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EVALUATION OF THE EFFECTIVENESS OF AIDS HEALTH EDUCATION INTERVENTIONS IN THE MUSLIM COMMUNITY IN UGANDA

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Neema Nakyanjo, Yusuf Walakira, and Janice Hogle

In 1992 the Islamic Medical Association of Uganda designed an AIDS prevention project and conducted a baseline survey prior to community level activities. Results of that baseline were previously reported in this journal. During 2 years of prevention activities in local Muslim communities, 23 trainers educated over 3,000 religious leaders and their assistants, who in turn educated their communities on AIDS during home visits and at religious gatherings. After 2 years, there was a significant increase in correct knowledge of HIV transmission, methods of preventing HIV infection and the risk associated with ablution of the dead and unsterile circumcision ($p < 0.001$). There was a significant reduction in self-reported sexual partners among the young respondents less than 45 years. In addition there was a significant increase in self-reported condom use among males in urban areas ($p < 0.001$). Collaboration between health professionals and religious leaders can be achieved and can contribute to the success of AIDS prevention efforts.

Health education interventions to reduce risky behaviour are at present among the major strategies available to limit the spread of HIV infection (Heymann & Edstrom, 1991; Oakley, Fullerton, & Holland, 1995; Potts, Anderson, & Borly, 1991). The Islamic Medical Association of Uganda (IMAU) is a nongovernmental organization working closely with the Muslim community for health promotion. It is estimated that as many as 25% of Ugandans are Muslims. In 1992 the IMAU designed a project called Family AIDS Education and Prevention Through Imams (FAEPTI). This project was based on the assumption that in the Muslim community, the imam (mosque leader) is the usual teacher of family values and behavior, including those related to

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households to educate repeatedly, so that every month one or two new topics or issues were discussed and old topics revisited to encourage the family to put them into practice. The imam introduced the FAW to the household and made periodic visits to encourage the family. In addition, the imam was encouraged to give talks about AIDS during religious gatherings. The imams were given bicycles to assist them in transport for home visits. The FAWs were provided with two local hens for rearing so that they could generate some income to compensate partially for their voluntary work in the community. Between workshop sessions, the IMAU trainers made periodic field visits every quarter, to support the Imams and their assistants and assist them in dealing with some of the problems they were experiencing in training the community. The visits included both impromptu on-site checks and prearranged group discussions with the Imams and FAWs.

EVALUATION METHODS

BASELINE SURVEY

A cross-sectional survey was done in March 1992 where respondents living around randomly selected mosques were interviewed. The details of the methodology for the baseline survey were reported elsewhere (Kagimu et al., 1995). The results of the baseline survey were used to identify areas where intensive education was needed. For example, the baseline survey found that very few respondents were aware of the potential for HIV positive mothers to pass the infection to their infants. Similarly, the risks associated with using one razor to circumcise many male infants during the same occasion and the risks associated with ritual washing of the dead (ablution) were also not well known. These were some of the areas targeted for intensive education.

MAIN OUTCOME MEASURES

The baseline survey findings were used to define the main outcome measures to be used in the subsequent evaluation. These included correct knowledge of HIV transmission and prevention, self-reported use of condoms, number of self reported sexual partners, and risk perception to risky practices common in the Muslim community such as ablution of the dead and circumcision.

FOLLOW UP EVALUATION

ROUTINE PROJECT DATA

Reporting forms from trainers, imams, and FAWs were used to monitor the activities of the project. These were tabulated every 3 months and analyzed to assess the overall process of implementation during the 2 years of the project.

FOLLOW-UP COMMUNITY SURVEY

A questionnaire was designed which included the same questions as those in the baseline survey and additional questions to get more informative data. For instance, we learned during the analysis of the baseline survey data that, given the high rates of polygamy in these communities, it was difficult to determine the frequency of extra-

Imam talk about AIDS. Not directly exposed to the project was defined as a respondent who did not recall talking with a FAW and also did not recall talking with or listening to a trained imam talk about AIDS. This somewhat conservative definition of "exposure to the project" may have made the differences between the exposed and nonexposed less impressive, as some of those we categorized as nonexposed may in fact have been exposed, either directly but without specific memory of the exposure, or were exposed indirectly through contact with community members who were exposed and recalled this exposure. Thus, our results regarding differences between these two groups are probably a conservative estimate of the impact of the project. It is likely that some of the improvements in knowledge, attitudes, and behavior between baseline and follow-up in both groups are partially the result of national level AIDS education efforts. The observed differences between those exposed and those nonexposed are likely to be associated with activities of the project. Significant differences between districts were not observed, and therefore results from both districts were combined.

FOCUS GROUP DISCUSSIONS

The quantitative data were supplemented with qualitative data obtained through focus group discussions and key informant interviews. This was not done during the baseline survey but rather was a study methodology added during the final evaluation. Nine focus group discussions with about 75 participants were conducted, 3 from Mpigi district, 3 from Iganga FAEPTI area and 3 from Iganga non-FAEPTI area. The first of the three focus groups in each area consisted of adult married males between 25 and 40 years, the second group comprised adult married females between 20 and 29 years, and the third group was composed of unmarried female youth between 15 and 19 years. The age and gender structure was selected in this way because these categories are thought to represent those groups at the highest risk of HIV infection in Uganda. All participants were selected from rural areas to assess the changes in these areas where the majority of the Ugandan population lives. The focus group discussions for male participants were conducted by male moderators whereas those for females were done by female moderators. The guiding questions used in these discussions were derived from a story. The moderator read out a story thought to be similar to the experiences of the participants. Questions were then read out regarding this story and the participants gave their responses. Notes and transcripts of these sessions were analyzed individually, and the major themes, trends, and patterns were categorized.

