savings (and eventually investment) to care. There have also been attempts to model the economic impact for specific countries, including Tanzania[3], Cameroon[4], and Zambia[5]. These models show that HIV may well reduce the rate of economic growth and, over a period of 20 years, this may be significant (up to 25 % lower than it would otherwise have been). However, in order to make this prediction, projections of both the AIDS epidemic and economic trends have to be combined. Both are difficult to model and combining them compounds the uncertainty.

It is more likely that the impact of AIDS will be felt in the political, social and business environment. Examples of this are:

- The private sector may be able to adapt to absenteeism and the death of employees. However governments are less able to do so and the result may be increasing government inefficiency - delays in granting licences, approving applications and so on.
- Service providers may operate less efficiently – it is reported from Zambia that the increase in mortality among the electricity corporation has resulted in interruptions to the electricity supply.
- The increase in orphans may increase the rate of crime and the number of street children.[6]



- The security apparatus and political leadership may experience increased mortality, particularly at the middle levels, which may decrease stability.
- The overall state health system may experience increasing pressure, which will, in turn, lead to a deterioration in the level of and quality of service. The result will be poorer health in general.
- Government resources may be diverted into care and prevention with consequent opportunity costs.
- A concern peculiar to South Africa is the impact on affirmative action. For historical reasons the levels of infection are higher in the black population than the white. The national policy of affirmative action is likely to be hindered by the AIDS mortality.

The Business Response

What can and should companies do about AIDS? Essentially the response can be in four areas:

The impact on employees

Areas for consideration would be ensuring that the production process is not vulnerable to staff loss, and responses might include multi-skilling, recruiting and training additional labour, contracting out, and capital intensification. In addition the company might seek to prevent its workers from becoming infected through education and training, provision of condoms and health services, and examining the root causes of HIV transmission and addressing these. There are many examples of education and condom programmes and there is evidence to show that they can bring the levels of STDs down, and hence are assumed to reduce HIV infections. However companies need to recognise that their employees are members of the community and this is where transmission occurs. It is therefore important that interventions are primarily at community level.

The impact on costs

The costs of the disease need to be monitored and either reduced or accepted. It should be remembered that although a company may be able to reduce its costs, through, for example, reducing medical benefits, these costs will have to be borne by someone somewhere. The state may be forced to step in or communities and households, already under pressure, will have to provide care.

The impact on markets

The effect of increased illness on markets is an issue for companies, and each will have to assess it on the basis of their particular markets.

Business and the society

AIDS is such a serious and far-reaching problem that it will define how societies develop over the first half of the next century in Africa. The structure and shape of society, and the business environment will be determined by the epidemic and how society responds. Business has an important role to play in this, as is discussed in the next section.

Partnerships against AIDS?

There has been a lot of emphasis in recent years and months about partnerships against AIDS. The idea is that there should be a coalition against the epidemic involving government, business, NGOs and broader civil society. This paper ends with a few reflections on what this means and some suggestions as to how this might actually move forward in the Southern African setting.

The first point to note is that the business of business is business, not running or funding AIDS campaigns. If the private sector is to be involved it must be clear that there will be benefits. It may be helpful to locate the response in the hierarchy of what drives the private sector. It must be noted that the response in this context may go against what was intended. For example it may seem to the individual company that it makes sense to test potential employees and exclude those who are HIV-positive and are a potential drain on the company. Activists and advocates need to be sensitive to this.

The Hierarchy of Business

Profitability	businesses must make a profit to survive, if not they disappear.
⇩	
Legality	the legal framework includes international, national and local legislation as well as shopfloor agreements and setting the framework for operations.
⇩	
Social Responsibility	how does the business see itself in society?
⇩	
Publicity	what benefits can be gained from good publicity and can be avoided from bad?

The second point is that all too often, when the business sector is asked to be involved in «partnerships», this does not mean real partnership but rather that business is being asked to provide resources (usually money) and put in place AIDS programmes among their employees – indeed they are most frequently asked to pay others to provide the programmes. Partnership should involve more than this: it should involve give and take from both sides. For example if tax breaks are provided for training (as is the case in most countries), should they be provided for AIDS awareness? Can businesses be used for their skill rather than simply financial contribution? South Africa has many examples of this in the fight against crime.

The conclusion is stark. With the scale of the epidemic being experienced in Southern Africa, business involvement in AIDS prevention is necessary for more than commercial reasons. It is needed if the region is to survive economically, politically and socially.

References:

1 *United Nations Development Programme, Human Development Report 1996 and 1998, Oxford University Press, New York 1996 & 1998. United States Bureau of the Census, World Population Profile 1998, Population Division, International Programme Centre, Washington DC, 1998.*

2 *Over M. «The Macroeconomic Impact of AIDS in Sub-Saharan Africa». African Technical Department, Population, Health and Nutrition Division, Technical Working Paper No. 3. Washington, D.C. World Bank, 1992.*

3 *Cuddington J T. «Modelling the macroeconomic effects of AIDS, with an application to Tanzania». World Bank Economic Rev 1992. 7:403-417.*

4 *Kambou G, Devarajan S, Over M. «The economic impact of AIDS in an African country: simulations with a computable general equilibrium model of Cameroon». J Afr Economics 1992. 1:109-130.*

5 *Forgy L, Mwanza A. «The Economic Impact of AIDS in Zambia». Lusaka, Ministry of Health, 1994.*

6 *This hypothesis is put forward in an article for the African Security Review by Martin Schonteich, Age and AIDS: South Africa's crime time bomb, May 1999.*

Literature:

«AIDS and Development: Socio-Economic Perspectives», speech presented at HIV and Development seminar, Danida, Copenhagen, Denmark, by Anita Alban, UNAIDS, 22 April 1999.

«AIDS in Kenya: Socioeconomic Impact and Policy Implications», AIDSCAP/Family Health International, Arlington, VA, 1996, funded by the U.S. Agency for International Development.

«AIDS Poses Grave Threat to Industry», The Nation, Nairobi, Kenya, 10 June 1999.

Diplomatic Initiative Briefing Papers on HIV/AIDS prepared for U.S. Ambassadors to Kenya, Malawi, Namibia, Nigeria, Rwanda, South Africa, Zambia, and Zimbabwe by the Implementing AIDS Prevention and Care (IMPACT) Project of Family Health International, funded by the U.S. Agency for International Development, June 1999.

«HIV/AIDS in Africa» Briefing Paper for U.S. Secretary for Health and Human Services Donna Shalala by Mary O'Grady, AIDSCAP/Family Health International, for the U.S. Agency for International Development, January 1995.

HIV/AIDS data collected and modelled by Steven Forsythe, Health Economics Lecturer, Liverpool School of Tropical Medicine, formerly AIDSCAP/Family Health International, Arlington, VA.

«The Impact of HIV/AIDS on South African Markets», Anthony Kinghorn, AIDS Analysis Africa, Vol. 9, No. 5, Feb/Mar 1999.

The Status and Trends of the HIV/AIDS Epidemics in Sub-Saharan Africa, Monitoring the AIDS Pandemic (MAP) Network, Abidjan, Côte d'Ivoire, 3-4 December 1997.

The Status and Trends of the HIV/AIDS Epidemics in the World, Monitoring the AIDS Pandemic (MAP) Network, Geneva, Switzerland, 23-25 June 1998.

Sexual y ransmitted HIV Brings Much-Needed

Peter Lamptey, Family Health International, Arlington, USA

Peter Lamptey, MD, DrPH, is director of the Implementing AIDS Prevention and Care (IMPACT) Project, funded by the United States Agency for International Development (USAID), and senior vice president for HIV/AIDS programs at Family Health International

Website: www.fhi.org

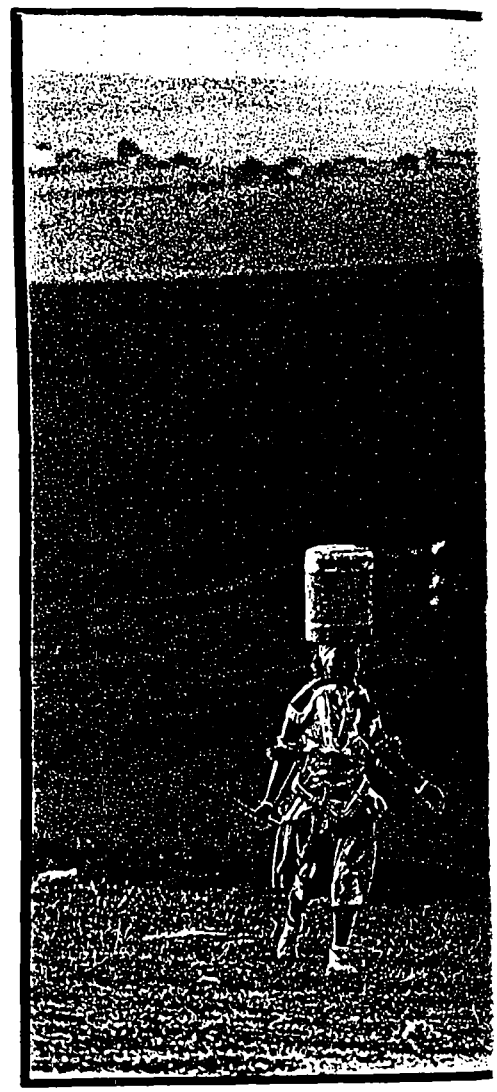
One reason why sub-Saharan Africa has the world's most severe HIV/AIDS epidemic is the high prevalence of other sexually transmitted infections (STIs) in the region and the inadequacy of its STI services. The presence of an STI increases the risk of HIV transmission during unprotected sex as much as tenfold.

This link with HIV has cast some light on a long-ignored public health problem of staggering proportions: an estimated 330 million new curable STIs a year worldwide.

Sixty-five million of those new infections occur in sub-Saharan Africa. The World Health Organization (WHO) estimates that Africa has the highest regional prevalence by far for each of the four major curable STIs – syphilis, gonorrhea, chlamydial infection and trichomoniasis.[1] The same is probably true of two incurable STIs, human papillomavirus (HPV) and herpes, which may affect billions of people worldwide.

Throughout the non-industrialized world, STIs are among the top five diseases for which adults seek health care and the second leading cause of years of healthy life lost among women of reproductive age. The consequences of untreated STIs are particularly severe for women, who suffer complications such as pelvic inflammatory disease, infertility and adverse pregnancy outcomes, including abortion and stillbirth. STIs during pregnancy can also cause congenital abnormalities and blindness in newborns.

Yet this preventable public health tragedy has largely been ignored in Africa and other parts of the world where STIs still flourish. Associating STIs with commercial sex, promiscuity and extramarital sex, most societies have looked the other way.



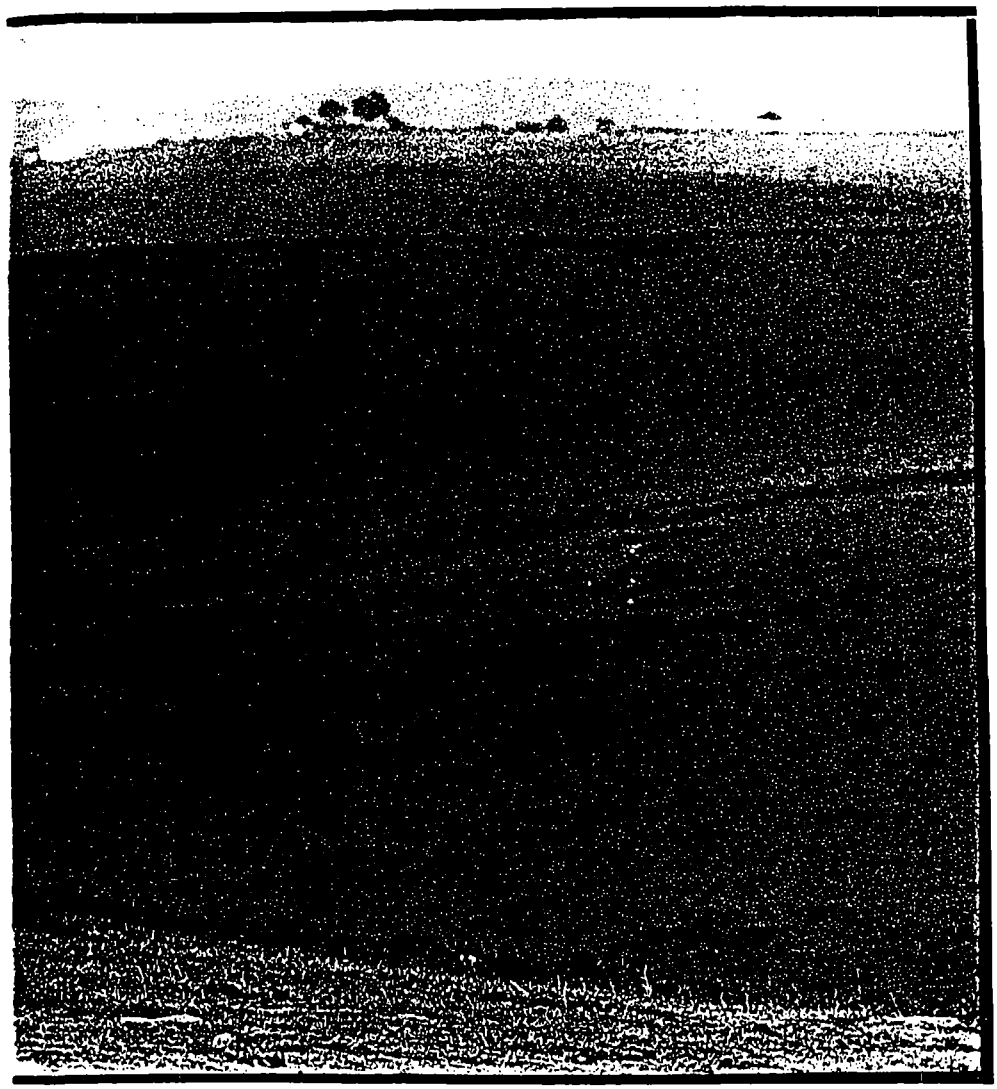
Quality and Access

STI services in African countries show the effects of decades of neglect. Many people prefer self-treatment – however ineffective it may be – to the cost, inconvenience and embarrassment of seeking treatment at a clinic. The pervasive lack of confidence in STI services is often justified because of drug shortages, inadequate information about drug resistance, limited access to laboratory diagnosis, and health care workers' lack of knowledge and poor attitudes toward people with STIs, including lack of confidentiality.

With the exception of Zimbabwe and Zambia, few African countries have mounted effective programs to reduce STIs. However, many governments in the region are beginning to recognize the need to strengthen STI services as part of national efforts to prevent HIV. International donors have also increased their support for STI programs during the past decade.

The aim is to prevent further transmission of STIs by encouraging people to recognize and seek early treatment for STI symptoms and by making STI services more effective and convenient. Studies using a rapid ethnographic assessment tool, Targeted Inter-

nfections 'n Sub-Saharan Africa: Attention to a Hidden Problem



vention Research (TIR), have identified barriers to early, effective STI treatment as well as opportunities for strengthening services.[2]

In order to improve STI services, many African countries have adopted the syndromic approach endorsed by WHO. This approach was used in a landmark study in Mwanza, Tanzania, in which community-based syndromic management of STIs cut the number of new HIV infections by 42 %.[3] It is also part of a project in Kenya that has reduced the prevalence of various STIs by 50 to 79 % among target populations and has contributed to a 30 % decrease in HIV prevalence among youth.[4]

Syndromic management involves recognizing a group of clinical signs and patient symptoms, or syndrome, and prescribing treatment for the major causes of that syndrome. It enables health care workers without specialized skills or access to sophisticated laboratory tests to effectively treat most symptomatic STIs during a patient's first visit to a local clinic.

Flow charts outlining treatment algorithms for the major STI syndromes help clinicians prescribe medications and remind them to offer condoms, instructions on treatment compliance, and advice about STI prevention. Assessments of the STI care provided by clinicians trained in this approach have found

marked increases in the percentages of clients receiving effective treatment.

Most of these training efforts have built the capacity of public health staff, but Africans are more likely to seek treatment for STIs in the private sector. Therefore, it is even more important to improve STI care and referrals given by private physicians and pharmacists and to reduce the number of patients seeking care from street vendors and other unqualified providers.

Another way to improve access to effective STI treatment is through sales of kits that include drugs for a particular syndrome, condoms and educational materials. A prepackaged therapy kit for male urethritis proved popular with patients in a pilot study in Cameroon, but its sale was restricted to a handful of clinics, and providers were reluctant to prescribe it.[5] This approach has garnered greater support in Uganda, where a similar kit is being field-tested.

Options and Obstacles

Syndromic management is beginning to improve STI care in Africa, but it is by no means a panacea. Because syndromic algorithms are based on patient symptoms and clinical signs, they are only effective when people seek treatment for symptoms. In Africa, most women and many men with STIs are asymptomatic. Moreover, even for women who do experience symptoms, syndromic management is of limited value because current algorithms for vaginal discharge do not work very well.

Until simpler, less costly diagnostic tests for gonococcal and chlamydial infections are developed, the options for improving STI treatment for women are also limited. They include syphilis screening of pregnant women and various forms of presumptive treatment (treatment without diagnosis based on the likelihood of infection).

A rapid, simple, inexpensive diagnostic test for syphilis is available and could be used to identify and treat maternal syphilis, a significant cause of fetal loss, infant death and congenital abnormalities. In Lusaka, Zambia, for example, routine syphilis screening and subsequent treatment at antenatal clinics reduced the adverse pregnancy outcomes caused by syphilis by two-thirds.[6] Yet throughout Africa, managerial and logistical constraints make this cost-effective intervention a rarity.