KEY INFORMANT INTERVIEWS

A total of 25 key informant interviews were held with community peer educators who included FAWs, imams, imams assistants, county sheikhs, and district kadhis. They were asked about how the community responded to the project, the strengths and weaknesses of the project, and the anticipated response to a community-based condom distribution and sales program.

RESULTS

The findings from our evaluation exercise are presented in three sections. First we describe the survey sample population, and next we present quantitative findings related to changes in knowledge, attitudes, and behavior based on the survey sample.

Table 2. Knowledge of Modes of HIV Transmission, Prevention, and Risk Perception

Characteristic	Baseline		Non-Exposed (Follow-Up)		Exposed (Follow-Up)		p
	n	%	n	%	n	%	
Correct modes of transmission							
Sexual intercourse	1636	(86)	507	(90)	1220	(97)	< 0.001
Vertical	22	(01)	13	(02)	126	(10)	< 0.001
Unsterile objects ^a	695	(36)	286	(51)	1012	(80)	< 0.001
Correct modes of prevention							
Abstinence	735	(39)	321	(57)	892	(71)	< 0.001
Faithfulness	1278	(67)	351	(62)	981	(78)	< 0.001
Condoms (prompted)	1185	(64)	340	(60)	1027	(82)	< 0.001
Condoms (unprompted)	189	(10)	129	(23)	439	(35)	< 0.001
Sterile practices ^b	552	(29)	233	(41)	807	(64)	< 0.001
Risk perception							
Ablution of dead	501	(27)	137	(24)	756	(60)	< 0.001
Circumcision ^c	843	(45)	253	(45)	979	(78)	< 0.001

Note. ^aIncludes dental instruments, razor blades, needles and other skin-piercing instruments.

^bIncludes use of gloves by medical practitioners and avoidance of unsterile injections and unscreened transfusions.

^cRisk associated with use of common or unsterile razor blades during circumcision.

marital status, but unfortunately during the analysis we found that respondents were not consistent in responding. In general in Uganda, there is a high prevalence of long-term relationships that are functionally marriages but have not yet been sanctioned legally or in the mosque or church. Some people in these situations consider themselves to be married; some do not, and there are no local terms that are universally interpreted in the same way. Thus, we are uncertain of the comparability of data on marital status between baseline and follow-up, and these data are not presented.

CHANGES IN KNOWLEDGE, ATTITUDES, AND BEHAVIOR

There were statistically significant increases in correct knowledge of sexual transmission of HIV, of mother-to-child transmission, and of the risk of unsterile skin-piercing instruments, as shown in Table 2. Persons in these communities who had contact with the project were much more likely to understand that there are ways, such as abstinence and marital faithfulness, which may help to protect oneself from HIV infection.

Knowledge of the protective value of condom use increased at a rate that is statistically significant. However, it appears that survey respondents were reluctant to volunteer without prompting that they knew that condoms could help prevent HIV transmission, though many more responded positively after prompting. Among those exposed to the program, only 35% spontaneously volunteered that condoms can prevent HIV transmission, though 82% knew this when they were asked a direct question.

These quantitative results regarding increases in knowledge of AIDS and protective behaviors were supported by comments made during interviews with the key informants. Most of these key informants believed that the knowledge and understanding of many AIDS-related issues had increased as a result of the educational efforts of the FAWs and imams. Areas of increased knowledge mentioned by these key informants included how to avoid HIV infection, how to care for those with AIDS, and modes of HIV transmission.

Table 3. Number and Type of Sexual Partners Reported in Last 12 Months Among Those Sexually Active

Characteristic	Baseline		Non-Exposed (Follow-Up)		Exposed (Follow-Up)		p
	n	%	n	%	n	%	
Two or more partners							
Males							
15-24	72	(45)	23	(59)	36	(32)	0.007
25-34	69	(48)	24	(51)	36	(30)	0.006
35-44	45	(59)	23	(88)	23	(47)	0.002
45+	58	(48)	14	(61)	46	(49)	0.517
Females							
15-24	49	(13)	22	(16)	12	(6)	0.004
25-34	11	(5)	17	(20)	8	(4)	< 0.001
35-44	2	(2)	5	(18)	4	(5)	0.006
45+	1	(4)	2	(13)	1	(2)	0.232
Extra-marital Partners (married respondents)							
Males	NA	NA	68	(45)	93	(24)	< 0.001
Females	NA	NA	61	(20)	61	(10)	< 0.001

Note. NA = Not available.

and women under age 45 were less likely to have more than one partner if they were exposed to the project. In focus group discussions, it was not uncommon for participants to express the belief that "Young people have not changed behaviour." Our quantitative findings do not support this belief.

Although reduction in the number of sexual partners is an appropriate public health message, it had to be modified to suit the Muslim communities in these districts. Many in the target audience were already in polygamous marriages and the project had no intention to disrupt these families. Therefore, another important message of the project was to discourage extramarital sexual relations. At follow-up, all sexually active respondents were asked a series of questions about their sexual partners. This exact series of questions was not asked during the baseline survey, so comparisons can only be made between those exposed and unexposed to the project. By combining responses to this series of questions regarding marital status and number and types of partners, it is possible to determine the percentage of persons reporting an extramarital relationship in the last 12 months. The term extra-marital was defined in our analysis based on persons who clearly reported that they were married but had sexual partners in addition to their spouses. As seen in Table 3, there are statistically significant differences between those unexposed and those exposed, with those exposed less likely to report extramarital relationships.

These results were supported by key informant interviews. One imam from Mpigi mentioned that marital stability has increased as "husbands and wives settle issues that may arise there and then. Divorce and separating is dying out." "Decrease in promiscuity" and "decrease in girlfriend/boyfriend relationships" are additional phrases used to describe reductions both in number of sexual partners and in the number of extramarital relationships. These changes also came out during key informant interviews. Comments were made such as "People nowadays have fewer sexual partners," and "Sexual behavior has changed for the better. People no longer go out."

Condom education was one of the strategies that was used in the FAEPTI Project

use for AIDS prevention, one participant replied, "Nothing (is known). People are just protecting themselves by sticking to partners but for the condom, no." They added that it was only the FAWs who knew how to use condoms. The situation was even worse in the non-project areas. Most of the female focus group participants had never seen a condom and did not know who uses one. One participant wondered "You mean to say both me and him wear it?" Other participants seemed to confuse a balloon with a condom saying "Children often play with them" and "I see children buy them." Most of the female focus group participants were not sure about where condoms were sold or how much they cost. A focus group participant from a project area said "For us we have not seen anyone selling them....Those who teach us about AIDS show them to us but we have not seen anyone selling them." These women thought that the FAWs could sell condoms in their homes or "they could move to people's homes as they have been doing while teaching."

The change in attitude towards condoms was supported by key informant interviews. One leader said, "Initially I was totally against condoms on religious grounds in that distributing condoms would promote sex outside marriage. However, when I learned of the medical point of view that condoms have a role to play in saving the community from AIDS, I now think they have a place for some people in my community."

The issue of making condoms available in the community was also supported by key informant interviews. One female FAW readily said that, "The community in general would be very pleased about it. Selling them countrywide on village basis would still be a very good thing. There should be one depot in each area, that is where whoever wants to buy can buy them." One Imam said that the youth would welcome increased availability of condoms while the adults and the old people would not, but that, "It would be a good thing if they were sold at the village level because, it would save so many peoples' lives." Another Imam said "the youth will welcome the idea and will support it because they have failed to avoid sexual contact."

HOW THE RESULTS WERE ACHIEVED

Respondents who were exposed to the project were more likely to have higher levels of correct knowledge of HIV transmission and prevention, they were more likely to understand the risk of ablution of the dead and circumcision, they were less likely to report multiple partners and extramarital partners, and they were more likely to report condom use. We believe that the combination of successful project implementation, providing correct education and information to these communities, actual contact with change agents, and changes in social norms encouraged by imams and their assistants contributed to these positive results. To explore this relationship, data on project outputs were compiled based on project records, and, in addition, survey respondents were asked questions about their contact with the project. Table 5 shows the planned project achievements at the time of project design and the actual achievements after approximately two years of project implementation.

With the exception of FAWs, all other training targets were essentially achieved or exceeded. The number of FAWs needed could not be predicted accurately before the project began. On the ground it was found that there were on average 75 households per mosque instead of the initially estimated average of 150 households.

Table 5. Planned and Actual Persons trained and Served

Category	Planned	Achieved
MAU trainer sheikhs	2	2
IMAU trainers	18	21
District kadhis	2	2
District kadhi assistants	4	4
County sheikhs	12	13
County sheikh assistants	24	26
Imams	400	396
Imam assistants	800	792
Family AIDS workers	4,000	1,774
Household visits	60,000	114,634 ^a
Sexually active persons	300,000	584,994 ^a

Note. IMAU = the Islamic Medical Association of Uganda.

^aThese figures refer to education contacts and include some repeat visits.

2-year project. General knowledge regarding AIDS is high in Uganda, and even at baseline or among those unexposed to the project, the sexual transmission of HIV infection is well known. Increases in knowledge of sexual transmission were observed among those exposed to the project, but these changes were modest, given the preexisting high level of knowledge.

We have also found that such an intense community level education project can result in changes in behavior. Numbers of sexual partners reported in the last 12 months were much lower in those exposed to the project; younger males and females were less likely to report multiple partners if they were exposed to project interventions. This suggests that young people may be more receptive to HIV and AIDS prevention messages than those who are older and have long-standing patterns of sexual behaviour. Further, those persons exposed to the project were much less likely to report extramarital sexual relations during the last twelve months.

Condom-use rates increased only slightly, though knowledge of condoms increased to over 80% of those exposed to the project. This confirms the general observation that it remains difficult for individuals in Muslim communities to openly recommend or acknowledge condom use as a protective option. There continues to be a public campaign, primarily sponsored by some religious groups, to discourage condom use in Uganda. These groups assert that condoms are not 100% effective in preventing HIV transmission and that condom use encourages promiscuity. This alleged association between condom use and promiscuity may have resulted in a reluctance on the part of respondents to acknowledge condom use openly. Qualitative data also suggest that another reason condom-use rates increased only slightly may have been inadequate supply of condoms in rural areas.

Our findings also document that a strategy of training both religious leaders and community-level lay volunteers contributed to the impact of the project. Community residents reported high rates of knowing about the project and having contact with the Family AIDS Workers and imams. An important factor contributing to the success of the project was the opportunity for repeated contacts with these trained workers. Imams have the opportunity at religious services to discuss AIDS and family behavior; these opportunities recur on a regular basis. We believe this opportunity for ongoing education, counseling, and community support for reduced risk behavior was an essential element in the success of this project. It is therefore, concluded that a cadre

Uganda's Response to the AIDS Epidemic and Current Trends

Presentation by:
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Response of Non-Governmental Organizations

- Mission hospitals began AIDS care programs
- The AIDS Support Organization (TASO) established in 1987 by 16 Ugandans affected by the epidemic
- The AIDS Information Centre (AIC) began providing HIV counseling and testing in 1990
- Numerous smaller NGOs established to provide care to persons with AIDS and support for orphans
- Associations of PWAs (People with AIDS) organized for education, mutual support