Because men are more likely to have and seek treatment for STI symptoms, notification and presumptive treatment of their partners is another promising though rarely used strategy for identifying and treating asymptomatic infections in women. Partner notification by a health care provider with a patient's consent is difficult, expensive and labor-intensive. Studies in Botswana, Rwanda and Zambia, however, have demonstrated that partner referral by patients is feasible and effective in resource-poor settings.[6]

Presumptively treating an entire community may be an effective emergency measure for reducing STI prevalence when HIV and other STIs have reached alarming levels. But, as was demonstrated in a large trial in Uganda's Rakai district, mass treatment cannot stand alone as a control measure because of the likelihood that STIs will be reintroduced into the treated population.[7] Primary prevention and improved case management must be in place to sustain lower rates of STI.

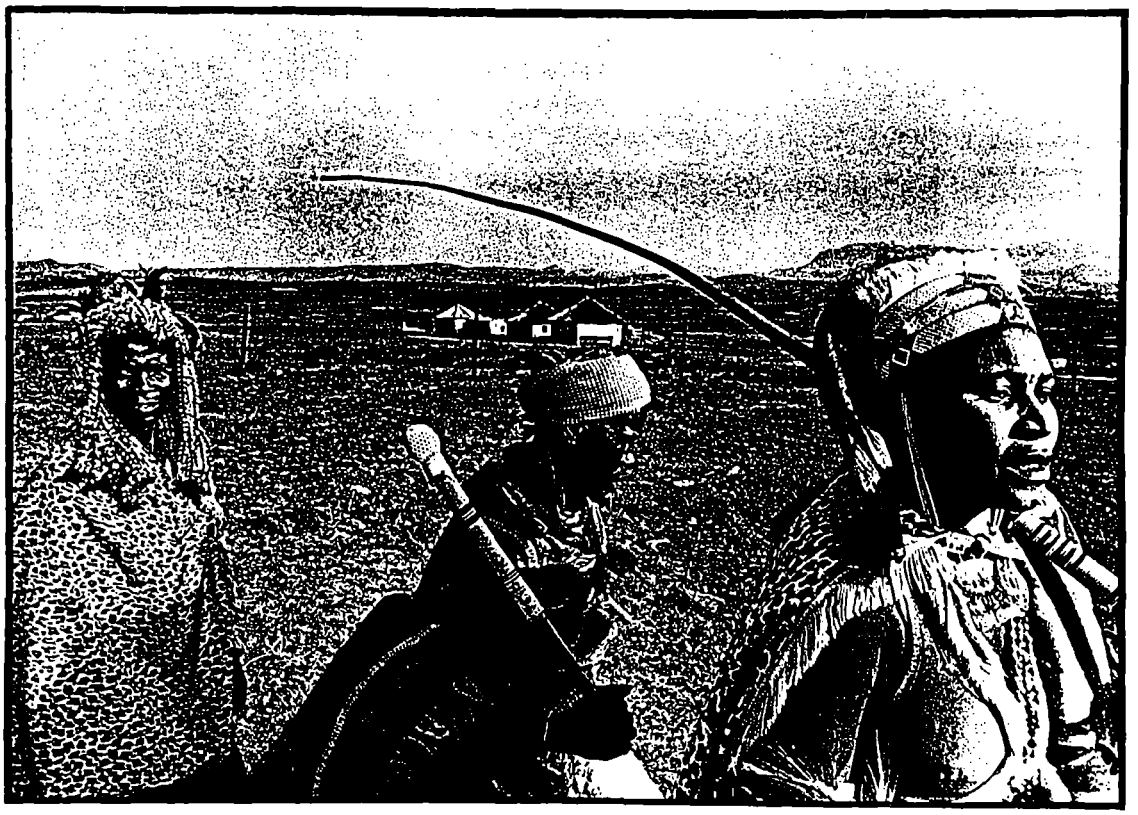
Presumptive treatment is most cost-effective when applied to groups with high STI prevalence and rates of partner change high enough to maintain epidemic growth of STIs – what are known as «core transmitter groups». In South Africa, for example, periodic presumptive treatment and peer education among women in mining communities have resulted in significant reductions in STIs among the women and their miner partners.[8]

Continuing Challenges

Those working to reduce the high levels of STIs in Africa face formidable economic, technological, logistical and behavioral challenges. The available tools and resources are limited, and providers' resistance to new approaches is often strong.

Another kind of resistance – the biological resistance of organisms that cause STIs to a growing number of antibiotics – forces STI programs to rely on more expensive drugs. This drives up the cost of treatment and exacerbates chronic shortages of essential medications.

Even when medications are available, the complexity of current drug regimens makes patient compliance a difficult and expensive proposition. The standard treatment for chlamydial infection in Africa, for example, takes ten days to complete. Inexpensive, effective therapies that could be taken



in a single oral dose would revolutionize STI treatment in the region – as would inexpensive, rapid diagnostic tests.

Yet even without further technological advances, much more can be done now to reduce STI prevalence in Africa. We can – and must – make STI management and prevention services more accessible, affordable, acceptable and effective, particularly for individuals in the core groups that drive the STI and HIV epidemics. Doing so is vital, not only to reduce the tremendous burden of death and disease caused by STIs in Africa, but also to contain the region's explosive HIV/AIDS epidemics.

References:

1 *AC Gerbase, JT Rowley, DHL Heymann, SFB Berkley, P Piot. «Global prevalence and incidence estimates of selected curable STDs.», Sexually Transmitted Infections 1998, 74 (suppl 1):S12-S16.*

2 *ML Field, J Price, C Niang, et al. «Targeted intervention research studies on sexually transmitted disease (STD): methodology, selected findings and implications for STD service delivery and communications.», AIDS 1998, 12 (suppl 2):S119-S126.*

3 *H Grosskurth, F Mosha, J Todd, et al. «Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial.», The Lancet 1995, 346:530-536.*

4 *Strengthening STD/AIDS Control in Kenya-Phase II. Annual report to CIDA, April 1998 to March 1999.*

5 *F Crabbé, JP Tchupo, T Manchester, et al. «Prepackaged therapy for urethritis: the «MSTOP» experience in Cameroon.», Sexually Transmitted Infections 1998, 74(4):249-252.*

6 *CJ van Dam, G Dallabetta, P Piot. «Special aspects of STD/HIV prevention and control in developing countries and resource poor settings in industrialized countries.» In: KK Holmes, PF Sparling, P-A Mardh, et al. Sexually Transmitted Diseases. Third edition. New York: McGraw-Hill, 1999, pp.1381-1390.*

7 *M Wawer, NK Sewankambo, D Serwadda, et al. «Control of sexually transmitted diseases for AIDS prevention in Uganda: a randomised community trial.», The Lancet 1999, 353:525-535.*

8 *R Steen, B Vuylsteke, A DeCoito, et al. «Evidence of declining STD prevalence in a South Africa mining community following a core group intervention.», Sexually Transmitted Infections, in press.*

HIV Prevention for Mobile and

Anthony Bennett, Family Health International, Arlington, USA

Anthony Bennett is Associate Director, Field Programs, for the global, USAID-funded HIV/AIDS IMPACT Project which is currently managed by Family Health International (FHI). Bennett was director of FHI's HIV prevention activities in Thailand from 1990-1994 and has helped design other prevention programs in Asia, Africa and the Caribbean.

Website: www.fhi.org

In the realm of HIV prevention programs today, it is generally accepted that extended or repeated overnight travel away from home and community is associated with higher risk of being infected with HIV. This travel can be divided into three types:

1. usually voluntary and job-related (e.g., trucker, trader, mine worker, free lance sex worker);
2. legally required (e.g., military conscription, deportation of illegal immigrants); or
3. coerced (e.g., war-related population movements, political refugees, trafficked sex workers).

Slowing down the movement of populations might slow down the spread of HIV, but no prevention program is proposing any strategy to impede mobility (with the possible exception of anti-human trafficking programs). Instead, most programs try one or a combination of three strategies to access the more vulnerable of the mobile populations, and to extend HIV/AIDS prevention services:

- at the point of origin;
- at the point(s) of destination;
- at the cross roads en route.

Work-related mobility often creates an imbalance in the gender ratio (proportion of women to men), and this facilitates an environment in which sex partner sharing becomes normative. Extreme examples of this are truck stops in which female sex workers, vendors and drink shop owners outnumber the men who may be transiting through the truck stop at any given time. The reverse is true in mining camps where men greatly outnumber women. In both cases, HIV and other STDs tend to flourish because of the greater likelihood of sharing the same sex partners.

Examples of effective program strategies in Africa to address these imbalances include

(A) periodic presumptive treatment for STDs Among Sex Workers in South African mining camps;[1]

(B) the prevention work of the African Medical & Research Foundation with trucker populations in Tanzania through a model worksite intervention approach;[2]

(C) CARE INTERNATIONAL's crisis intervention approach with Rwandan refugees in Tanzanian camps;[3] and

(D) the Ghana armed forces project.[4]

As impressive as these programs are, they primarily deal with mobile populations on an individual basis, as opposed to a contextual approach. For example, qualitative assessments of extremely high-risk communities along the Durban-Lusaka highway indicate that men and women change their be-

Displaced Populations

havior when in cross-border communities and engage in risk behavior that they would not otherwise do when at home.[5] This phenomenon strongly argues for a contextual and community response to risk-reduction rather than one that focuses on the client.

In addition, while most mobility is domestic, funding agencies and prevention programs need to focus much more on international mobility for the following reasons:

- HIV epidemics tend to erupt at the periphery of a country first before diffusing to the larger cities and rural communities further in land;
- Busy, international border crossings often have a relatively higher risk environment than other trade towns;
- National prevention programs are relatively weaker at border towns and international ports when compared with services in the capitol and central part of the country; and
- Mobile populations can be reached more efficiently at international border «funnels» than at other points along a travel route.

Cross-border prevention programs range from minimal, one-way information-based services (leaflets, pamphlets) to comprehensive, community-wide intervention programs including STD control, peer education and condom social marketing. Data on the effectiveness of these programs is still limited since cross-border prevention is a relatively recent strategy. Nevertheless, enough experience has accumulated to permit the following tentative recommendations:

- Prevention services need to be linked on both sides of a border. This can be achieved through cross-referral, or an easily recognizable symbol or project logo, which serves as a signal of user friendly services for mobile populations;
- Cross-border communities need to be considered as a single, extended town due to the heavy interaction between the populations on either side. This will help to promote a seamless transition of service outlets and messages as the mobile populations move through the border area;
- Mobile populations need to be forewarned that the border crossing area presents an environment of unusually high risk for HIV/STDs, and that they need to anticipate the need for protection when transiting through the area.
- Communication materials need to be produced in all of the major languages spoken at a border area (usually at least two);

Mobile populations need access to the full range of prevention options including quality STD diagnosis and treatment, affordable and accessible condoms, and information on assessing self-risk and opportunities to reduce/eliminate risk. But in addition, there are special intervention strategies that are especially suited to mobile populations.

Prepackaged STD Treatment Kits:

A number of projects around the world are testing the introduction of inexpensive kits for men with urethritis (i.e., a gonococcal or chlamydial infection). The kits contain a complete dose of an effective antibiotic, plus basic information on preven-

tion of future episodes, partner referral cards and condoms. The kits are usually subsidized and marketed over the counter in settings in which antibiotics are being sold without medical prescription. This type of «prevention marketing» is ideally suited for the male traveler who may not have time for a clinic visit, but can afford to buy an inexpensive prevention package.

Employer Programs for Encamped Populations:
Large infrastructure or industrial projects (dams, roads, mines), which require hundreds or thousands of workers to camp near the work site for months or years at a time, need to recognize the importance of allowing families to live in the camp or provide for comprehensive STD/HIV prevention services when men greatly outnumber women. This is already occurring in a few selected sites but has not yet become the norm – as it should be in areas of high or increasing HIV prevalence.

Customs Regulations:
Often, men who drive trucks through several countries are required to spend nights at the border town while the goods they are transporting are cleared for passage. Spending the night with a sex worker is often less expensive for a driver than a staying at a hotel. A structural intervention to accelerate the processing of trucks through the border to reduce overnight stays might go a long way toward reducing transmission of HIV among high prevalence countries.

Trucking Company Policy:
Trucking companies have a strong vested interest in keeping their drivers HIV-negative. To that end, they need to provide intensive education on prevention, free STD screening and treatment, and ample condom supplies. Trucking companies need to institute policies that discourage overnight stays in border communities and provide adequate per diem so that drivers can afford to stay at hotels, rather than in sex workers' bedrooms.

In sum, populations are becoming more mobile around the world. Without increased prevention action, the distribution of HIV will increase in proportion to population mobility. Programs are already being implemented that expressly intend to serve people who cross borders, or may be away from family and home community due to economic need or coercion. These programs need to be assessed for effectiveness, and the model projects replicated as soon as possible in areas of high or increasing HIV prevalence. Cross-border sites are an important place to begin these programs since epidemics tend to erupt first at the periphery of a country. Interventions and policy can be tailored to meet the needs of the more vulnerable mobile populations as suggested above.

References:

1 *Steen R, B Fuylesecke, T Decoito, et al. «Evidence Of Declining STD Prevalence In A South African Mining Community Following Core Group Intervention.», Sexually Transmitted Diseases. Vol 27 No 1. pp 1-8 January 2000.*

2 *Family Health International. «Final Report For The AIDSCAP Program In Tanzania: October 1991 – September 1997» pp 63-65.*

3 *Family Health International. «Final Report For The AIDSCAP Program In Rwanda: October 1993 to April 1997». pp 4-5.*

4 *Family Health International. AIDSTECH Final Report: Volume I. p. 167.*

5 *Wilson D et al. «The Corridors Of Hope Regional Assessment». Family Health International. Draft Report. November 1999.*

HIV Prevention Among Commercial Sex Workers in Kenya

Dr Elizabeth N. Ngugi, Lecturer, University of Nairobi, College of Health Sciences, Department of Community Health, Co-Director Strengthening STD/HIV/AIDS Control Project of the Department of Community Health, University of Nairobi, Kenya

Professor Frank A. Plummer, University of Nairobi and Manitoba (Canada), Department of Medical Microbiology, Co-Director Strengthening STD/HIV/AIDS Control Project of the Department of Community Health, University of Nairobi, Kenya

Aine Costigan, Programme Manager, Strengthening STD/HIV/AIDS Control Project

Women in Africa generally have a lower socio-economic status as compared to men, with sex workers being among the most disadvantaged. Sex workers experience discrimination and harassment from both clients and the police and often have little power to negotiate interactions due to poverty and a lack of knowledge. This situation is a driving force behind HIV transmission in Africa, where the prevalence in the general population is 10-40 %.[1] HIV prevalence among sex workers is even higher, ranging between 30-88 %.[2]

The Kenyan government's concern and commitment to the overall improvement of the social welfare of the country is well articulated in various policy documents, including the Session Papers and the Development Plans. For example, the Seventh Development Plan 1994-1996 considered gender issues within the overall development process, highlighting the steps to be taken in policy formulation, including the creation of a comprehensive database on the situation of women and girls in Kenya (MOPND-1994-1996).[3]

There are diverse social/cultural and economic issues in Kenya, given the presence of 40 indigenous cultures and ethnic groups. These groups have different languages and social structures as well as differing traditional cultural beliefs and practices. Some of these practices, such as «wife inheritance» (taking the wife of a diseased relative to be your own) and polygamy conflict with HIV prevention.[4,5,6]

In the various communities, it is the men who decide on issues of economic productivity – such as land, capital, and technology – since the men have more education and economic power than the women. Men are also favoured by cultural beliefs and practices. In addition, the participation of men is more pronounced regarding national and political issues – to the exclusion of women.

Given the resulting lower socio-economic status of women when they are divorced or separated, they are driven into commercial sex work due to the sheer necessity to survive. Also some parents disown daughters who are attending school and become pregnant. Such girls flee to the nearest town and do the only thing they know how to do for money, namely, sex.

The first cohort of female sex workers was established in 1985 in Nairobi at Pumwani. Lessons learnt from this experience have enabled the establishment of a dozen other operational sites in Nairobi, Nakuru and Thika. The towns of Busia, Webuye, and Mumias are in preparation. While this in itself is an achievement in the fight against AIDS, it fails to address the overall need. In reality, an intervention in every one of the 64 district headquarters (towns) in Kenya is badly needed. In every town we visited (75 % of the 64), there is demand for paid sex, and women provide this service for money or some other remuneration.

The most important principles for interventions to assist sex workers are threefold:

- Sex workers must be allowed to exercise their basic human rights without being subjected to discrimination on the basis of gender, socio-economic status, political conviction, or sexual orientation.
- Peer education programmes must be established which empower women to prevent the transmission of HIV and other STDs. This approach leads to ownership and sustainability.
- User-friendly STD treatment centres need to be established within existing health care structures.

In order to achieve the above, all activities should involve creating a conducive environment for sex workers to participate as equal partners. This entails securing the support of the appropriate authorities and others in order to facilitate the implementation process. The sex workers can then be organised and provided education and counselling so as to take personal responsibility for safer sex practices, including consistent proper condom use. The education methods are designed to be non-threatening, focusing on participation. Condoms are made accessible and affordable by working in partnership with government supply structures, NGOs, and the private sector (e.g., pharmacies).

Evaluation

Surveys of self-reported sexual behaviour, condom use, and knowledge of STDs among the sex workers were carried out in 1994 (n=2082) and again in 1998 (n=785).

Several changes in sexual risk behaviour were observed in 1998 as compared to 1994: 96 % reported some form of change in their behaviour; 64 % used condoms 100 % of the time; 33 % had reduced

the number of sexual partners; 20 % lived strictly monogamously; 7 % had stopped performing sex work all together; and 27 % had found an alternative source of income.

Interventions Promoting Economic Empowerment

Offering women in the sex industry alternative sources of income is another aspect in the process of promoting socio-economic empowerment and thus strengthening negotiation skills for safer sex practices. Although the sex workers themselves strongly request this kind of support, the response from authorities has been limited due to lack of funding.

A subset of 90 women received loans from the Kenya Voluntary Women's Rehabilitation Centre (K-VOWRC) to invest in alternative income generating activities. Of these women, 77.8 % stated that their health status had improved and that they were experiencing other positive changes mainly due to a reduction «in the health dangers» associated with commercial sex work. Also, 16.7 % said, «We are no longer subjected to beatings and rough treatment by clients.» Women participating in focus groups said, «We are no longer misusing our bodies.» Positive changes have also taken place in relation to drugs; that is, 71.1 % stated that their drug use had changed since joining the K-VOWRC. More specifically, 96.8 % reported positive changes in terms of drug use, with 46 % having stopped drinking alcohol and 31 % having reduced smoking and other types of drug use. In regard to social changes, 27.7 % said they felt more respected and had more confidence in interacting with other people. An important point that emerged during the focus group discussions can be summarised by the statement, «I have gained the respect of my children.» The majority of women (76 %) said they had become financially stable, with 10.7 % earning more than from the previous sex work, 9.3 % being able to meet their expenses, 9.3 % always having

some money at hand, and 9.5 % having regular earnings. However, 4 % said that their economic status had worsened.

The target population is involved in all aspects of the programme, including articulating their needs and how the programme can best respond. The supportive structures for the women are managed by personnel with technical and administrative skills as well as by technically trained field staff with community organising and STD/HIV/AIDS management skills.

Major Obstacles

The major difficulties encountered include:

- The magnitude of the HIV/AIDS problem and the associated need is overwhelming for the relatively small number of staff employed. A nucleus of well-trained staff is needed in every town in Kenya in order to mount a comprehensive and systematic mobilisation of sex workers and their clients for STD/HIV/AIDS prevention and control.
- Health care systems need to be supported in order to address the needs of clients referred for STD care. This includes pre and post test counselling for HIV as well as a continuum of comprehensive services.
- Networking among social welfare and health care institutions is a vital component which has been given low priority in providing services to sex workers. This includes networking among governmental agencies, NGOs/CBOs, the private sector, and international agencies.
- The lack of condoms and the lack of drugs for the treatment of STDs and AIDS-related opportunistic infections and well as the need to support laboratories in providing HIV counselling and testing are major barriers to success.
- The female condom is generally not available in Kenya.
- The financial support is grossly inadequate when compared to the need for services.

These barriers can only be addressed through a collaborative partnership between governmental bodies, NGOs (CBOs), the private sector, and international agencies. However, a significant increase in resources is necessary for each and every one of these sectors. It is a fact that no one country alone can rid the world of HIV/AIDS. Pulling together is the key.

Conclusion

There is considerable evidence that the interventions described for sex workers in Kenya:

- Decreased risk behaviour among sex workers
- Had positive effects on the sexual behaviour of the general population
- Improved the economic status of sex workers
- Increased sex workers' self esteem and the amount of respect they receive from others
- Improved sex workers' health status due to a reduced prevalence of STD/HIV/AIDS

In addition, it is clear that such interventions are in urgent need of expansion.

References:

1 *Trantola D., Lamptey P., Moodie R. «The Global HIV/AIDS Pandemic: Trends and Patterns – Preventing HIV in Developing Countries, Biomedical and Behaviour Approaches», Kluwer Academic/Plenum Publishers, New York, Boston, Dorderecht, London, Moscow, 1999*

2 *Ngugi E.N., Branigan E., Jackson D. «Intervention for Commercial Sex Workers and their Clients», Kluwer Academic/Plenum Publishers, New York, Boston, Dorderecht, London, Moscow, 1999*

3 *Ministry of Planning and National Development (MOPND), National Development Plan 1994-1996 Kenya.*

4 *Women's Bureau (1996): «Women and Men in Kenya – Facts and Figures 1995», Nairobi, Kenya*

5 *Women's Bureau (1990): «National Policy on Gender and Development», Draft Sessional Paper 1996, Nairobi, Kenya*

6 *Women's Bureau (1992): National Policy on Gender and Development, Nairobi, Kenya*

Outreach-Based Prevent on Involved in

Amine Boushaba, Director of Prevention Services and Trainer, The Moroccan AIDS Service Organisation (ALCS – (Association de lutte contre le sida Maroc)

Professor Hakima Himmich, Chef de Service, University Hospital Centre Ibn Roth, Casablanca Lecturer, Department of Medicine, Chairman of the Board, The Moroccan AIDS Service Organisation (ALCS)

E-mail: alcs@casanet.net.ma

In 1993, the Moroccan AIDS Service Organisation launched a process of outreaching men who are involved in prostitution. The first contacts to this scene revealed the clandestine and diffuse nature of male prostitution in Morocco.

Prostitution is principally an urban phenomenon, more visible in the large cities frequented by tourists. However, it would be erroneous to view male prostitution as being solely associated with tourism. There is indeed a form of prostitution among Moroccans themselves which is also important, existing on the margin of that for tourists. This phenomenon is known to exist even in smaller cities, although to a lesser extent.

This form of prostitution, characteristic of Arabic Muslim countries, faces many challenges. The perception of sexual identity in Morocco is far removed from the concept of a gay culture developed in the West.[1] One is more likely to talk about «normal» or «natural» sexual relations, referring to sexual contact between men and women. Other forms of sexuality are considered deviant. Although homosexuality may have always existed within Arabic Muslim societies, this is far from being acknowledged, the behaviour often vehemently condemned.[2, 3]

Sex between men is seen as being more of a problem related to gender than one of sexual identity, as defined in the West. A person having same sex relations does not identify himself as homosexual; whether he is «active» or «passive» tends rather to constitute his identity. As far as we are aware, there does not exist a concept within Arabic Moroccan society which would designate people as being either «heterosexual» or «bisexual».

It is important to note that homosexuality constitutes a crime in Morocco punishable by three to six months in prison.

Method

In order to have reliable data concerning the behaviour, perception, and lifestyle of this population, the ALCS initiated an action research project in 1995.[4] The goal of this study, the results of which have been reported previously,[5] was to gather qualitative data and to develop prevention strategies adapted to the needs of the target population. A questionnaire was developed and pre-tested. The instrument was distributed to a sample of 172 at the places where men taking part in prostitution meet. Group interviews as well as individual in-depth interviews were also conducted. We were able to identify four categories of variables which appear to be essential: social profile, sexual behaviour, knowledge and perception of HIV risk, and knowledge of how to use a condom. These variables enabled us to examine the population within its social context, furnishing us with certain indicators of the degree to which these men are marginalised.

Results

Viewed schematically, the principal problems found among the subjects were:

- A lack of knowledge concerning AIDS transmission and prevention.
- A large number of partners.
- A lack of skill in negotiating prevention and lower risk sexual practices with clients.
- Precarious living situations due to economic dependence.
- A high rate of violence taking place where men meet potential clients.

The average age of the first paid sexual contact was 15 years old. It is important to note that the number of partners varied between 1 and 30 per week, according to the socio-economic status of the subject. This difference can be explained by the fact that 38 % of the sample practised prostitution only occasionally; whereas, for 62 % this activity provided their principle source of revenue.

Concerning the nationality of the men's sexual partners, 37 % had contact exclusively with Moroccans. This provides evidence for the existence of a form of prostitution among Moroccans themselves, contrary to the frequent claim that this activity is only found in connection to tourism.

Regarding sexual practices, 97 % of the subjects reported having anal intercourse. The second most common practice was fellatio (78 %). Although a total of 98 % of the subjects had knowledge of condom use, 57 % had never or rarely used one. A portion of those who had used condoms reported often doing so at the request of the partner.

The reasons for not using condoms were: Refusal of the subject or his partner due to a dislike of condoms or discomfort during their use (50 %); the choice of partner; the lack of access to condoms (24 %); as well as a perception that there was no risk (17 %).

in Morocco Among Men Prostitution

In light of these data we are able to conclude that the interaction of the factors related to sexual behaviour (number of partners, mobility of the population, type of sexual practices, etc.) make this population vulnerable, largely due to their lower socio-economic status.

Intervention

Our interventions are essentially based on outreach approaches focused on:

- Peer education. Men from or close to the prostitution scene are recruited to communicate the prevention message to the group. This allows for a more effective initial contact with the intervention and increased acceptance of the project.
- An attempt to reach the most marginalised segments of the population through an ongoing presence in the places where men meet and by making use of personal contact.
- Refraining from all moral judgement concerning the conduct of the men. Listening to and respecting differences.

This approach enables prevention workers to become invested within the lives of target group members and to develop personal relationships based on trust. The specific interventions undertaken are:

- Offering services at the places where men meet
- Offering services at the offices of the ALCS
- Organising discussion groups on specific topics
- Organising social events
- Providing access to HIV testing
- Providing access to STD services

When performing outreach services, prevention workers discuss all aspects of HIV/AIDS and other STDs with members of the target group, raising awareness and providing information. Large quantities of condoms, lubricant, and information brochures about AIDS are distributed. The workers also accompany members of the target group to centres of the ALCS which offer free and anonymous testing. STD services are recommended to those expressing a need.

The prevention work has been confronted with a major obstacle: The police consider the possession

of condoms to be a proof that illegal prostitution activity is taking place. Therefore, the most committed members of the target group prefer not to have large quantities of condoms on them.

During the outreach work, members of the target group are invited to come to the ALCS offices to view informational films and to obtain condoms, or simply to talk with volunteers or to take an HIV test.

However, many of the men show a certain mistrust or apprehension in relation to all structures of an official nature. This is the result of their often being rejected due to their prostitution activities, their way of acting, their social status, and sometimes because of their appearance.

In order to avoid ALCS being identified with these structures, social events are organised on a regular basis. Although questions regarding HIV/AIDS are addressed by way of games and support, these events maintain a party atmosphere with music and cocktails. Discussion groups on specific topics are also organised, providing the opportunity to talk about problems which directly relate to homosexuality in Arabic Muslim countries, the role of the target group within ALCS, violence, homophobia, and acts of aggression in the places where men meet. The topics for these discussions are suggested by members of the target group themselves with the support of a project worker.

Conclusion

Through the approach described above, ALCS seeks to provide an open ear as well as a place for discussion and psychosocial support for the tar population. We are aware of the fact that prev tion work of this kind cannot be truly succes unless it attempts to address as much as possi the vulnerability and precarious situations of men being served. In spite of the difficulties countered, interventions such as this could su be replicated in other countries with a sim socio-cultural context. The success of this proach depends on the interventions being im mented in such a way as to maximise participat and community-based input of the population c cerned.

References:

1 *Denis Altman, «HIV, Homophobia, and Human Rig Health and Human Rights, n° 4, vol.2.*

2 *Malek Chebel, «L'esprit de sérial. Perversion et margina sexuelles au Maghreb», Lieu commun, 1988, 232 p.*

3 *Hakima Himmich & Latéfa Imane, «Ethique et Sida en I d'Islam: un combat difficile», Islam et Santé, éd. de la Ma des sciences de l'homme d'Aquitaine.*

4 *ALCS, Maroc, «Etudes des caractéristiques de la prostitu masculine au Maroc: Recherche-action sur Casablanc Marrakech 1995/96»*

5 *Latéfa Imane, «Un programme de sensibilisation et de tien auprès des prostitués masculins», Le journal du n° 92-93 janvier 1997.*

6 *Oussama Tawil, K. O'Reily, IM. Coulibaly, A. Tiémélé Himmich, A. Boushaba, K. Pradeep and M. Caraël «HIV vention among vulnerable populations: outreach in the veloping world», AIDS 1999, 13(suppl A).*

The Economic Context

Morocco is a developing country with a population of 30 million. The budget of the Ministry of Health represents only 3 % of the total national budget. Only 15 % of Moroccans benefit from the social welfare structures.

The Situation of Those Infected with HIV/AIDS in Morocco

The cumulative number of AIDS cases as of 1 December 1999 had risen to 735. This estimate is only a rough approximation due to the inaccessibility of testing to confirm new infections and a lack of reporting. Sexual transmission of HIV accounts for 60 % of all cases.

The Moroccan AIDS Service Organisation (ALCS – Association de lutte contre le sida Maroc)

Created in 1988 and recognised as a voluntary organisation in 1993, the ALCS seeks to provide outreach-based prevention for the groups most affected by HIV, those most vulnerable due to their socio-economic situation. The ALCS provides support and care services and defends the rights of people affected by HIV.

The Role of the Family in HIV Prevention

Dr Samuel Kalibala, Population Council, Nairobi, Kenya

Email: Skalibala@popcouncil.or.ke
Website: www.popcouncil.org

The family is the closest social network to which an individual belongs. The so-called nuclear family is supposed to consist of parents and their children. However, in some communities such as Africans and Asians, the family is more likely than not to include uncles, aunts, cousins, nephews, nieces, grandparents and other close relatives. This traditional extended family has always been relied upon as the safety net for handling social ills.

However, the needs and suffering caused by the epidemic have proved that this safety net can no longer hold.[1] The AIDS epidemic has also shown us that one's family stretches far and beyond blood relations. The traditional family is withering away in Africa just when its caring influence is most needed to confront the calamity of the AIDS epidemic.

The family has a great influence on how an individual responds to the epidemic. They are instrumental in the lessening or increasing the vulnerability of an individual due to HIV/AIDS. They can reject an individual who is known to practice behaviors that put them at risk of HIV, such as a Commercial Sex Work or IDU or one who is known or suspected to be already living with the virus. On the other hand a good family can support such an individual and hence help to reduce their vulnerability to HIV and its associated physical and social ills.

How can the family help reduce the vulnerability of youths to HIV?

A major issue is the way adults perceive the sexuality of youths. Many adults may be intellectually aware that children start sex quite early in their adolescence. For example, 65 % of the 11 - 19 year old in Lusaka are sexually active.[2] However, very few adults can emotionally accommodate this fact when it comes to their own children. Thus most parents prefer to imagine that the sexuality of their youths is something which does not exist. The only mention most parents make about sex to their youths is that sex is dangerous and should not be undertaken until one is happily married. They fail to recognize the fact that adolescence is the period when the biology and social setting of young people induces them to feel sexually attractive to others and to want to be loved and that the temptation for sex grows rapidly during this period. Often adults cannot emotionally live with the fact that their own little boy or girl is already having sex.

Talking to Children about Sex

Loaded with such emotions parents run the risk of rejecting and abusing their own children at this stage. Parents start to view every behavior of the youth with suspicion and this attitude erodes trust and builds a communication barrier between youths and their adults. Unfortunately, this is the very period when young people need to learn about their own sexuality. During this period parents are supposed to educate children how to get life's best and nicest things related to sex such as love and planned child birth and yet avoid the dangers that go with sex such as HIV and other STDs as well as teenage pregnancy.

Parents need to learn how to talk to children about sex because youths should learn from parents. Parents need the correct knowledge about reproductive health including the biology of the body, how to avoid unplanned pregnancy, STD and HIV.

During the period of youth there is much experimentation and risk taking and youth face many dangers including alcohol and drug addiction, HIV, STD, teenage pregnancy, rape and other forms of violence. Disclosure of risk taking and of consequences such as teenage pregnancy, HIV and STDs requires understanding and communication and assurance on the part of the parents.

Indeed the perceived insensitivity of parents to adolescent sexuality causes a dilemma when a health worker discovers that a young person is pregnant or has an STD. It remains debatable whether it is ethical to treat a 13-year-old for a sexually transmitted disease without notifying the parents. Some have argued that informing the parents could be counterproductive, while counseling by the doctor or another adult could be more useful.[3]

How does the family structure affect the ability of Women and Men to protect themselves from HIV?

HIV is sexually transmitted and hence is closely linked to all aspects of sexual partnerships. Most of these relations are usually linked to or intended to result in the formation of a family. The desire to form a family is often overwhelming among many African communities. In Rwanda where many men were killed during genocide women have now developed a system called Kwinjira, where they will-

ingly set out to share men in order to be able to have children and family.[4] In Zambia it has also been asserted that in some cases it is women who promote polygamy by «looking down upon single women in society», thereby encouraging them to marry men who already have wives.[5]

Marriage is a risk

Married women are vulnerable to HIV because their male partners may be having other spouses (polygamy) or other extra-marital relations. Married women may also suffer different forms of abuse at the hands of their husbands including forced sex, which may be associated with a higher risk of HIV transmission due to bruising in the genitals. Many women have no power to negotiate safer sex or to insist that their sexual partners use condoms outside marriage.[6]

HIV/AIDS interventions should aim to focus on the strengthening of the women-men partnerships in order to reduce the above risks. Communication, love, understanding and mutual respect as well as equal access to options by both partners can prevent most of the suffering in marriages and hence reduce the risk associated with this important institution of society.