Government of Uganda Response

- President Museveni spoke openly and widely about AIDS as early as 1986
- AIDS Control Programme established in 1986; educational programs, mass media and blood safety efforts began
- Intense public information efforts have continued to the present
- International AIDS researchers encouraged to work in Uganda; President Museveni requests vaccine trials
- 1991: multisectoral Uganda AIDS Commission established

Response of Religious Communities

- with USAID funding, Church of Uganda (Protestant) and the Islamic Medical Association of Uganda initiated active programs of AIDS education for religious leaders and lay workers at the community and parish level
- Catholic church active in AIDS care and orphans programs

Response of the USG

- NIH funding for numerous research projects
- CDC technical assistance; research in variant strains, health information systems, and evaluation of interventions
- since 1988, USAID has provided very generous and sustained funding for multi-faceted, intense and extensive AIDS prevention activities
- USAID funding for AIDS activities has now exceeded \$40 million

Response of U.S. Universities

- US Universities active in Uganda include Case Western Reserve University, Columbia University, Johns Hopkins Univ
- with NIH funding, long term biomedical research projects began in 1988 in the areas of:
 - pediatric AIDS
 - mother to child transmission
 - HIV and TB
 - community epidemiology
 - STDs, Kaposi's sarcoma & HIV
 - Vitamin A for HIV+ children
 - preparation for AIDS vaccine trials
 - social and anthropological aspects of the epidemic

USAID funded Activities

- AIDS education in the workplace, military, local communities, religious groups
- professionally designed information and education campaigns through mass media and local level IEC activities
- condom promotion and distribution
- HIV counseling and testing
- AIDS care and support
- detection and treatment of other STDs
- capacity building and technical training

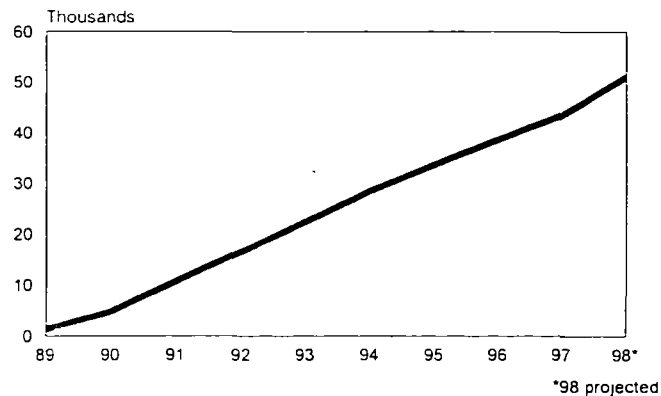
Results of USG supported efforts

- greater understanding of the epidemic in Africa, esp in the area of HIV/TB and mother to child transmission
- application of therapeutic interventions in Africa-- trials of short course AZT during delivery, HIVIG, preventive TB therapy, vaccine trials, mass STD treatment
- behavioral impact of interventions documented, esp for HIV CT and community education
- Hundreds of Ugandan scientists, physicians, social workers, health educators, and program managers have been trained and developed skills
- feasibility of projects demonstrated
 - community education, esp with religious groups
 - increased acceptance, use, and sales of condoms
 - AIDS care and support
 - voluntary counseling and testing

Results: Community Education through Religious Groups

- over 2,000 religious leaders trained
- over 14,000 community workers and volunteers trained
- over 1.6 million documented contacts with individuals and families
- decrease in multiple and/or casual partners reported by those reached by the projects
- increase in condom acceptance and use

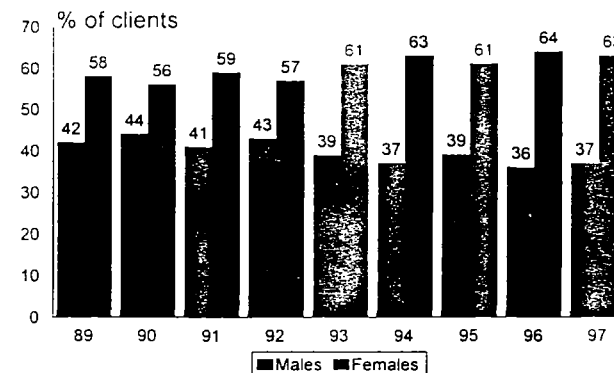
Cumulative Demand for TASO Services: Numbers of New Clients Registered



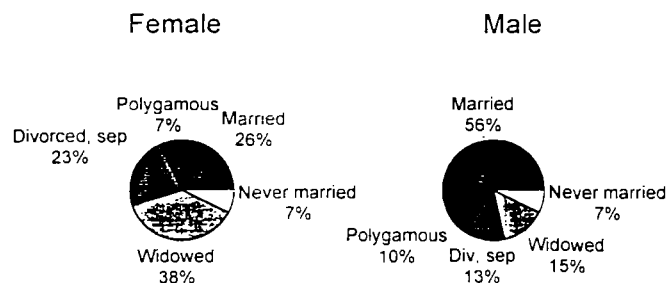
Results: AIDS Care and Support

- through TASO, The AIDS Support Organization, over 50,000 persons living with AIDS given care and support
- TASO has also trained over 600 AIDS counselors and thousands of local volunteers
- a model of AIDS care and counseling developed which is being replicated throughout Uganda and throughout Africa