Ritual Sexual Cleansing

Some societies have a practice of widow-inheritance or widow-sexual cleansing of women who have been widowed due to any cause. This is done supposedly to chase away the spirits of the deceased husband but it increases the widows' risk of HIV transmission or re-infection. Advocates have called for the abolition of this dangerous tradition and its replacement with safer rituals.[7] In the meantime educators and counselors have advised such widows to either refuse the ritual or insist on condom use during the sexual cleansing. But widows who refuse the ritual may be sent away from their husband's land by the relatives. Therefore, since most widows are uneducated, do not own property, and are unemployed, the practice of wife inheritance continues unabated. And for most widows the choice is between being inherited and being infected and have food, or starving. To help combat this problem, a number of groups like «Women Fighting AIDS» in Kenya are launching programs to help women generate their own income.

However, without resources some widows ju walk away from such a situation and seek a ne life with new risks of HIV transmission and re-in fection. L. Adeokun et al.[8] have observed in Masi ka in Uganda that there is a tendency to re-mari or develop new relationships after the previous on or two relations were ended due to death o spouse/partner from AIDS.

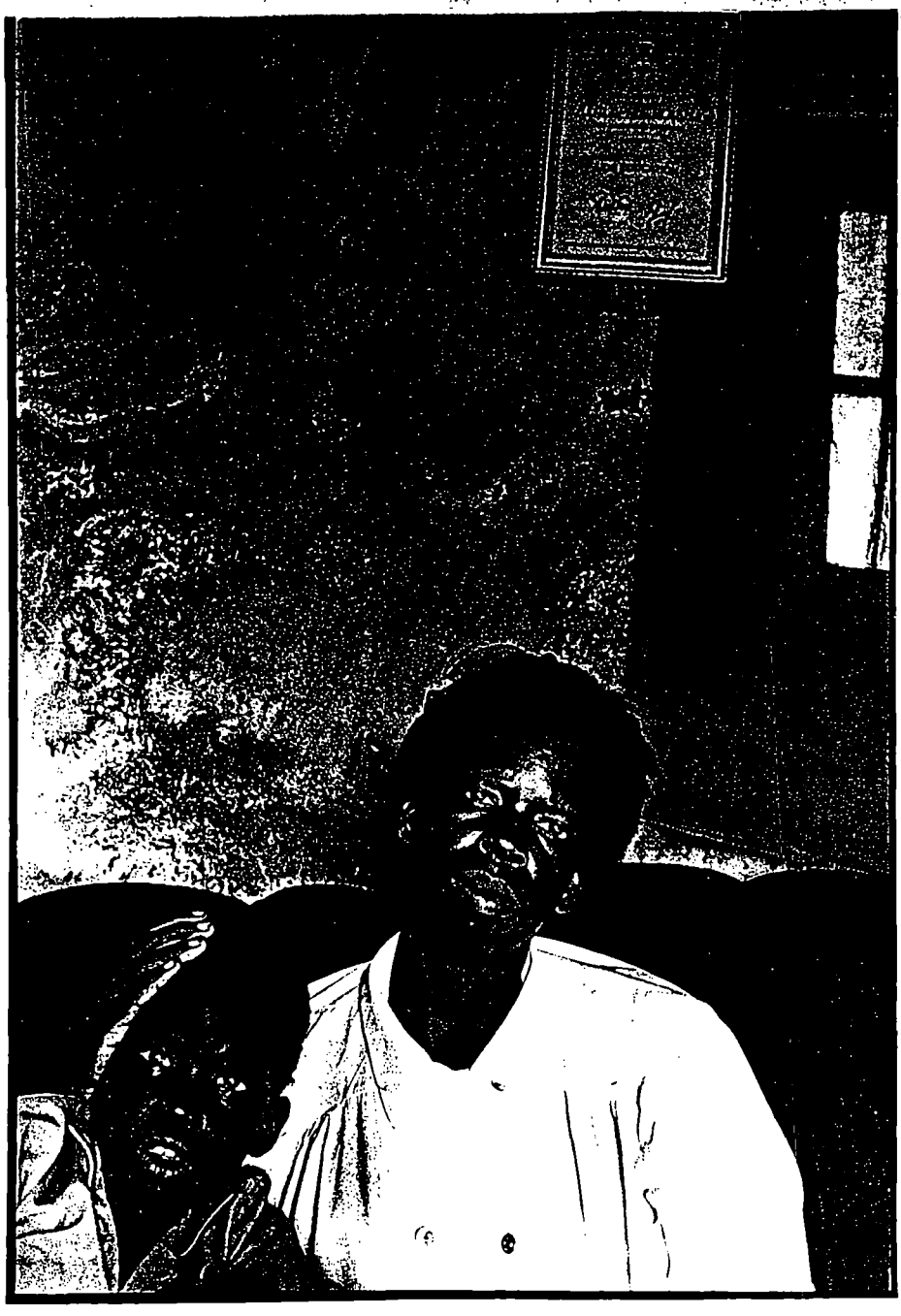
How do families influence the sexual behavior of People Living with HIV/AIDS (PLHA)?

When a person learns that they are living wit HIV/AIDS one of the major concerns they have i about the reaction of their loved ones once the learn of this fact. Learning that a loved one is livin with HIV/AIDS may provoke either acceptance o rejection from the family.

If the family reacts to knowledge of HIV statu with acceptance they may facilitate better care an support for the person living with HIV/AID (PLHA) than if they did not know the HIV status. supportive family can be available for the PLHA t discuss problems with and they can help a PLH seek and receive medical care, counseling as wel as material support. Some of the problems PLHA encounter include the difficulty of sharing thei HIV status with their spouses/partners and ofte tend to inform their other relatives first[9] who ma then help the PLHA to break the bad news to th spouse/partner. The close family may also help th couple to work out strategies for addressing th problem and this may prevent rejection by th partner/spouse. As observed by Meursing K.[10] i Zimbabwe, most who disclose get some social sup port from family and sexual partners although th effectiveness of this support may be limited by de nial, misinformation, helplessness, stigmatization and poverty. Secrecy and infrequent discussion after disclosure also increases loneliness, misery and helplessness.

On the other hand HIV positive women who disclosed their status to their husbands were chased away from their houses or replaced by another wife, some were beaten up and one committed suicide.[11] Such reaction from the family may cause the PLHA to withdraw and this may increase feelings of revenge and anger.

Disclosing to loved ones is no easy task and usually takes time and support. But with continued

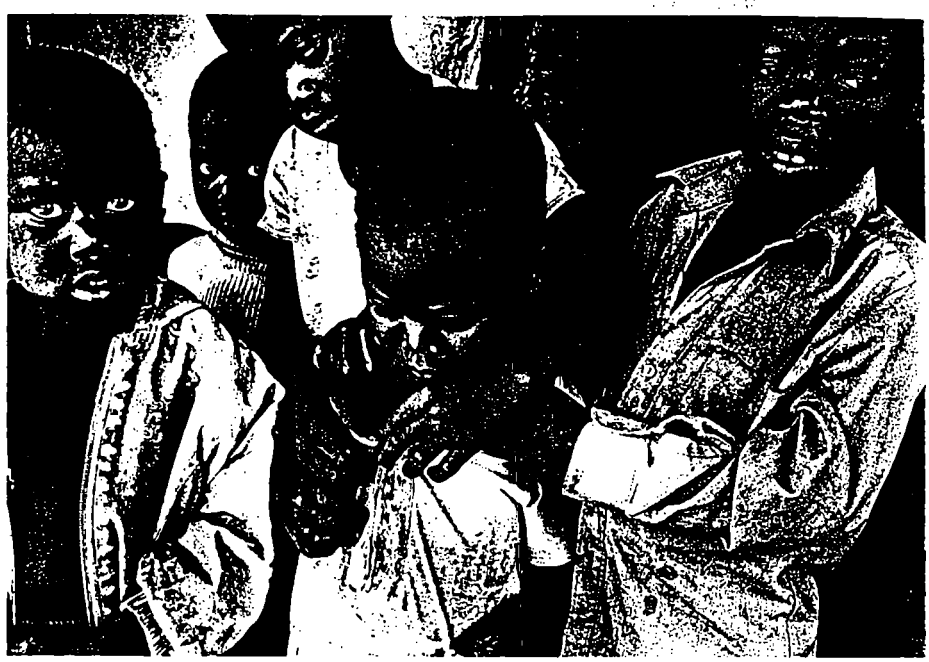


counseling PLHAs eventually disclose to their families.[10, 12, 13] Counselors and other providers should from the outset engage PLHAs in a discussion of who they will disclose to and begin working on the difficulties they anticipate in doing so. Indeed poor communication with the family results in poor emotional coping and may result in risk behavior.

Conclusion:

HIV prevention strategies have been summarized as a scenario of three boats, one of Abstinence, the other of Faithfulness and a third of Technology (condom) use that are keeping afloat in a sea of HIV. In this scenario it has been proposed that if one wants to avoid sinking in the sea of HIV/AIDS, they need to be in one of the three boats.[14]

The information presented in this paper has indicated that the family is a double-edged sword in HIV prevention. On one hand they can love and support an adolescent, a PLHA, a CSW, a IDU, a woman or a man and keep them in one of the boats above. On the other hand they can reject, ostracize, discriminate and drive them into the sea of HIV. Hence if the role of the family in the prevention of HIV is to be enhanced, efforts to convert the family into a supportive and loving institution should be undertaken.



Promotion of marriage for example would appear to be a logical intervention based on the assumption that Faithfulness is easier to practice by married people. But the existing cultural norms in some communities, which permit males to have multiple partners, are a major hindrance to this strategy.

Understanding, love, communication, and observance of child rights are vital for the optimal sexual health of children. If these prerequisites are met they may in the long run help youngsters to remain in the boat of Abstinence and others to join the boat of Technology.

Increased awareness of risk among single, separated, divorced or widowed people and counseling as well as testing if desired, should be encouraged in order to enable them to choose either the Abstinence or Faithfulness boat. Married people who are polygamous or have extra-marital sex should be counseled about joining the Technology boat. They can also seek Voluntary Counseling and Testing (VCT) and after learning their HIV status choose to join either the Faithfulness boat or the Technology boat.

References:

1 *Ankrah, M. E. 1993, «The impact of HIV/AIDS on the family and other significant relationships: the African clan revisited», AIDS Care 5, 1, 5-22, 1993*

2 *Mfula N, «A Study on the Knowledge and Attitudes Towards Sexual Intercourse of Children Aged 11-19 years old in Lusaka, Zambia», The International Conference on AIDS and STDs in Africa (ICASA) Session Number: 13ET3 Sept 1999, Lusaka, Zambia*

3 *American Medical News. «Is It Appropriate to Notify Parents of a Minor's STD?» (08/25/97) Vol. 40, No. 321, p. 19*

4 *Gough, David «Rwanda AIDS Risk Increases; Husband Sharing Causes Concern», Cleveland Plain Dealer (02/13/00) p. 9A*

5 *«Zambia: Women Admit Being Perpetuators of Polygamy Africa Information Afrique (11/05/97)*

6 *Caldwell J C et al. African Families and AIDS: context, responses and potential interventions. Health Transition Series No. 4, ISBN 0 7315 1901 9, 1994*

7 *Malungo J.R.S. «Sexual Cleansing (kusalazya) and Levirate Marriage (kunjilila mung'anda) in the Era of AIDS: Changes in Perceptions and Practices», The International Conference on AIDS and STDs in Africa (ICASA) Session Number: 13ET3 Sept 1999 Lusaka, Zambia*

8 *Adeokun L et al. «Serial Marriage and AIDS in Masaka district (Uganda)», Health Transition Review, Supplement to Vol 7, 1997, 49-66. 1997*

9 *Lie G T and Biswalo PM «HIV positive patient's choice of significant other to be informed about the HIV test result: findings from an HIV/AIDS counseling program in the regional hospitals of Arusha and Kilimanjaro, Tanzania» AIDS Care (1996). Vol. No.3 pp. 285-296*

10 *Meursing K. and Sibindi F, «Condoms, Family Planning and Living with HIV in Zimbabwe». Reproductive Health Matters No. 5, May 1995*

11 *Temmerman M et al. «The right to know HIV test results» The Lancet Vol. 345. April 15, 1995*

12 *Baggaley R et al. «HIV counselling and Testing in Zambia: the Kara Counselling Experience». Safaids News June 1995 Vol. 6 No. 2, pages 2-8*

13 *Kaleeba N et al. «Participatory Evaluation of Counselling Medical and Social Services of the AIDS Support Organization (TASO) Uganda». AIDS Care 9, 1, 13-26*

14 *Joinet B et al. «The Fleet of Hope: a symbolic approach to the prevention of AIDS in a pluralistic society». Abstract No. MoD 037, The International Conference on AIDS and STDs in Africa (ICASA) Dec 1995, Kampala, Uganda*

Do A r can Health Care Systems Really Address the Problem of AIDS?

Marc-Eric Gruénais, Social Anthropologist, Director of Research, Institut de Recherche pour le Développement, Paris
SHADYC (Sociologie, Histoire, Anthropologie des Dynamiques Culturelles)
Ecole des Hautes Etudes en Sciences Sociales/Centre National de la Recherche Scientifique, Marseilles
E-mail: gruenais@ehess.cnrs-mrs.fr

The efforts deployed for more than fifteen years by governments and funding agencies in Africa have apparently resulted in the fight against HIV becoming a priority, both politically and in terms of public health policy. But the statements of certain Heads of State and technical experts made both home and abroad raise the question to what extent they are committed to this fight, given that they at times present positions which may differ from universally accepted values regarding AIDS prevention and care. Nevertheless, the strategies to combat AIDS have without a doubt improved. This is the result of institutional reforms as well as improvements in established modalities of addressing the disease, most notably the advent of new treatments. However, due to the organisation of the national AIDS strategies and to the general state of health care systems in Africa, all of the various initiatives run the risk of having a very weak impact due to the sheer magnitude of the epidemic if they fail to create a veritable «AIDS culture» among the majority of health care personnel. This risk exists even if efforts to inform the population about the disease are successful.

About fifteen years since the first official HIV prevention campaigns in Africa, one can safely say that virtually every African adult and adolescent has heard about AIDS. One is sometimes surprised – particularly with regard to the school-educated population – just how detailed the knowledge of the means of transmission can be as relates to particular characteristics of the virus. On a regular basis there are very explicit condom use demonstrations at schools and market places, more explicit than one can imagine would take place in European schools. «Traditional» African interpretations of disease have on occasion uniquely incorporated AIDS into their systems of disease categorisation. Certain traditional healers have not hesitated to create an «AIDS of the witches», that is, a form of AIDS which is «caused» by an aggressive nocturnal attack of an evil being moving within the «invisible world». Religious leaders, whether Moslem or Christian, have often transformed AIDS into a new ontological experience imposed on humankind.[1] All of these observations attest in various ways to the «success» of the diffusion of information in Africa concerning AIDS. Certainly, with regard to the attitude of religious populations and of the traditional healers, one can be distressed at the tendency toward «externalisation» of the epidemic. For these people, AIDS is less a reality hic et nunc than an event related to the imperfect relationship between God and humanity or to the evil intentions of an invisible being. This opens the door to searching for magical and/or divine protection or «healing» which does not place any limits on risk behaviour. However, this sort of information gathered by anthropologists does not sway AIDS prevention programs in their preaching about the important role of religious leaders and «traditional healers» in relaying information within the context of HIV/AIDS information campaigns. In general terms, the discourse concerning AIDS is conducted in multiple places within Africa. At the same time, the epidemic continues to progress and preventive behaviours are far from becoming the norm.

Following a period of denial at the start of the epidemic[2] all African countries progressively set up specific programs beginning in 1985, displaying a strong political will to combat AIDS. Most notably at international African AIDS conferences, the Heads of State themselves[3] progressively showed their determination to involve their countries in prevention activities and to address the problems associated with HIV infection. However, one can pose the question to what extent these messages were intended predominantly for those abroad. When it comes to domestic affairs, certain presidents as well as governmental technical and consulting staff deliver messages which, at the very least, can be characterised as ambiguous. In this vein, the former president Lissouba of Congo-Brazzaville regularly likes to evoke AIDS during interviews with the foreign press, while not hesitating to characterise HIV infection as the primary symbol of social and political disorder in his country in 1993 and 1994. More recently, in July 1999, the president of Kenya «declared war» on AIDS, while affirming in the same speech his staunch opposition to all initiatives to promote condom use in his country.

When staff employed in HIV prevention programs address non-medical problem areas, they adopt positions which can open the door to the stigmatisation of certain populations. In Senegal, a country under strong Islamist influence, some technical workers consider the prevention strategy which has

been adopted to be exemplary, given the low prevalence rate in that country. This opinion is based most notably on national values placed on specific religious and cultural aspects which are believed to explain the low prevalence: the practice of Islam, the role of the imams, the pervasive practice of circumcision, as well as the surveillance of certain «risk groups», in particular female prostitutes who are subject to strict regulation. In Ivory Coast the assertions of certain technical staff are not always in line with promoting a greater acceptance of those affected, the latter being considered potential sources of «contamination» as part of a legal project seeking to require HIV testing as a pre-requisite for marriage. Representatives of the Central African Republic, themselves members of a network on ethics, are considering a law which would allow those infected with HIV to be condemned on suspicion of «voluntarily contaminating» others.[4] Congo-Brazzaville, having signed an international charter condemning involuntary testing and being well-aware of the wide-spread practice of testing without informed consent in Africa, officially considered in 1997 requiring all prison inmates to be tested.

In spite of certain questionable positions which have been taken, one cannot deny the importance of the mobilisation of the various national and international players regarding such areas as: the information campaigns, the social marketing of condoms, the safety of blood transfusions, prevention, the treatment of opportunistic infections and medical care for HIV more generally, as well as the reduction of mother-child transmission by using antiretroviral drugs. This mobilisation has been achieved and is continuing to be organised as a result of the top-down HIV prevention and care strategies set up beginning of 1985 in African countries under the aegis of the WHO according to a unique model. These national programs, which have been criticised from the start,[5] have been the subject of important transformations since their creation, especially in developing multi-sectorial approaches.