TASO Clients by Gender



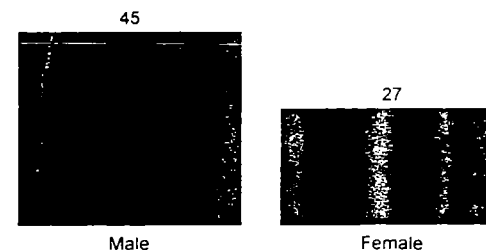
Marital Status of New Clients - 1997



66% of men are in a union, but only 33% of women

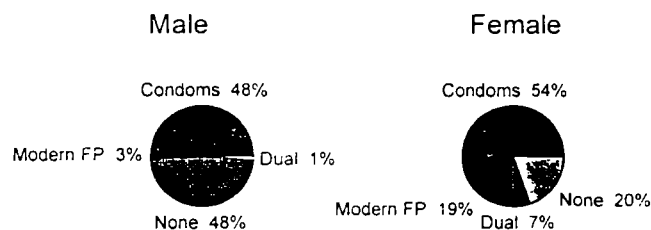
Percent of Adult TASO Clients reporting Sexual Activity

Most Clients are not sexually active



total n with data: 9129

Contraceptive Use among TASO Clients - 1997

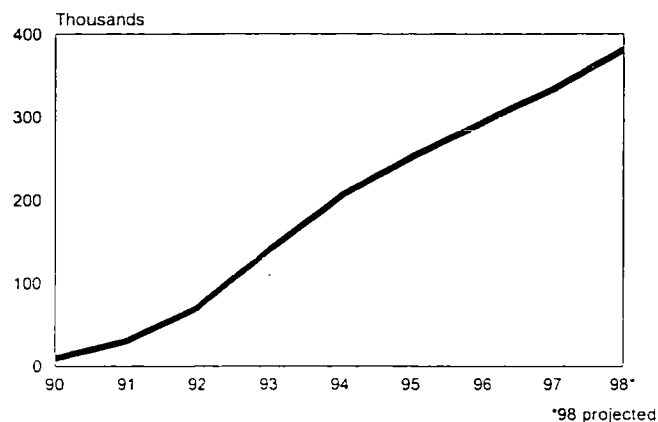


n=3000

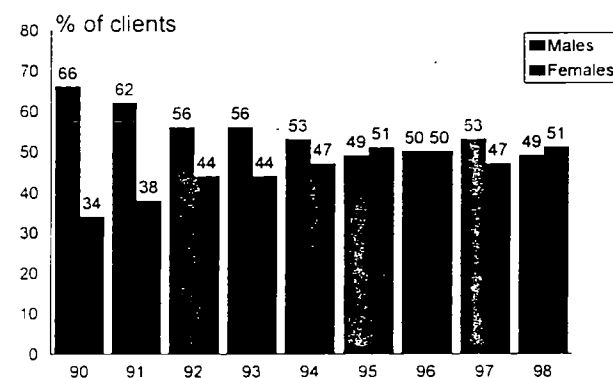
Results: Voluntary Counseling and Testing (VCT)

- USAID/Uganda supported the first site to offer voluntary counseling and testing (VCT) in Africa
- project has successfully served almost 400,000 since 1990
- other donors are now funding VCT (DFID, UNFPA, UNAIDS)
- the AIDS Information Centre (AIC) has served as site for research on effectiveness of VCT, TB preventive therapy, discordant couples, and will assist with prevention of mother to child HIV transmission projects in Uganda
- AIC has piloted the use of rapid tests for same day results
- AIC is now providing integrated reproductive health services, including family planning and STD detection and treatment
- VCT demonstrated to be feasible and well accepted by local population; model is now being replicated in other sites in Africa

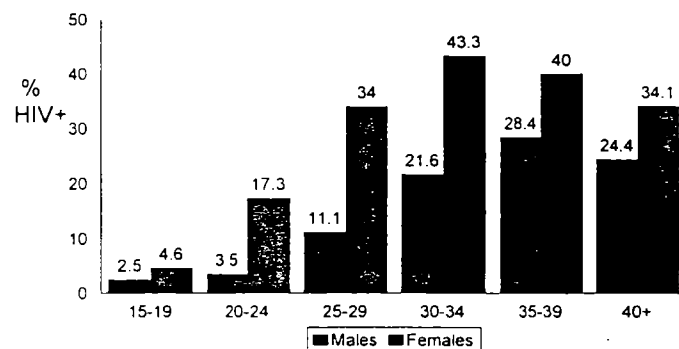
Cumulative Demand for VCT at AIC



VCT Demand by Gender at AIC

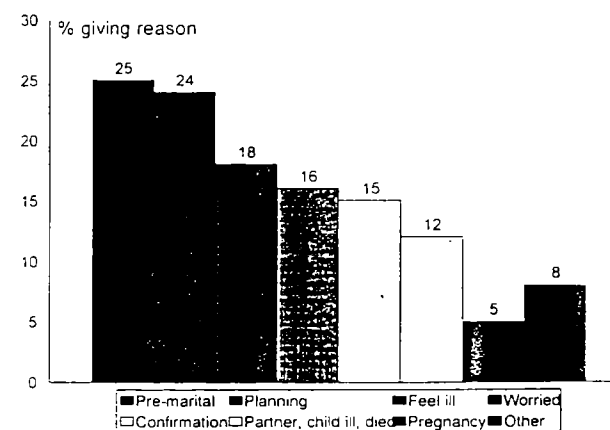


Women who request VCT in Uganda are more likely to be HIV+ than men in all ages

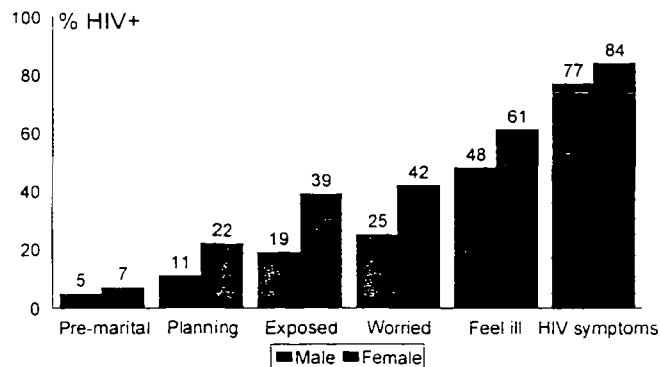


source: 1997 data, the AIDS Information Centre, n=37,694

Reasons for seeking VCT, 1997



HIV rates by Reasons for Requesting VCT -- 1997

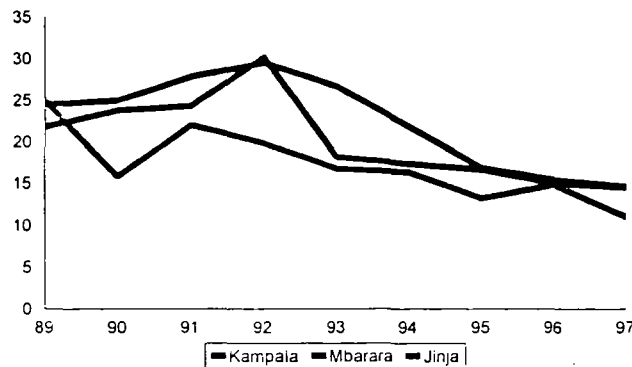


Overall Results of Uganda's Response to AIDS

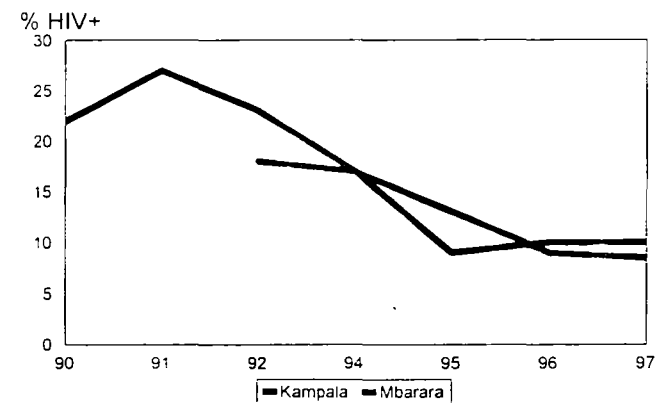
- almost 100% level of awareness of AIDS
- evidence for behavioral changes
- evidence of changing social norms, esp regarding multiple partners, condom use, pre-marital testing
- restoration of hope for the future of Uganda
- citizens have observed the power of candid and collaborative approach to national problems
- evidence of declining trends, esp in rate of new infections in young people

HIV Infection Rates in antenatal clinics in Uganda

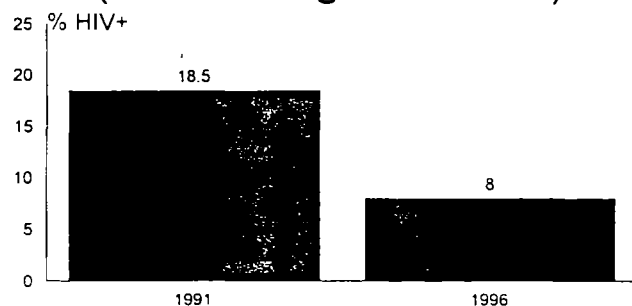
Ministry of Health Data



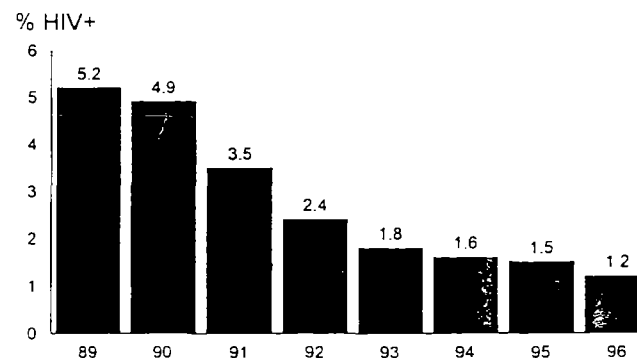
HIV Rates in 15-19 year old ANC attenders



HIV Prevalence in young men aged 19-22 entering the army (Gov't of Uganda data)



HIV Prevalence in Secondary School Blood Donors



Essential Components in Uganda's Response to AIDS

- consistent political support for AIDS interventions from the highest level
- consistent and generous donor support, esp USAID, since 1988
- PWAs have been involved in the design and implementation of projects
- PWAs, TASO, and other groups have successfully reduced stigma, discrimination, and fear of testing
- Religious groups have had active community programs and for the most part now support condom education and promotion
- well run pilot projects (AIDS care, VCT) have been sustained long after pilot phase
- interventions and local organizations have gained credibility and trust from both public and donors

Conclusion

- intense response to the AIDS epidemic can achieve measureable results
- intense & sustained collaboration between host government, non-governmental organizations, American scientists, & USG agencies (USAID, NIH, CDC) can significantly enhance a nation's response to the AIDS epidemic

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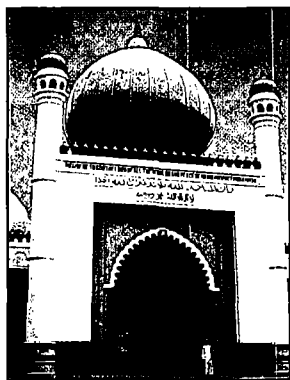
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Islamic Medical Association of Uganda

AIDS education through Imams:

*A spiritually motivated
community effort
in Uganda*



UNAIDS
UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

**UNAIDS
Case study**

October 1998

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NPR

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HIGHLIGHT:

NPR's Brenda Wilson reports on the problems that AIDS is causing on farms in the African nation of Zimbabwe. She visits a 3,000-acre commercial farm in the Mashonaland region of northeastern Zimbabwe, where an estimated one in five persons is infected with HIV. One of the biggest problems is what to do with the orphans left behind by parents who die from the disease. There may be as many as 500,000 children in Zimbabwe who have lost one or both parents because of AIDS.