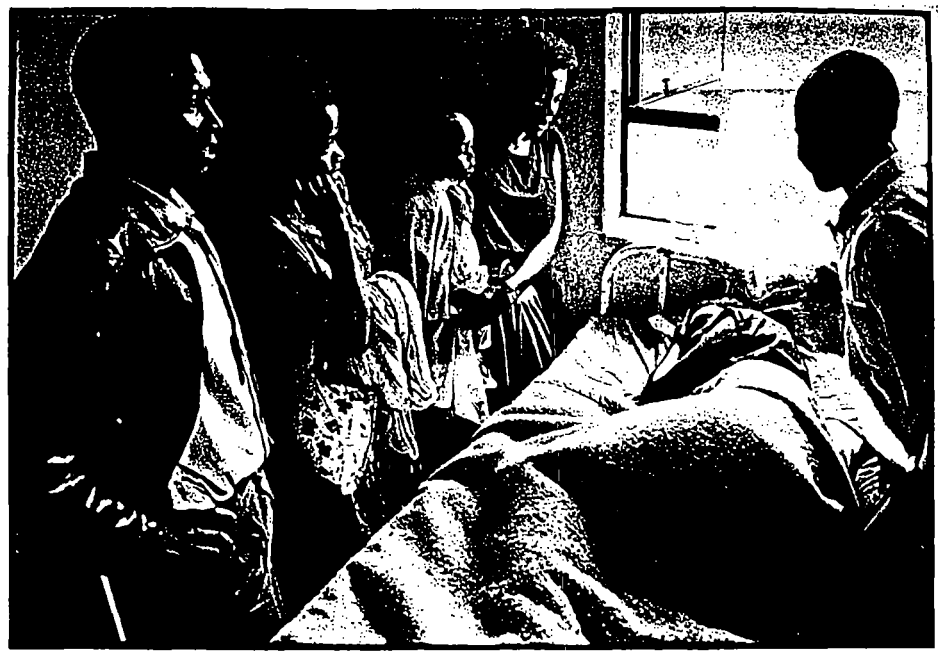
Originally, the national strategies were exclusively focused on prevention, an area with which the medical establishment has very little experience. A focus on sexual behaviour in relation to an incurable infection with a complex course did not fit well – in either the North or the South – with the classical inpatient clinical practice focusing on cure. The programs addressing AIDS have therefore been relegated to young, less established physicians who are less acquainted with the ways of the medical lobby, thus not boding well for a sufficient integration of HIV work within the administrative structures of a health care system dominated by professors of medicine. The HIV programs themselves have been even more difficult to integrate into the national public health strategies, as their leaders have been directly answerable to the ministers of health and not to the usual public health authority structures. These programs have therefore received funding directly, thus bypassing the usual arcane administrative procedures characteristic of the public health sector. It is for this reason that tensions arose at all levels of the public health hierarchy between the staff of AIDS programs and other public health workers, the former viewed as being too highly favoured with regard to the relatively unimportant role AIDS plays in comparison to the magnitude of other health problems. Most importantly, AIDS became de facto the unique responsibility of a chosen few with the result that other public health staff took no interest in HIV risk within the context of their day-to-day activities. But even where AIDS programs have found a place within the public health administration structures and the tensions have eased, has not AIDS work remained the domain of only a few professionals in Africa – even in regions where the prevalence in the general adult population is more than 25 %?

The question as to what degree HIV infection should be addressed by specialised structures and staffing is exceedingly difficult to answer. Particularly in Africa – with regard to the problems in training, supplies of medications, the quality of laboratories, etc. – it is unquestionably neither possible (given the state of the current health care systems) nor desirable (for HIV patients) that AIDS-specific activities (from testing to treatment) be included as part of standard care throughout the various countries. At the present there is an increasing number of pilot projects in HIV care, some including antiretroviral treatments. However, these projects remain very limited and they are not immune to possible negative effects. Does not the considerable rise in the costs of providing care, related to the new treatments, create the risk of increasingly concentrating resources and energy on a small proportion

of the overall health care structures? The members of self-help groups for people living with HIV/AIDS, generally created at the initiative of the national AIDS strategies, could legitimately be viewed as those who should receive privileged access to the new treatments. But does this not create the risk of a growing dependency between the self-help groups and AIDS programs? Self-help groups play an important role in critiquing health care professionals, a role which has contributed to an evolution in care for people with HIV in the North. Is this role not threatened by such a potential dependency?

African clinicians ask themselves constantly what they can possibly do in light of the growing number of cases in their daily practice. Will they not finally lose interest in posing this question? Indeed clinicians work within structures at the periphery of the system. They do not have effective treatments at their immediate disposal, but they know that these treatments are available in another part of the country. Will they not want to refer systematically all HIV patients to specialised structures and thus refuse to treat all AIDS-specific symptoms? Will they not do this based on a conviction that whatever they do at their level in the health care system will be ineffective? To sum: Given the limited access in Africa to the new treatments, do we not risk hindering current feeble medico-psychosocial attempts to prevent HIV, including the outbreak of opportunistic infections? Will we not return to the focus on curative care, an approach well-established within medicine? In general, given the magnitude of the epidemic, the pilot projects in HIV care – however useful they may be – will only have a limited impact on public health in the near term if the standard practice of staff within the general health care system is not changed.

Indeed, to this day the majority of staff within the health system who are not specifically assigned to AIDS care and prevention do not give thought to HIV risk within their standard practice, in spite of being generally informed about the problem. For the most part, minimum standards of hygiene to prevent infection are not observed. For example, gloves are rarely used when administering injections and taking blood samples. Perhaps of most concern is the frequent problem of maintaining a supply of bleach and alcohol; it is not rare that the same instruments are used for several women giving birth without their being disinfected between patients. In cases where a blood transfusion is necessary (serious anaemia in pregnant women, car accidents, etc.) the smaller clinics which do not have access to HIV testing and which are located far from the nearest blood bank are forced to take the risk in an emergency of using donors and conducting the transfusion without having conducted a test. In the small laboratories on the periphery of the health care system one can often find blood products and syringes simply left around. And how many smaller hospitals in Africa currently have functional incinerators? Irrespective of questions of hygiene, there is the problem of health care staff being reticent to elicit information from patients which could relate to AIDS.[6] Although many African physicians in the various smaller clinics report an increase in the number of



AIDS cases within their practice, they refuse to investigate further the status of those affected because: «It's too complicated», «There are other emergencies», «There is no test or medications available», «You don't know how to manage the information with the family and the spouse», etc. In some cases these are the same physicians which I would claim perform exceptionally in that they separate people with AIDS from other patients in their practice «because the other patients cannot deal with sitting beside someone with AIDS». In other cases one finds nurses who have boxes of condoms to distribute to patients for free, but who place them carefully on a shelf in the cupboard. When asked why they do not hand out the condoms, these staff members respond that «the people don't want them», «the religious convictions of their patients prevent them from using condoms», or very candidly, «that they were never trained to address AIDS and sexuality in their practice». These reactions provide more evidence for the fear of staff within the health care system regarding the problem of AIDS than for the so-called non-receptivity of the patient populations. This fear needs to be thoroughly addressed, particularly within training programs. In light of these observations one needs to pose the question why the information campaigns should not be directed to health care staff before being targeted to the population in general.

The development of pilot projects is indispensable, making access to the new treatments possible. This development risks, however, achieving nothing more than islands of care in an ocean of need if one does not attend to the large majority of health care staff not directly involved in AIDS work. The «AIDS culture» has generally been well cultivated in the general population, as I highlighted in the introduction, accompanied by apparent ongoing limitations as well as false and even harmful ideas. This culture seems to be less present among staff within the majority of African health care structures. Developing this «AIDS culture» among staff would contribute positively to the management of HIV infection as a risk and consequently transform the fight against AIDS into an important issue for public health.

The author has conducted work concerning health care for people with HIV/AIDS, HIV testing, organising national strategies for combating HIV in Africa, and the role of the «civil society» (NGOs, religious and voluntary organisations, etc.) in the fight against AIDS. This article is based on research on the reform of the health care systems in Central Africa and on reproductive health. Principal geographical areas covered: Congo-Brazzaville, Cameroon, Gabon, and Kenya. The projects conducted concerning AIDS also include Ivory Coast and Senegal.

References:

1 *Cf. M.E. Gruénais, «La religion préserve-t-elle du sida?», Cahiers d'Études Africaines, 39 (2), 1999: 253-270.*

2 *AIDS, as a sexually transmitted disease, «shameful» and lethal, has potentially tarnished the negative image of this region of the world even more, given that it is already associated with famine, war, corruption, political coups, capricious politicians, etc. (Cf. J.P. Dozon, «D'un tombeau à l'autre, Cahiers d'Etudes Africaines, 31 [1-2], 1991: 135-157.)*

3 *For example: President Museweni of Uganda, President Diouf of Senegal, and former Presdident Bédié of the Ivory Coast.*

4 *See in particular the presentations from the Tenth International Conference on AIDS and STDs in Africa held in Abidjan in December 1997.*

5 *Cf. D. Tarantola, «Grande et petite histoire des programmes sida», in Le Journal du Sida, 86-87, 1996: 109-116.*

6 *To speak of a «dialogue» within the therapeutic relationship would be inappropriate as the consultation mostly takes place with little or no communication between the patient and the clinician.*

The International Partnership Against AIDS in Africa

The way AIDS in Africa is perceived has shifted. Once seen as a largely medical crisis, the epidemic in sub-Saharan Africa – where 23.5 million people live with HIV or AIDS, and where 13.7 million have died since the virus began to spread – is now considered a full-blown development and human security emergency.

The impact of AIDS in sub-Saharan Africa is society-wide, with few sectors untouched, whether social, economic or political. The long-term impact of the crisis is clear: in the worst affected countries, a reversal in decades of development and tremendous loss of investments in human capital and economic development. The epidemic is eroding GNP, stretching health and education systems sometimes to breaking point, destroying a significant portion of the productive workforce through illness and premature death, and generating orphans on an unprecedented scale.

The AIDS crisis is so acute in Africa that on 10 January 1999, the United Nations Security Council broke with tradition and adopted HIV/AIDS in Africa as its meeting theme, the first time the Council has ever dealt with a health issue.

Contributing to the crisis is a conspiracy of silence that shrouds HIV and AIDS, often based on shame or fears of infection which have in turn fueled ostracism or rejection of people living with HIV/AIDS. The silence is compounded by limited access to, and use of, voluntary counselling and testing. An estimated 90 % of those living with HIV do not even know they have it.

Though silence and stigma continue to obstruct much of the open debate about AIDS and to penalize those who suffer from its effects, African leaders have begun to break their silence and to speak out publicly, demonstrating courage and a willingness to come to grips publicly with the epidemic.

But the progress of the virus continues to outpace projections and fighting back requires a scaled-up response on all fronts. Building on the momentum generated by African leaders, UNAIDS and its seven cosponsoring agencies – UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO and the World Bank – recently joined forces with African governments, donor countries, the private sector and civil society to establish the International Partnership Against AIDS in Africa.

In late 1998, the UNAIDS Secretariat began a broad consultation process with African governments, donors, the United Nations, civil society and the private sector, which would eventually lead to the formation of a truly international partnership.

The International Partnership addresses the fragmentation of current responses, where different actors implement agendas in isolation from one another. It also addresses the inadequacy of efforts so far to galvanize the necessary financial and technical support to slow down the epidemic.

The Partnership unites national governments, the UN, donors, civil society and the private sector to work together with a shared vision, common goals, coherent strategies, and agreed principles to generate effective, energetic and sustained national responses to the AIDS crisis.

The Partnership's Framework for Action is now under discussion, as are a series of principles and priorities that will underpin the Partnership's actions:

- African ownership of the Partnership at all levels: country and community priorities to drive the action, and implementation plans will be based on local priorities and contexts
- Active involvement of people living with AIDS in setting the parameters of the Partnership
- Respect, protection and fulfillment of human rights, compassion and active opposition to all forms of stigma and exclusion of people living with HIV/AIDS
- Promotion of public awareness both within and outside Africa of the AIDS epidemic as a development crisis that requires an urgent and sustained response on an unprecedented scale
- Support for the development and implementation of joint national strategic action plans involving all relevant sectors
- Partners fully committed to joint working.

These principles and priorities are fundamental to the Partnership's vision: to accelerate changes already underway in Africa by providing additional resources, expertise, and a framework within which the partners can work together to reduce sharply the impact of AIDS on human suffering and on the development of human, social and economic capital in Africa.

The Partnership will build on existing efforts and enhance and replicate successful actions, while creating no new structures. It is, in fact, a series of overlapping partnerships, operating at different levels and among different sectors, working from a

Peter Piot, Executive Director, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva, Switzerland.

Dr Peter Piot was appointed Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Assistant-Secretary-General of the United Nations on 12 December 1994. Peter Piot joined UNAIDS from a position as Associate Director of the Global Programme on AIDS of the World Health Organization. He served as the President of the International AIDS Society from 1991 to 1994.

Website: www.unaids.org

shared strategic agenda in the belief that through synergy with others, the impact of individual actions can be dramatically enhanced.

The Partnership's significance lies in the value it will add to existing responses and interventions to AIDS in Africa.

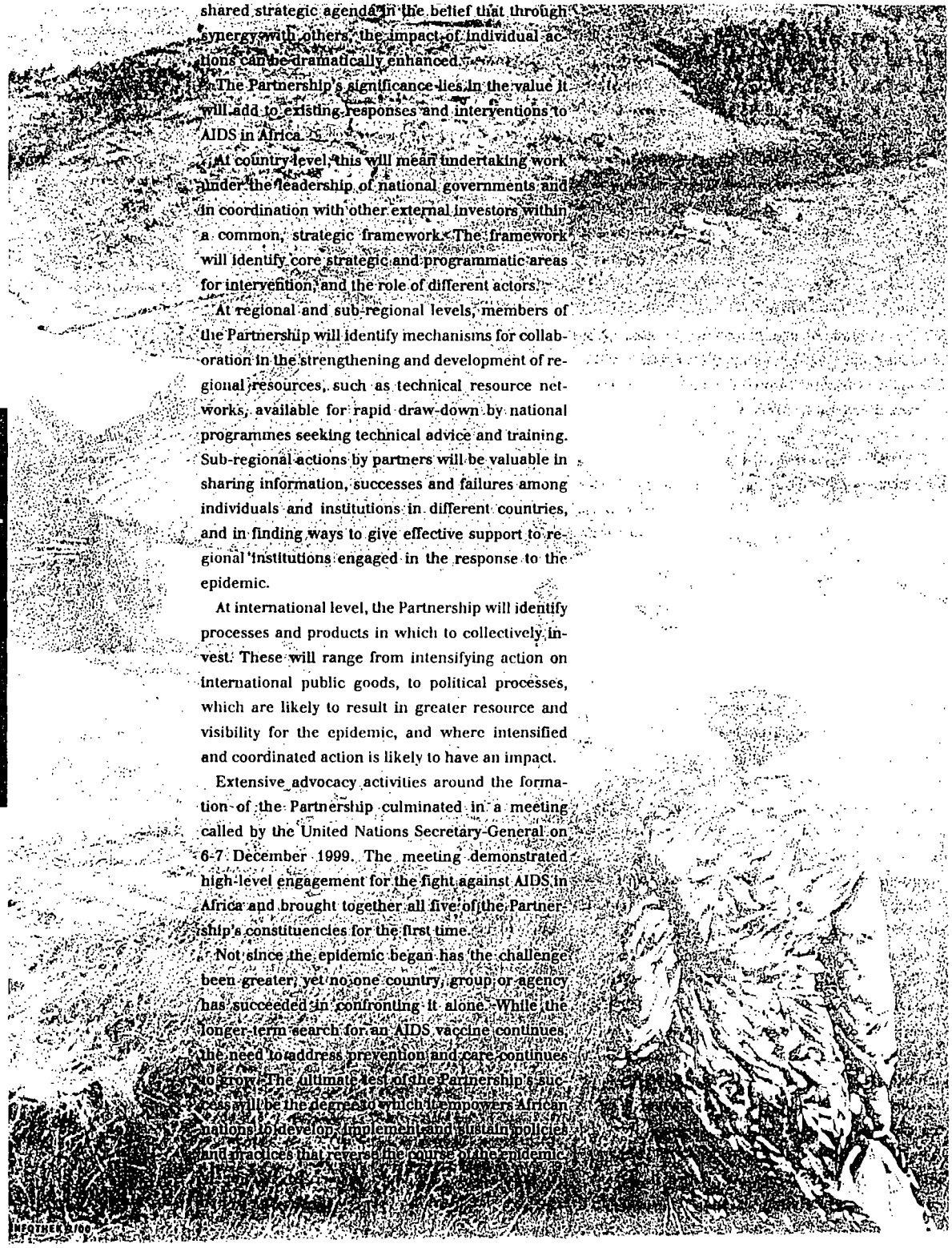
At country level, this will mean undertaking work under the leadership of national governments and in coordination with other external investors within a common, strategic framework. The framework will identify core strategic and programmatic areas for intervention, and the role of different actors.

At regional and sub-regional levels, members of the Partnership will identify mechanisms for collaboration in the strengthening and development of regional resources, such as technical resource networks, available for rapid draw-down by national programmes seeking technical advice and training. Sub-regional actions by partners will be valuable in sharing information, successes and failures among individuals and institutions in different countries, and in finding ways to give effective support to regional institutions engaged in the response to the epidemic.