BODY:

BOB EDWARDS, HOST: This is NPR's MORNING EDITION. I'm Bob Edwards.

In most parts of the world AIDS has struck hardest in urban areas. It has followed roads into suburbs and small towns, but usually has not taken hold.

The situation is different in Zimbabwe, a mainly agricultural country with one of the best highway systems in Africa, a highly mobile population, and one of the highest rates of HIV infection in the world.

NPR's Brenda Wilson reports that farms in Zimbabwe are beginning to reap the bitter harvest of AIDS.

BRENDA WILSON, NPR REPORTER: Manera (ph) Farm is a 3,000-acre spread in Northeastern Zimbabwe. Late on a Zimbabwe spring afternoon, children at Manera are playing in the workers' dusty compound.

SOUNDBITE OF CHILDREN PLAYING

The farm supports about 400 people, 150 workers and their families. The owner, Ben Gilpin (ph), pays the wages, which in his own words are about average. But he also provides housing for his workers and the compound's necessities --

water from a central pump, electricity for some, and basic health care.

At the compound's new two-room schoolhouse, the yard has been swept clean and the day's lesson is well underway.

TEACHER AT MANERA FARM SCHOOL: OK, what is the man doing? The man needs a plow. Yes, Jesse?

STUDENT: (Unintelligible)

TEACHER: Yes, he is plowing. Say it together: plowing.

STUDENTS: Plowing.

TEACHER: Plowing.

STUDENTS: Plowing.

WILSON: The farm seems like a self-contained world, but Manera is no more immune than the rest of Zimbabwe to a creeping sense that something has gone terribly wrong. Like the rest of Zimbabwe, it has been hit by what some are calling the worst AIDS epidemic in the world. It's a byproduct of people traveling between towns and villages and from country to country. No area is untouched by the virus. In this region, Mashonaland East, it's estimated that one in every five persons is infected with HIV.

Four years ago, Gilpin says, workers and their families started dying. A cemetery on the edge of a clearing that for the longest time had five graves now has markers for 30.

BEN GILPIN, OWNER, MANERA FARM, ZIMBABWE: We've got in the cemetery over there, we've got several kids who have died in the last few years as babies who haven't made it. Whereas preschool enrollment was 25 children, now we're getting down 15, 16. We'll find it difficult in the next few years to actually sustain this class.

WILSON: Gilpin reckons that a third of the adults on the farm are infected with HIV, even though few of the workers have been tested. But Gilpin's wife is a doctor who has treated many of the workers and they both recognize the symptoms. Inside a round red-brick hut with a thatched roof, a woman cradles a two-month-old baby.

SOUNDBITE OF WOMAN TALKING TO BABY

Is it he or she?

SOUNDBITE OF GILPIN TALKING TO WOMAN IN ZIMBABWEAN DIALECT

GILPIN: A little girl.

WILSON: The baby, named Normata, is the daughter of one of Gilpin's tractor drivers who appeared at his door one day with the baby strapped to his back.

GILPIN: The wife gave birth to this baby and died very shortly afterwards. And he was left looking after the baby, unable to cope. And he's taken on a new

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wife who is now looking after the baby.

WILSON: Gilpin says he tried to explain to the father that he may be infected, but contagion and the idea of a disease like AIDS that lies dormant, only to manifest itself years later, can be disbelieved.

GILPIN: We've had people who we've counseled against having other children who have gone ahead and had more children and while they've lost two babies, the third baby's alive and healthy. Life carries on. And the practical need for this man is that he needs a care giver for the baby.

WILSON: But that means in all likelihood the third wife is being exposed to the virus. The baby, Normata, could end up being orphaned a second time.

There already are orphans living on the farm. Monica Rice (ph), a health worker employed by Gilpin, says that four years ago, four young children, the oldest about 10 years old, were found living in the compound alone.

MONICA RICE, HEALTH WORKER, MANERA FARM: In 1993, Mr. Gilpin asked all the people in this compound who want to help these children (unintelligible) to want to stay with them. And I tell my husband, my husband, he said: yes, we can do it.

WILSON: There are almost no orphanages and adoption is rare in Zimbabwe where the extended family usually assumes such responsibilities. But many families have been dispersed by constant movement and adoption seldom occurs across cultures.

In Zimbabwe, the Shona (ph) people make up the majority of the population. They believe that the spirits of Ingozi (ph), the ghost of the dead, accompany and protect their descendants, often seeking retribution for injustices that were suffered in life.

So the Gilpins came up with a solution: children who lose their parents and have no relatives belong to the community. In this case, the Gilpins pay for food and school fees; Rice and her husband have the main responsibility for the children.

RICE: I told him (unintelligible) hoping somebody could help us when we keep these children.

WILSON: It's estimated that there may be as many as 500,000 children in Zimbabwe who have lost one or both parents because of AIDS. There are at least a million children living with their families on commercial farms, so much of the problem finds its way to the farmer's doorstep.

Gilpin's wife Sue Perry (ph) has joined a movement in Zimbabwe that is trying to head off a crisis of children orphaned by AIDS that is expected to get worse. She's organizing the Farm Orphans Support Trust.

SUE PERRY, ZIMBABWEAN DOCTOR; ORGANIZER, FARM ORPHANS SUPPORT TRUST: Where are we going to put all these children? If only 10 percent of those children require care, require to be put in an institute, it would mean that Zimbabwe would have to build, if you put 50 children per institute, a hundred institutes per month for the next year just to absorb 10 percent of that. And the next

year it's going up and the next year it's going up.