At international level, the Partnership will identify processes and products in which to collectively invest. These will range from intensifying action on international public goods, to political processes, which are likely to result in greater resource and visibility for the epidemic, and where intensified and coordinated action is likely to have an impact.

Extensive advocacy activities around the formation of the Partnership culminated in a meeting called by the United Nations Secretary-General on 6-7 December 1999. The meeting demonstrated high-level engagement for the fight against AIDS in Africa and brought together all five of the Partnership's constituencies for the first time.

Not since the epidemic began has the challenge been greater, yet no one country, group or agency has succeeded in confronting it alone. While the longer-term search for an AIDS vaccine continues, the need to address prevention and care continues to grow. The ultimate test of the Partnership's success will be the degree to which it empowers African nations to develop, implement and sustain policies and practices that reverse the course of the epidemic.



Intensifying Action Against HIV/AIDS in Africa – The World Bank's Response to a Development Crisis

Debrework Zewdie
World Bank HIV/AIDS Coordinator,
Lead Population and Reproductive Health Specialist,
Head, ACTafrica
The World Bank
Washington D.C., USA

Email:
dzewdie@worldbank.org

Sheila Mitchell
Consultant,
Public Health Specialist,
ACTafrica
The World Bank
Washington D.C., USA

Email:
smitchell@worldbank.org

Before joining the Bank in 1994, Dr Debrework Zewdie was Deputy Regional Director of the Africa Region for the AIDS Control and Prevention Project (AIDSCAP) of Family Health International in Nairobi, Kenya.

Sheila Mitchell is a World Bank consultant with more than 25 years of experience in designing and managing health and development programs in Africa, Asia, and Latin America.

Website:
www.worldbank.org

A Growing Crisis

The spread of HIV/AIDS in Africa and its impact have exceeded the worst projections by far and yet we have only seen a small proportion of the illness and death that this epidemic will bring. The real impact on people, communities, and economies is yet to come.

For nearly two decades, sub-Saharan nations and their development partners have been fighting this serious public health problem yet not focusing on the serious threat it brings to the region's development. Decades of gains are being wiped out by the epidemic and we are only beginning to realize the impact it will have on all sectors of society. Because it kills so many adults in the prime of their working and parenting lives, it decimates the workforce, fractures and impoverishes families, orphans millions, and shreds the fabric of communities. The costs imposed by the epidemic force countries to make heartbreaking choices between today's and future lives, and between health and dozens of other vital investments for development. Perhaps the most disturbing long-term feature of the HIV/AIDS epidemic is its impact on life expectancy. In some countries in southern Africa, life expectancy has declined to levels that prevailed in the 1960s.

The World Bank's Response

The World Bank has been assisting governments to finance HIV/AIDS activities since 1986 and is consistently one of the largest donors in the global efforts to curb the epidemic. However, since Fiscal Year 1994, new World Bank lending for HIV/AIDS in Africa has been decreasing and is seriously lagging behind the growth of the epidemic. In most cases, the activities were implemented through overburdened health sectors, severely limiting the response and ignoring the impact the epidemic was beginning to show on the development sectors that form the framework of the Bank's assistance strategy.

As it became more apparent that this epidemic was undoing decades of development in Africa, the World Bank responded to the «wake-up call» and issued a new strategy focusing on the critical needs in sub-Saharan Africa. The strategy, Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis, launched in September 1999, cites the HIV/AIDS epidemic as the foremost threat to African development. The strategy builds upon the important partnerships of the World Bank with five partners: African governments, United Nations agencies, donor governments, the private sector, and NGOs. It summarizes the World Bank's contribution to the common framework for action agreed upon by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in support of the International Partnership Against HIV/AIDS in Africa.

The goal of the World Bank is to urgently assist African governments and mobilize the Bank, development partners, the private sector, and civil society to intensify action on multisectoral and sustainable policies and programs to address the compelling and evolving implications of the HIV/AIDS epidemic to halt further reversal of human, social, and economic development in Africa. To reach this goal, the Bank's approach will stand on the following four pillars:

- Advocacy to position HIV/AIDS as a central development issue and to increase and sustain an intensified response.
- Increased resources and technical support for African partners.
- Prevention efforts targeted to both general and specific audiences, and activities to enhance HIV/AIDS care.
- Expanded knowledge base to help countries design and manage prevention, care, and treatment programs based on epidemic trends, impact forecasts, and identified best practices.

This strategy is the responsibility of Bank staff in the entire Africa region. However, to stimulate and support implementation of the strategy, the Bank has established a multisectoral AIDS Campaign Team for Africa (ACTafrica), which is based in the Office of the Regional Vice Presidents. The high-level placement of ACTafrica underscores the Bank's commitment to HIV/AIDS prevention and care and enables the team to maximize collaboration among the Bank's sector families. The team serves as the World Bank Africa region's focal point and clearinghouse on HIV/AIDS and provides a variety of services, including:

- Equipping and supporting Bank country teams to help mobilize African leaders, civil society, and the private sector to intensify action against HIV/AIDS.

- Reviewing the Bank's country lending portfolios and helping to retrofit existing projects in all sectors with HIV/AIDS components where possible,
- assisting in the development of new dedicated HIV/AIDS projects, and building AIDS-mitigation measures into other projects where necessary.
- Supporting Bank country teams in addressing HIV/AIDS in their country assistance strategies.
- Collecting and disseminating information on the progress of the epidemics, country-by-country statistics, and best practices.

The ACTafrica team has helped to strengthen the Bank's capacity to serve its clients by developing customized toolkits for the Bank's country directors and working with more than 20 country teams to review portfolios and develop plans for retrofitting existing projects in all sectors with HIV/AIDS activities. Response from all of the Bank's country directors has been high with many of them taking direct action to revise their portfolios to address HIV/AIDS and finding creative ways around existing budget constraints. The ACTafrica team is currently working to develop new funding instruments that will improve the critical flow of funds and enable rapid disbursement of funds to the community level, a requisite for scaling-up interventions to the national level.

Responding to urgent needs of national planners for information on cost estimates for HIV/AIDS programs, the Bank has commissioned the development of a model that projects the cost of scaling-up effective interventions for more than 20 African countries. This model will help African planners as well as donors program funds to bring the response to the necessary scale.

As the Bank rapidly gears up to implement its strategy, it will continue these efforts and begin to translate operational guidelines into national, multisectoral programs with its multiple partners. The Bank is collaborating with the UNAIDS International Partnership Against HIV/AIDS in Africa to identify countries that place a high priority on scaling-up their programs and is developing implementation plans for intensifying action with those countries. Additionally, the Bank will focus on identifying innovative means of financing the development of prevention options such as microbicides and vaccines and support research efforts to provide decision-makers with the data and tools needed to intensify efforts.

Vision for the Future

The World Bank has joined the International Partnership Against HIV/AIDS in Africa to help mobilize all development partners and African nations to bring to scale the response needed to halt the epidemic spread and mitigate its impact. Despite the lack of strong political commitment in many countries, the competing priorities, lack of sufficient resources, and inadequate capacity to mount the necessary level of response, there is considerable hope. The Bank joins others with an optimistic vision for the immediate future that includes the following:

- HIV/AIDS will be at the center of development efforts in Africa.
- AIDS prevention and mitigation efforts will be led by governments.
- National programs will have been re-invigorated, made multisectoral and fully financed.

Ultimately, all partners hope to see a world without AIDS and the development agenda back on track.

Literature:
UNAIDS 1999, AIDS Epidemic Update, Geneva, December 1999.
World Bank 1999, Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis.

Family Health International: Modeling HIV/AIDS Programs in Africa

Mary O'Grady, Associate Director for Information Programs, HIV/AIDS Prevention and Care Department, Family Health International, Arlington, Virginia, USA

Ms. O'Grady, a former broadcast and magazine journalist, has 12 years of experience working on international development projects and holds a master's degree in international affairs from Georgetown University in Washington, D.C., USA

E-mail: mogrady@fhi.org
Website: www.fhi.org

For nearly 15 years, Family Health International (FHI) has been committed to designing, implementing and evaluating state-of-the-art strategies for preventing the spread of HIV and for providing care and support to people living with (PLWHA) and affected by HIV/AIDS in sub-Saharan Africa. A nonprofit, nongovernmental (NGO) organization founded in 1971 and based in the United States with a mission «to improve the well-being of populations worldwide through research, education and services in family health». FHI formed an AIDS Task Force in 1986 to proactively respond to the HIV/AIDS epidemic in Africa. With funding from the American Foundation for AIDS Research (AmFAR) and USA for Africa in 1987, FHI launched HIV/AIDS prevention pilot programs in three West African countries, Ghana, Cameroon and Mali.

By working with local partners and community members, interventions are designed to respond to the realities of the populations being served. Managing more than 1,200 HIV/AIDS prevention and care projects in partnership with more than 700 NGOs and community-based organizations (CBOs) in 60 countries since 1987, the majority in sub-Saharan Africa, FHI has based its HIV/AIDS programming on its many years of experience in contraceptive technology, family planning (FP) and maternal and child health (MCH) research, service delivery and technical assistance in more than 100 non-industrialized countries, as well as the new lessons being learned in through HIV/AIDS programs and research every day.

Most of the projects FHI has managed in HIV/AIDS prevention and care have been funded by the U.S. Agency for International Development (USAID), including: the AIDS Technical Support Project (AIDSTECH), 1987–1992, with 185 projects in 55 countries in Africa, Latin America and the Caribbean, and Asia/Near East; the AIDS Control and Prevention (AIDSCAP) Project, 1991–1997, the world's largest international HIV/AIDS prevention program undertaken to date, with more than 600 projects in 50 countries in the aforementioned regions, and, since 1997, the five-year Implementing AIDS Prevention and Care (IMPACT) Project, ongoing in 55 countries to date in the same regions as well as Eastern Europe.

Pioneering the Prevention to Care Continuum

During the AIDSCAP Project, FHI pioneered linking HIV prevention and care, known as the «prevention to care continuum». In Tanzania, strengthening CBOs and NGOs to provide both HIV prevention and care programming has resulted in integrated community-based services. Community home-based care and support for PLWHA in Nigeria has been organized by IMPACT through nine hospitals serving as collaboration and referral centers, as well as the provision for home visits and counseling, and work with the Federation of Women Lawyers to provide legal aid.

In Kenya, FHI has focused on community-based care and prevention through voluntary counseling and testing (VCT) services provided by the Kenya Association of Professional Counselors (KAPC), its local partner in the first randomized, controlled trial of the efficacy of VCT as an HIV prevention strategy, organized by FHI and its international partners, including UNAIDS, WHO and the Center for AIDS Prevention Studies in San Francisco.

Various FHI projects have integrated HIV prevention education and activities into the curricula and counseling available in STD and family planning clinics, including in both rural and urban settings in Kenya. AIDSCAP supported its partner, MAP International, in creating a powerful HIV/AIDS prevention and support grassroots campaign in Kenyan churches and the communities they serve, which has been sustained in these communities since the project ended in 1997.

Initiating a Policy Agenda

To emphasize the importance of focusing national attention on HIV/AIDS policy issues, such as women, families, orphans, HIV modeling, macroeconomic impact, business and legal issues, among others, FHI documented six years of policy advocacy and HIV/AIDS impact work specifically in Kenya through its AIDSCAP book published in 1996, «AIDS in Kenya: Socioeconomic Impact and Policy Implications», which involved researchers and coauthors from Kenyan, Canadian and U.S. universities as well as several Kenyan government agencies.

In 1996, FHI published the «Private Sector AIDS Policy: Businesses Managing HIV/AIDS» kit, including six modules and ten appendices, highlighting workplace HIV prevention programs in Africa. This kit has been disseminated by FHI, USAID's Africa Bureau and the U.S. Commercial Service in Africa, and it is being used by many businesses, UNAIDS, and NGOs in a wide variety of countries, including the United States.

To respond to the fact that more women were infected with HIV than men in sub-Saharan Africa, in 1994 FHI launched the global AIDSCAP Women's Initiative and published several training manuals and publications on gender and HIV/AIDS.

Promoting Rapid-Response Mechanisms

While managing major grants to international private voluntary organizations (PVOs) and large NGOs, FHI also works at the other end of the spectrum, issuing Rapid Response Fund (RRF) grants for US$5,000 or less for innovative initiatives proposed by CBOs and community groups. During the AIDSCAP Project, FHI managed more than 220 rapid-response grants; and, in January 2000, FHI and the Elton John AIDS Foundation announced the launch of a new RRF program for eight countries around the world, including three in Africa: Kenya, Nigeria, and Rwanda.

To give an example of FHI's HIV/AIDS experience in one sub-Saharan African country over ten years, FHI managed the following projects in Kenya: creating national rural HIV surveillance, designing national screening of HIV-infected blood, introducing national quality assurance for HIV testing, computerizing national blood bank data, piloting a community home visitation program for PLWHA, improving STD case management, developing HIV/AIDS prevention materials for STD and MCH/FP clinics, strengthening HIV counseling, including the provision for voluntary counseling and testing services, training field workers in HIV prevention to improve the socioeconomic and political status of women, testing the acceptability of the female condom, empowering mother/daughter communication, and investigating strategies for renegotiating sexual relationships.

Sustaining Community Development

In Tanzania, FHI has done historically important work in organizing sustainable «NGO clusters» in nine regions of the country, encompassing a community mobilization effort of a population of four million people. Perhaps the largest capacity-building initiative ever undertaken for sustainable community-based HIV/AIDS prevention and care in a single country, FHI's NGO cluster project in Tanzania has just concluded its seventh and final year.

To document the work done in Tanzania, FHI published and disseminated worldwide a special report on this initiative entitled «The Tanzania AIDS Project: Building Capacity, Saving Lives, The AIDSCAP Response 1993–1997», explaining the cluster strategy and positioning it as a new model for sustaining HIV/AIDS prevention and care within communities.

Senegal, where FHI has worked for 11 years, is a country frequently cited as an HIV prevention «success story» because of its relatively low HIV prevalence in sub-Saharan Africa: about two percent in pregnant women nationally. With very supportive political and religious leadership, Senegal epitomizes an African country with progressive insight on HIV prevention: in 1997 FHI launched behavioral surveillance surveys (BSS) to gain better understanding of the HIV/AIDS epidemic in Senegal, complement the findings of HIV sentinel surveillance, and allow a contextual analysis of trends.

Carrying out these surveys in groups engaging in high-risk behaviors can help determine whether prevention efforts are working, and in low HIV prevalence settings, they can also provide an early warning of where HIV may appear in the future. This is just one method for evaluation, launched by FHI in 20 countries worldwide, to guide more effective programming as well as to better understand the social dynamics and human behaviors at play that synergistically spread HIV in Africa.

Finally, in its role as the international coordinator of the seven-year HIV Network for Prevention Trials (HIVNET), funded by the U.S. National Institutes of Health, FHI worked with its international partners in Kenya, Malawi, South Africa, Uganda, Zambia and Zimbabwe on HIV vaccine research, developing topical microbicides, preventing mother-to-child HIV transmission (through the landmark study on the efficacy of providing nevirapine to pregnant women in Uganda), and evaluating programs to reduce sexual risk behaviors.

In 2000, FHI is continuing as the manager of the HIV Prevention Trials Network (HPTN), the successor project to HIVNET.

The Horizons Project: Improving HIV/AIDS Prevention, Care, and Support Through Operations Research

Nearly two decades after the emergence of the HIV/AIDS pandemic, biomedical, behavioral, and epidemiological research has identified and described in great detail the nature of HIV infection and its modes of transmission.

Yet far less research has been devoted to basic operational issues that affect the delivery of services in prevention, care, and support. We have learned much about which behaviors place persons at risk, and have some sense of what types of interventions work to prevent HIV transmission – but we know far less about why and how these interventions work, what they cost, and where and when they can be successfully replicated on a large scale. These questions are critically important in developing countries – where more than 90 percent of HIV-infected people live – because affordable prevention, care, and support interventions remain the primary tools for dealing with the epidemic.

The Horizons Project is designed to help identify and disseminate best practices in HIV prevention and mitigation for program managers, policy makers, and others who need accurate and timely information on the operational mechanisms that can make HIV/AIDS programs successful. A global, five-year project (1997-2002) funded by the United States Agency for International Development, the Horizons Project is managed by the Population Council in collaboration with five partners: the International Center for Research on Women, the International HIV/AIDS Alliance, the Program for Appropriate Technology in Health, Tulane University, and the University of Alabama at Birmingham.

The Horizons portfolio includes more than 60 operations research activities in 21 developing countries. Research is focused on 11 broad themes: prevention and management of sexually transmitted diseases (STDs), youth, gender, integration of services, barrier methods, voluntary counseling and testing, capacity strengthening and scaling up, stigma and discrimination, social marketing and the private sector, care and support, and community mobilization.

Horizons in Africa

Although Horizons works in developing countries around the world, a majority of Horizons' research activities are based in a dozen African countries, from Burkina Faso to Kenya to South Africa. In every case, Horizons researchers build working partnerships with national, local, and regional health officials, research institutions and universities, advocacy organizations and NGOs, and other stakeholders.

Prevention and Management of STDs

Preventing and treating sexually transmitted diseases such as gonorrhea and chancroid, which are epidemic in sub-Saharan Africa and increase vulnerability to HIV infection as much as tenfold, are critical to the success of HIV prevention efforts. A multi-site Horizons study based in Zimbabwe, Zambia, and South Africa seeks to gauge the effectiveness of targeting high-frequency HIV and STD transmitters with HIV prevention interventions and treatment of STDs. The study compares three different levels of an intervention program focusing on sex workers operating in the vicinity of mines and large agricultural enterprises.

Another study that focuses on STD/HIV interventions is based in the gold mining area of Carletonville, South Africa, where Horizons supports an STI/HIV intervention project that seeks to assess the effect and cost-effectiveness of an intervention package consisting of peer education among sex workers and miners, condom promotion and delivery, and strengthened STD management, to which a periodic presumptive STD treatment intervention for sex workers is added. Outcome indicators include STD rates among sex workers, miners, and the general population; HIV incidence in miners and the general population; and prevalence of condom use and preventive or safe behaviors. Particular attention is being paid to the effects of the intervention on social and community mobilization.

Integration of Maternal-Child Care and HIV Prevention

One of the most important breakthroughs in HIV treatment research in recent years has been confirmation of the efficacy of antiretroviral drugs in preventing mother-to-child transmission (MTCT) of HIV – but how to most effectively deliver such treatment remains unclear. A groundbreaking Horizons study in Kenya and Zambia addresses the acceptability, operational concerns, cost, and im-

Andrew A. Fisher, Horizons Project, Population Council, Washington, D.C., USA

Andrew A. Fisher, Sc.D., Project Director and Senior Associate, oversees the planning, design, implementation, and evaluation of project activities. At the Population Council, Dr Fisher has managed and directed large, field-based reproductive health and family planning operations research programs in Asia and Africa.

Email: horizons@pcdc.org
Website: www.popcouncil.org

pact of a package of antenatal clinic services on MTCT and child morbidity and mortality. Among other things, the research examines such interventions as voluntary HIV counseling and testing and the provision of antiretroviral drugs and breast milk substitutes to HIV-infected mothers. Horizons and its regional partners have also developed a training curriculum targeted to health workers and supervisors, community leaders, and other service providers.

Care and Support

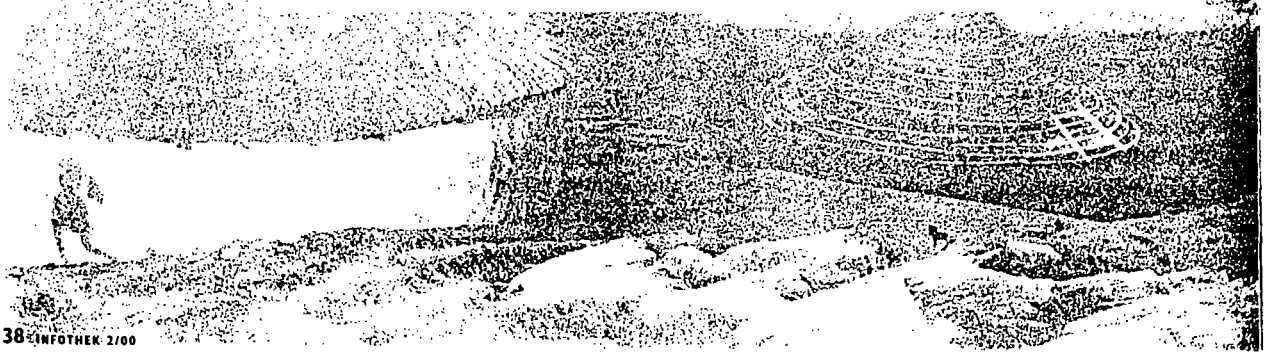
Horizons is conducting a pioneering diagnostic study on the involvement of people living with HIV/AIDS (PLHA) in the delivery of community-based prevention and care services in four countries (Burkina Faso, India, Ecuador, and Zambia). The goal is to identify factors that facilitate or limit such involvement in community-based organizations (CBOs) and to assess the impact it may have on the health and quality of life of service recipients. Key findings from the pilot phase of the research, conducted in Burkina Faso, show that PLHA involvement in the design, management, and delivery of these services varies widely, and that the greater the leadership role of PLHA in the organization, the higher the likelihood that the group will be able to identify and respond to the real needs of PLHA service recipients and their families.

Throughout the continent, millions of children have been orphaned by AIDS – and millions more face the same fate. In Uganda, Horizons is examining the impact of an orphan support program and testing an innovative «succession planning» program that helps AIDS-affected families prepare for the child's future before the parents die.

Among other Horizons research activities being conducted in Africa are the following:

- In Tanzania, an examination of violence against women who disclose their HIV-positive status to sexual partners.
- In Kenya and Uganda, research on the feasibility and acceptability of voluntary HIV/STD counseling and testing among youth.
- In Senegal, a diagnostic study to increase understanding of the sociocultural context within which male-to-male sexual contact takes place and identify nonstigmatizing strategies for providing information and services.
- In South Africa, an intervention study to identify effective school-based approaches that foster safer sex among in-school youth.
- In Zambia, research to determine whether young people who provide care and support to people living with HIV/AIDS and receive training to become stigma reduction advocates will reduce their own risky behaviors and attitudes.
- In Uganda, a study to determine best practices for integrating voluntary counseling and testing into primary health care services.

The Population Council is an international, nonprofit, nongovernmental institution that seeks to improve the wellbeing and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health research and helps build research capacities in developing countries. Established in 1952, the Council is governed by an international board of trustees. Its New York headquarters supports a global network of regional and country offices.



Full steam ahead...

for the XIII International AIDS Conference, Durban, South Africa, 9-14 July 2000

I would like to imagine that many thousands of individuals throughout the world who are dedicated to limiting the further spread of HIV and to improving care, treatment and rehabilitation of those already infected, share our anxieties at the prospect of some untoward event or failure which could compromise the success of the first global AIDS Conference in a country which is relatively poor.

Well, I am able to say with greater confidence that such fears can be put aside and people can join us in a collective sigh of relief. Things are going well! We have a superb team of 25 first-rate staff in our Durban office, they are handling the hundred and one issues, big and small, with smooth efficiency and unfailing competence. Please call on them for any assistance (e-mail aids2000@aids-2000.com; Fax +27 31 3010191; phone +27 31 3010400).

The Scientific Programme has consolidated all the Track Committees and includes 16 Plenaries, 24 Debate sessions (plus 6 community debates), 500 Abstract presentations, 5000 Posters and publication of all these, together with the remainder of submissions, in the Abstract Books. The final decisions on this were taken at the Marathon Meeting in March.

The Community Programme is simply outstanding with many unique features, and has already attracted the interest of a number of institutions in South Africa and internationally. The AIDS 2000 Development Project (ADP), which is rooted in community participation, empowers people and organizations through a set of comprehensive activities taking place before, during and after the conference.

We have explained to numerous applicants who have baulked at the not inconsiderable registration fee that this is an expensive conference to put together, and we are bound by conviction and agreements with the IAS to maintain high international standards. The conference is a non-profit venture with delegates' fees being calculated from past conference expenses and projected expenditure. Surplus funds will be used to support measures addressing the AIDS epidemic in Southern Africa. However we are genuinely concerned that monetary considerations do not form a barrier to opening the conference to people who should be there. We will offer as many Scholarships as we possibly can. We had aimed at much more than the previously agreed 1000 Scholarships but are frankly experiencing serious difficulties in raising additional funds. However we will continue our efforts as hope springs eternal in our ranks.

The organizers of AIDS 2000 take the safety and security of the delegates seriously and as such we have developed a safety and security policy which can be accessed via our web site.

The security policy includes a briefing document for activists who wish to demonstrate during the conference, and clearly highlights the different zones of the conference. It is important to highlight that KwaZulu-Natal is usually a zero tolerance level province when it comes to demonstrations, but we respect and value the viewpoints of activists and have therefore developed a comprehensive policy. Assistance will also be given to the various activist groups during the week of the conference in gaining permission for protests and rallies from the various authorities.

Contrary to reports circulating around the international cyberwaves there is still sufficient accommodation available in Durban. There is in excess of 5000 beds available in the following categories: Hotels, Bed and Breakfasts, Time share apartments, University Dormitories.

The opening ceremony and accompanying events, collectively called «The Break the Silence on AIDS Festival» is planned to be one of the most innovative and exhilarating productions ever seen in South Africa, celebrating at once the energy, passion and resilience of the African continent.

The people of South Africa are renowned for their hospitality – we look forward to welcoming you in July this year.

Professor Hoosen M. Coovadia, Conference Chair

3rd Prevention Works Symposium

hosted by International Partners, 8-9 July 2000, in Durban, South Africa

Judith D. Auerbach, Prevention Science Coordinator, Office of AIDS Research, U.S. National Institutes of Health, on behalf of the Planning Committee of the 3rd Prevention Works Symposium, Durban

The 3rd Prevention Works Symposium will be hosted in Durban, two days prior to the 13th International AIDS Conference. This Symposium is an official Satellite Meeting of the International AIDS Conference. Although issues relating to HIV prevention will feature strongly in the main Conference program, the Prevention Works Symposium provides a unique opportunity for in-depth and focused attention on HIV prevention research, policy formulation, and program implementation. As in previous years, the Symposium is designed to profile, share and deepen knowledge about international best practices, including models of successful HIV/AIDS prevention programs and policies.

Based on a concern about the historic lack of attention to HIV prevention in the International AIDS conferences, the first Prevention Works Symposium was initially conceived by the Canadian Public Health Association and organized with the following partners: Health Canada, the United States Center for Disease Control and Prevention (CDC) and National Institutes of Health (NIH), and the Joint United Nations Programme on HIV/AIDS. It was held in conjunction with the 11th International AIDS Conference in Vancouver, Canada in 1996 as an official Satellite meeting. This Symposium focused on three key themes: what works in HIV prevention programs and policies; why sound HIV prevention programs and policies are good public investments; and where attention should be directed in the future. Over 400 participants from 36 countries attended the Symposium, and developed a 14-point «Statement on HIV Prevention», reflecting consensus about principles of effective HIV prevention. This statement and the symposium summary report were circulated to over 1,000 people worldwide.

The enthusiastic response to the first Symposium led the organizers to consider hosting another in Geneva, Switzerland, also as a Satellite meeting to the 12th International AIDS Conference in 1998. Called the «2nd International Symposium on HIV Prevention», this symposium was organized by the original Vancouver sponsors, along with the following new partners: Swiss AIDS Federation, Swiss Federal Office of Public Health, Family Health International, and the United States Agency for International Development. The goal of the Geneva Symposium was, once again, to provide an international forum to profile best practices and exchange knowledge. The three key themes were: models of program experience in the development of effective and sustainable interventions; successful strategies that address social, policy, and legislative barriers to the implementation and sustainability of HIV prevention; and current research on HIV prevention and its application for effective and sustainable interventions. Over 500 people from 64 different countries participated in the Geneva Symposium.

Believing that the need to highlight HIV prevention would still be great in the 13th International AIDS Conference in Durban, 2000, the Geneva Symposium co-sponsors met with other, interested organizations early in 1999 to begin planning the 3rd Prevention Works Symposium. The Durban Symposium will: focus on implementation and capacity-building for HIV prevention; address structural, economic, cultural, and attitudinal barriers to effective HIV prevention; and identify short and long-term strategies for HIV prevention. Where appropriate, discussions will pay particular attention to the African context, drawing on experiences from this continent that are relevant to other settings.

The one and one-half day Symposium will consist of two plenary sessions, as well as, multiple, interactive sessions featuring invited speakers from around the world. The plenary speakers will highlight the themes noted above. The concurrent sessions will address a number of important HIV prevention issues in interactive sessions.

Throughout the Symposium, an effort will be made to maximize active participation among attendees, and to highlight creative and innovative approaches to HIV prevention research, program, and policy. Some of the session topics are:

- Ethics of Prevention Programmes and Research
- HIV Prevention: Focus on Heterosexual Men
- Role of the Family in HIV Prevention
- Impact of HIV/AIDS on Development & Sectoral Responses
- Sustainability of HIV Prevention Efforts
- HIV Prevention: The Context of Gender and Sexuality
- Addressing Emerging HIV Sub-epidemics
- Preventing HIV Among Mobile and Displaced Populations

- Impact of Treatment Advances on HIV Prevention
- Preventing Mother to Child Transmission of HIV
- HIV Prevention for Persons Who Use Drugs
- Vaccines
- Microbicides
- Mobilising Youth in Support of HIV Prevention
- Harm Reduction

It is the hope of the Symposium partners that the exchange of information and ideas at this meeting – as in the previous years – stimulates all of us to enhance our commitment to HIV prevention and keeps it at the forefront of international dialogue on HIV and AIDS.

The co-sponsors for the symposium are:
AIDS Training and Information Centre (ATIC) Durban, South Africa; Centers for Disease Control and Prevention (CDCP), Atlanta, USA; Family Health International (FHI), Arlington, USA; Health Canada, Ottawa, Canada; Medical Research Council (MRC), Durban, South Africa; National AIDS Convention of South Africa (NACOSA), Cape Town, South Africa; National Institutes of Health (NIH), Bethesda, USA; Swiss Federal Office of Public Health, Bern, Switzerland; UNAIDS, Geneva, Switzerland; World Bank, Washington, USA

If you would like to receive further information call: 0027 31 208 25 78 or
fax 0027 31 208 25 78
(Durban, South Africa)

E-mail: hivsymposium@global.co.za

he Sw ss Agency or Deve opment Pandemic and Development –

Peter Bieler, East and Southern Africa Division, and Jacques Martin, Multilateral Division, Swiss Agency for Development and Cooperation (SDC), Bern, Switzerland

Website: http://www.deza.admin.ch

Soon after the outbreak of the AIDS pandemic, Switzerland became quite aware of its importance, being among the developed countries with relatively high rates of HIV infection. In the framework of its development cooperation activities on three continents, and in joint activities with countries in transition, the Swiss Agency for Development and Cooperation early realised the threat posed by AIDS to people, societies and economies in its partner countries.

The particularly severe consequences of the HIV/AIDS pandemic in Africa were already apparent at the end of the 1980s, when some programmes supported by SDC began to suffer from the loss of staff members, particularly qualified professionals. The dramatic consequences for development became obvious from then on.

SDC began to disseminate information and offer preventive measures and related training in several countries, including Rwanda, Mali, Nepal, India, and Bangladesh. In addition, SDC supported local NGOs as well as specialised international agencies, such as WHO and UNAIDS. SDC has gradually been developing country policies and funding mechanisms, enabling it to demonstrate empathy and compassion, while Switzerland's experience with its own AIDS prevention programs is being shared with UNAIDS and other organisations.

What is Switzerland doing to help mitigate the pandemic?

One of the main objectives of SDC is to alleviate poverty. Thus many of its activities contribute directly or indirectly to improving the lot of women and men in developing countries and countries in transition. Improving the health of the population, providing education and training and employment opportunities, supporting initiatives in the field of human rights, and fostering the empowerment of individuals, particularly women, are among the activities carried out with the assistance of SDC. Dealing with the AIDS pandemic is considered part of these cross-sectoral concerns.

In response to the AIDS pandemic, SDC has taken the following steps over the last fifteen years:

- Ensured that appropriate up-to-date information is regularly shared with its staff at HQ and in the field, as well as with its partners. A first brief set of guidelines was prepared as early as 1987. Subsequent guidelines were issued in 1992. Finally, further policies are the responsibility of the geographical divisions and local offices. However, not all of them are fully equipped for this.
- Encouraged prevention in the framework of health projects and programmes, and also tried to promote prevention within projects and programmes in other fields, such as education, agriculture, women's affairs, etc. However, these objectives have not been systematically pursued, and related activities have not been implemented. In the view of SDC, there is a need for strong personal commitment by highly motivated individuals. There are still psychological and cultural barriers to overcome, as well as reluctance to deal with matters related to AIDS.
- Contributed financially to UNAIDS. Switzerland currently contributes CHF 2.3 million annually to UNAIDS and other organisations implementing HIV/AIDS prevention programs (such as UNFPA, WHO, IPPF, etc.), in order to enable them to play a key role in their respective fields.
- Helped finance studies drawing the attention of decision-makers to the pandemic and its consequences («Confronting AIDS», World Bank; «The hidden cost of AIDS», Panos; «AIDS and men», Panos).
- Ensured that the above support remains an SDC priority, particularly in view of the rapid deterioration of the situation in some areas. At present, total direct and indirect contributions for AIDS prevention amount to approximately CHF 6 million annually (approximately US$ 4 million).
- Encouraged the clear mention by SDC of HIV/AIDS in its country programmes as an important problem facing its partners, mainly in Nepal and in Eastern Africa, where conse-

and Cooperation: The AIDS a long and difficult process?

quences have been drawn at the programme level. Specific action plans are under consideration.

- SDC has tried to promote an empathetic institutional attitude towards specific individual cases among its own local staff in order to alleviate some of the hardship of disease and death due to HIV/AIDS. For practical reasons, however, it is difficult to offer such support to partners at large. Programmes remain limited in scope but can be efficient. For partner groups, emphasis has been given to prevention and providing means of protection. This will continue.

An example: Expressing solidarity with people living with HIV/AIDS in East and Southern Africa

The process at SDC can be described as bottom-up, in the sense that the commitment to address HIV/AIDS has not been imposed by management, but derived from individual commitments at lower levels in the hierarchy. The management is, however, very supportive of moves to address this problem.

In the East and Southern Africa Division of SDC, several staff members succeeded in making HIV/AIDS being acknowledged as a development issue and have it included in the new mid-term strategy. The Division has accepted responsibility for the necessary operational consequences, and for taking steps towards the implementation in its programmes. The approach is twofold. On the one hand, it focuses on how to handle cases of HIV/AIDS among SDC's own local and international staff including prevention activities. On the other hand, it is concerned with how to make good use of its programme and project structures for the dissemination of HIV/AIDS-related information, as well as for educational and prevention activities.

The approach chosen by SDC is not a major shift of priority, but a clear commitment to show solidarity with people living with HIV/AIDS. At present, SDC has no specific competencies in awareness building, provision of service, and subsequent counselling of individuals. It intends to open its project and programme structures to experienced organisations that could ensure appropriate awareness and prevention work as part of their regular activities. This will not be an easy job.

No easy task

While opportunities to address SDC's own staff with compassion and to provide them with education are manifold, the difficulty in making present project structures aware of the problem became obvious during a planning workshop in a bilateral agricultural project in the Southern Highlands of Tanzania in December 1999. During elaboration of the traditional log-frame, together with exclusively Tanzanian partners, no mention whatsoever was made of HIV/AIDS as a risk or constraint in project execution.

However, a subsequent discussion with a leader of the project revealed that the issue was more than relevant. Not only is the project operating in an area with an increasing number of households headed by children or elderly people, but the number of staff attached to the program affected by HIV/AIDS is also a matter of concern. In recent years many AIDS-related deaths have occurred among staff members.

The topic, however, is regarded as a taboo and is not addressed. Thus an open question remains: how can a donor agency put this issue on the agenda when it has not been asked to do so? Isn't this a typical form of top-down interference? How can a donor agency challenge a programme or a project to talk about HIV/AIDS and commit itself to do something about it?

The issue is definitely one that involves more than mere allocation of funds or a simple opening of the project structure to qualified actors who can educate and inform the staff. Lack of competence, inexperience, and uneasiness with the subject are counterbalanced by pressure to take a lead and assume a moral responsibility to act. Obviously, the question of addressing HIV/AIDS remains a difficult task for a development agency. It awaits a constructive push and strong support. Policy dialogues are also required. Who can and should take the first step?

The Swiss Federal Office of Public in Switzerland – Yesterday's Strategy

Roberto Indunì
Program Co-ordinator
AIDS Section
Swiss Federal Office of Public Health (SFOPH)
Bern, Switzerland
Website:
www.admin.ch/bag/aids

A Patchwork Quilt – Swiss Style

Switzerland is Europe on a smaller scale: It is a confederation composed of diverse regional entities characterised by a high degree of autonomy. This means that each activity, particularly regarding health policy, requires the participation of the various regions as well as of the Confederation. The authorities in each of the independent entities have the right to make their own choices independent of the others. Forming a structure such as a militia often demands long negotiations, and the slowness of the system is the price one has to pay. However, the emergency resulting from the encroachment of HIV into Switzerland in 1982 incited an exceptionally rapid collaborative process between the regional and national levels, as well as between governmental and grass roots community structures.

Top-Down and Bottom-Up

AIDS appeared in Switzerland in 1982. In 1985 the first group to be affected, homosexual men, founded the Swiss AIDS Federations. Intended to bring HIV prevention to the most vulnerable segments of society (homosexuals, prostitutes, drug users), this organisation complemented the work of the public authorities. The Federal Office of Public Health (as the Ministry of Health in Switzerland is called) took on the responsibility for the campaign STOP AIDS which was intended for the general population. The watch words were information and the promotion of low risk behaviour (safer sex and safer use). In 1998 a foundation for the collection and dissemination of all information about HIV/AIDS was founded (AIDS Info Docu Switzerland). And in 1991 there appeared PWA Switzerland (People Living with AIDS) in order to defend the interests of people living with HIV. This strategy based on collaboration has not always been harmonious, with the structures for AIDS prevention being often the victim of crisis (PWA Switzerland was dissolved in 1997). The crises resulted very often from divergent positions among NGOs and GOs or from conflicts concerning the interpretation of discrimination. In spite of all this, the end result has been the provision of information of a non-moralistic quality which has created a momentum of solidarity in the general population. In addition, an enormous diffusion of prevention materials has been achieved in record time.

Today in Switzerland HIV is, in a certain sense, «under control» – this stands in contrast to countries in Africa, Asia, and Eastern and Southern Europe. A fundamental process of reflection has enabled the various players to work together on a common basis, at the same time using very sophisticated means. The objective is certainly clear: Providing information so that all will be as informed and competent as possible to choose the means of prevention or therapy most appropriate for them.

Now the challenge is to preserve the quality of collaboration between the various players while providing the tools for improving the efficiency and efficacy of the work. The Federal Office of Public Health is drafting the «HIV and AIDS – National Program 1999–2003», including the various stages for its implementation. This document is intended to assure the transparency of the various projects, giving them over time the specific tools needed at their particular level of activity (negotiating priorities, clarifying tasks, developing tools for self-monitoring).

Participation and management – the two lines of attack in the fight against AIDS

Just as in the past, the well-known factor of participation is important. Not only participation on the part of different institutions – whether regional, national, or international – but also on the part of NGOs and volunteers who to this day perform an invaluable service.

Switzerland, a rich country, also makes use of interventions which are often found in countries with

Hea th: The Management of H V/A DS Works Today, As Well!

ess resources, which means placing value on local nd community-based networks; in other words, aluing the participation of everyone. However, if rofessional staff are to receive the support of the opulation served, community resources cannot be nvested without providing adequate training. This, alance – often fragile but of utmost importance – ets us see light at the end of the tunnel, when com- ined with improvements in medical care. By inte- rating community groups within the strategy, ublic health takes a giant step forward toward haring responsibility as well as toward managing vailable resources.

What's been happening...

«HIV and AIDS – National Program 1999–2003»

Process:

Based on the manual «AIDS Prevention in Switzer- and», published in 1993, a text is being written by public health officials to be submitted in several phases to all of the bodies involved in the fight against AIDS in Switzerland. «The HIV and AIDS Pro- gram 1999-2003» was published in February 1999[1] with the intention of firmly establishing AIDS policy within the country. Announced personally by Ruth Dreifuss, then President of Switzerland, the strategy has encountered a strong resonance in the media.

The National HIV and AIDS Program 1999–2000 in brief:

A fifty page booklet describes AIDS policy in Switzerland and thus attempts to establish meas- ures addressing HIV/AIDS for the long term. The success of prevention in Switzerland should not lead prevention workers and decision-makers to underestimate the dangers and damaging effects of the illness (a risk related to AIDS becoming a part of everyday life). The Federal Office of Public Health provides support at the local level as well as to private organisations through its various activi- ties and through implementation of the Program. Fourteen objectives are specified.

Implementation of the Program

Process:

During 1999, the regions were invited to provide a description of their activities by way of question- naires and through participation in fifteen regional forums. The latter provided an opportunity for the Federal Office of Public Health to communicate the nature of its services as well as the chance for re- gional authorities to supply detailed information about their situation and local strategy.

Results:

In spite of the large differences between regions, the findings could be summarised in a report pub- lished in February 2000[2] which discusses not only these differences but also the specific priorities, gaps, and needs in this area. This document is in- tended to become an integral part of the negotia- tions at both the regional and federal levels.

Things to come ...

A day of reflection for representatives from all can- tons is being planned for September 2000 in order to confer on current HIV/AIDS policy as well as to continue the process of consultation with the re- gions.

A vision for the year 2003: A policy of co-ordina- tion with the creation of a series of important meas- ures to facilitate communication between all part- ners. Evaluations being conducting by all partners regarding their needs and potential with proactive approaches to deficits and duplication. In a parallel process, all partners embarking on a process of re- flection firmly based on inter-regional networks, with the elaboration of one or more prevention strategies focused on a collaborative approach.

References:

1 *Available in French, German, and English through BBL, EDMZ, CH-3003 Bern, Switzerland, No. 311.930. Please specify language.*

2 *Available in French and German through BBL, EDMZ, CH-3003 Bern, Switzerland, No. 311.933. Please specify language.*

A DS Info Doc i Sw tzer and as Partners for

Christa Brunswicker, Executive Director

The Thirteenth International AIDS Conference in Durban raises fundamental questions which are not easily answered. In Western industrial countries an impending catastrophe for all civilisation has turned into a problem that can be managed by public health and medical care.[1] The number of new HIV infections is small and is continuing to fall. Very few people are now dying from AIDS and adequate medical care is the rule, regardless of income. The discussion concerning minorities and civil rights has abated. There is no open discrimination of people with HIV and AIDS. The formerly heavy flow of resources is rightfully being cut back, and the special organisations created to address AIDS are being dissolved or are seeking other areas of activity.

A total of 95 % of all AIDS cases and new infections are found in developing countries. Pharmaceutical companies invest internationally an annual amount of 50 billion Swiss francs in medical research, with not even 10 % of that amount being dedicated to finding solutions for the problems of the Third World. This is a critique which not only applies to the pharmaceutical giants. What are the governmental organisations in the rich countries of the world doing? What are we doing, we non-governmental organisations who are still well-financed?

We here at the AIDS Info Docu Switzerland still have a budget which is probably as much as some small Third World countries have to spend on their entire health care system. At the same time, we have a contract with our primary funder which limits our activities to Switzerland. And the opposition to our directing private contributions to developing countries is great – and embarrassing! This opposition comes often from the same people who stand at the podium at international conferences and pronounce, in a resounding voice, the importance of «Bridging the Gap» between the developed and the developing world.

What can the First World do, except to give money? In particular, what can a documentation centre do which is located in Switzerland, one of the richest countries in the world? Is not the commitment to the transfer of knowledge in the form of exchange and networking just a helpless gesture in light of totally incomparable problems?

In preparation for the «Durban» conference we made an unsuccessful attempt at networking. In 1998 at the Twelfth International AIDS Conference in Geneva we managed to organise an exchange of information between representatives from twelve AIDS information and documentation centres from Europe, Canada, and UNAIDS. This took the form of the one-day GAIN workshop. The idea for GAIN (Global AIDS Information Network) has existed since 1992. However up to this point, the global scope of the network had not been fully realised. From the beginning, the group has recruited participants almost exclusively from Europe and North America.

Leading up to the conference in Durban we wanted to organise such a meeting in Africa specifically to benefit African information centres, but we failed. The response to our attempts was meagre and the interest was almost zero. The starting point for the work of the various organisations as well as their needs and potential are too diverse, and travel and accommodations are too prohibitive, particularly for African participants.

GAIN can, however, report concrete results from its work:

- The European working group to create a multilingual thesaurus on AIDS and HIV infection produced a first edition between 1993 and 1999, published in eight languages. This resource is being used within and outside of Europe in the context of documentation in the interest of creating norms for information search and analysis.
- A general overview of more than 170 AIDS information centres world-wide is regularly updated, made available in both printed form and on the Internet.
- An electronic discussion forum specifically for the exchange of information between documentation centres was decided on during the workshop in Geneva in 1998. The forum, also known as «GAIN», initiated by the AIDS Info Docu Switzerland in August 1999, now includes 108 participants in more than 35 countries, with two-thirds being from Africa, Asia, Latin America,

– Doc ımentat on Centres Global Networking?

and Eastern Europe. Although it appears that this form of communication will take some getting used to, the use of the forum is increasing steadily. Particularly in the case of very concrete questions (e.g., names of contact people, addresses, and publications) answers are provided very quickly.

This special edition of the magazine AIDS Infothek is a further attempt to promote networking, to bring things into perspective and at least for a moment to focus attention on a region of the world where AIDS is truly «an impending catastrophe for all civilisation». The articles concerning the situation in South Africa, Kenya, and Morocco, from Family Health International, the Population Council, UNAIDS, and the World Bank, speak for themselves. And they also speak a truth about us: «When we view the global AIDS crisis as a whole, it is evidently clear that, with few exceptions (like the Netherlands), Europe has failed just as surely as other rich countries in the world.»[2]

References:

[1] *Rosenbrock R et al. «The AIDS Policy in Western Europe. From Exceptionalism to Normalization», AIDS Infothek 5/99, p. 4.*

[2] *ibid, p. 15*

Services

Special Documentation Services on HIV and AIDS

We maintain documentation, library, and multi-media services regarding HIV and AIDS, offering a systematic collection of materials on HIV/AIDS prevention from Switzerland and neighbouring countries.

Our collection includes books, journals, grey literature (research reports, magazine articles, etc.), posters, slides, videos, CD-ROMs, etc.

Internet access to our resources is available at www.aidsnet.ch

We publish the bi-monthly magazine AIDS INFOTHEK since September 1989. For each issue there are German and French editions with a special section in Italian. The circulation is 10,000 copies.

Centralised Mailing Office, Loan Department, and Administration

Or central Mailing Office sends out all currently available materials of the «Stop AIDS Campaign» as well as that of the Swiss AIDS Federation and other organisations.

We provide ongoing information by way of various special catalogues as well as through our complete catalogue in electronic form («Publifix») on CD-ROM.

Development and Support for Prevention Projects

In collaboration with the Federal Office of Public Health and the Swiss AIDS Federation we continually develop and update a collection of basic information concerning HIV prevention.

We develop and implement our own prevention projects, as well, particularly in the areas of youth prevention, schools, curricula, and new media (CD-ROM and the Internet).

We are responsible for maintaining the official Swiss prevention information through our site on the Internet: www.aidsnet.ch

We are taking our first steps in development work with Third World countries and provide support for a project in Kathmandu, Nepal, which was created to improve the situation of commercial sex workers.

Address:
AIDS Info Docu Switzerland
Schauplatzgasse 26
Postfach 5064
CH-5001 Bern

Tel. +41 31 312 12 66
Fax +41 31 311 64 14
E-mail: info@aid.ch

Calendar of Events

■ Baltimore, Maryland, USA
April 16 - 21
13th International Conference on Antiviral Research
Info:
Courtesy Associates
attn. Kelley Gillespie
2000 L Street, NW
Washington, DC 20036
USA
Tel. 001 202 331 2000
Fax 001 202 331 0111
http://www.isar-icar.com/future.html

■ München, Germany
May 5 - 7
8. Münchner Aids-Tage
Info:
Frau Müller
Verlag Moderne Industrie, mic
D-86895
Landsberg/Lerch
Tel. 0049 8191 125 291
Fax 0049 8191 125 600
http://www.m-i-c.de/info/873.002.htm

■ Stockholm, Sweden
May 10 - 12
Social causation of disease: biological mechanisms
Info:
The Swedish Society of Medicine
P.O. Box 738
S-10135 Stockholm
Sweden
Tel. 0046 8 440 8884
e-mail: annie.melin@svls.se

■ Santander, Spain
May 10 - 13
5th European Conference on Health Promotion and Health Education: «Towards a Healthy Europe for the Year 2010»
Info:
Asociación de educatión para la salud
Hospital Clínico San Carlos
Servicio de Medicina Preventiva 4a Norte
28040 Madrid
España
Tel. 0034 91 330 3422
Fax 0034 91 543 7504
e-mail: msainz@hcsc.es

■ St. Petersburg, Russia
May 19 - 24
8th International Conference «AIDS, Cancer and Related Problems»
Info:
Biomedical Center for Aids, Cancer and Related Problems
7, Pudozhskaja
St. Petersburg,
Russia 197110
Tel. 007 812 235 5875
Fax 007 812 230 5875
e-mail: biomed@mail-box.alkor.ru

■ Stockholm, Sweden
May 28 - 31
10th International Congress on Microbiology and Infectious Diseases
Info:
10th ECCMID 2000
Stockholm Convention Centre Bureau
P.O. Box 6911
Sweden
Tel. 0046 8 736 15 00
e-mail: eccmid@stocon.se
http://www.stocon.se/eccmid

■ Durban, South Africa
July 8 - 9
3rd International HIV Prevention Works Symposium
Info:
Tel. 0027 31 208 2578
Fax 0027 31 208 2578
Web:
http://www.aids2000.com

■ Durban, South Africa
July 9 - 14
XIII International AIDS Conference
Info:
Congrex Sweden AB
AIDS 2000
P.O. Box 5619
Linnégatan 89A
SE-11486 Stockholm
Tel. 0046 8 459 6600
Fax 0046 8 661 8155
e-mail: aids2000registration@congrex.se
e-mail: aids2000@congrex.se
Web:
http://www.aids2000.com

■ Glasgow, United Kingdom
October 22 - 26
5th International Congress on Drug Therapy in HIV Infection
Info:
Gardiner-Caldwell Communications
Tel. 0044 1625 664 222
Fax 0044 1625 664 156

O - AIDS INFOTHEK

THE WHITE HOUSE

WASHINGTON

June 28, 2000

Christa Brunswicker
Executive Director
AIDS Info Docu Switzerland
P.O. Box 5064
Bern, Switzerland
CH-5001

Wolfgang Wettstein
Editor
AIDS INFOTHEK
P.O. Box 5064
Bern, Switzerland
CH-5001

Dear Ms. Brunswicker and Mr. Wettstein:

I would like to take this opportunity to thank you for the recent briefing you gave Dr. Paul Gaist of my Office regarding your organization's recent activities. I also very much appreciate the special issue of AIDS INFOTECH, "HIV/AIDS in Africa." I understand that UNAIDS recently included this issue in its mailings and that it will be an official document at the upcoming XIII International AIDS Conference in Durban, South Africa. We have already found it most helpful here, and we have shared copies of the English version with the Presidential Advisory Council on HIV/AIDS and others.

The long-standing history and partnership among AIDS INFOTHEK, AIDS Info Docu Switzerland and the Federal Office of Public Health, Switzerland is truly impressive. Keep up the good work, and I hope such vital publications as AIDS INFOTHEK will continue to inform and motivate people to action in our global fight against HIV and AIDS.

Sincerely,

Sandra Thurman

Sandra L. Thurman
Director
Office of National AIDS Policy