WILSON: Perry tells a group of commercial farmers that with their financial support and government assistance more workers like Rice can be encouraged to care for young orphans and to supervise older children who may be able to manage on their own. Sue Perry tells them that it is not only the humane thing to do, it is in the farmers' self-interest.

PERRY: Look at your farms and look at who are the people you depend on most on your farms apart from yourself. Your foreman. Your senior tobacco grower. Your mechanic. Understudy all those key people, preparing against that certainly finding yourself in a situation where your mechanic is no longer there and nobody knows where the keys are. WILSON: On Manera, Ben Gilpin's assistant Isaac Kuroda (ph) has already seen how AIDS can eat away at the routine of simply getting the crops into the ground.

ISAAC KURODA, BEN GILPIN'S ASSISTANT ON MANERA FARM: I can see people dying in the hospitals, at the roadside. This one reportedly was ill, he's not feeling well. He reported the case today and he's going to the clinic. He comes back, started to work again, and he was putting his maximum effort on work, but nowadays he's exhausted. And so a few months later (unintelligible) he has passed away.

WILSON: Life at Manera goes on. Ben Gilpin says he wants to improve living conditions for the workers. New lodging is going up. A center is in the works for the elderly who are now tending the children of the children they outlived.

SOUNDBITE OF THEATRICAL PERFORMANCE

Late one evening, Gilpin brought in a troupe of players whose dramas impart timely messages about AIDS. Instead, this night they poke fun at pompous officials and a foolish worker whose wages are stolen while he's getting drunk -- injecting a note of levity into a place where some shadows go unnoticed, even in the light of a full moon.

SOUNDBITE OF AUDIENCE LAUGHING

Brenda Wilson, NPR News, in Mashonaland East, Zimbabwe.

EDWARDS: That story produced by NPR's Deborah George.

This is a rush transcript. This copy may not be in its final form and may be updated.

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Report on the global HIV/AIDS epidemic - June 1998

	Population 1997		Estimated number of people living with HIV/AIDS, end 1997					Estimated AIDS deaths		Orphans
Country	Total (thousands)	Adults 15-49 (thousands)	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)	Adults and children 1997	Adults and children cumulative	Orphans cumulative
Western Europe	400,181	201,131	480,000	480,000	0.23	100,000	5,000	15,000	190,000	8,700
Albania	3,422	1,815	<100	<100	0.01	...	...	...	<100d	...
Austria	8,161	4,203	7,500	7,500	0.18	1,400	<100	...	1,500d	...
Belgium	10,188	5,091	7,500	7,200	0.14	2,600	300	...	1,700d	...
Denmark	5,248	2,604	3,100	3,100	0.12	770	<100	...	1,800d	...
Finland	5,142	2,560	500	500	0.02	100	...	...	210d	...
France	58,542	29,347	110,000	110,000	0.37	...	1,500	...	35,000d	...
Germany	82,190	41,035	35,000	35,000	0.08	6,800	500	...	13,000d	...
Greece	10,522	5,222	7,500	7,500	0.14	...	...	...	1,300d	...
Iceland	274	142	200	200	0.14	...	...	...	<100d	...
Ireland	3,559	1,855	1,700	1,700	0.09	...	...	...	360d	...
Italy	57,241	28,939	90,000	90,000	0.31	27,000	500	...	31,000d	...
Luxembourg	417	215	300	300	0.14	<100	...	...	<100d	...
Malta	371	189	200	200	0.11	...	...	...	<100d	...
Netherlands	15,661	8,189	14,000	14,000	0.17	...	...	...	4,700d	...
Norway	4,364	2,172	1,300	1,300	0.06	...	<100	...	500d	...
Portugal	9,802	4,993	35,000	35,000	0.69	6,800	500	...	3,900d	...
Slovenia	1,922	1,004	<100	<100	0.01	...	...	...	<100d	...
Spain	39,717	20,893	120,000	120,000	0.57	25,000	...	...	33,000d	...
Sweden	8,844	4,127	3,000	3,000	0.07	730	<100	...	990d	...
Switzerland	7,276	3,722	12,000	12,000	0.32	4,100	<100	...	5,100d	...
TFYR Macedonia	2,190	1,171	<100	<100	0.01	...	...	...	<100d	...
United Kingdom	58,200	28,223	25,000	25,000	0.09	...	...	...	13,000d	...
Yugoslavia	10,350	5,235	...	5,000*	0.10*	...	...	...	...	...
North Africa & Middle East	322,211	164,259	210,000	200,000	0.13	40,000	7,000	13,000	42,000	14,000
Algeria	29,473	15,197	...	11,000*	0.07*	...	...	...	...	...
Bahrain	582	344	...	500*	0.15*	...	...	...	...	...
Cyprus	766	382	...	1,000*	0.26*	...	...	...	...	...
Egypt	64,465	32,675	...	8,100	0.03	850	110	930	5,400	750
Iraq	21,177	10,154	...	300*	<0.005*	...	...	...	...	...
Israel	5,781	2,933	...	2,100*	0.07*	...	...	...	...	...
Jordan	5,774	2,746	...	660*	0.02*	...	...	...	...	...
Kuwait	1,731	938	...	1,100*	0.12*	...	...	...	...	...
Lebanon	3,144	1,646	...	1,500*	0.09*	...	...	...	...	...
Libyan Arab Jamahiriya	5,784	2,600	...	1,400*	0.05*	...	...	...	...	...
Morocco	27,518	14,583	...	5,000*	0.03*	...	...	...	...	...
Oman	2,401	1,051	...	1,200*	0.11*	...	...	...	...	...
Qatar	569	341	...	300*	0.09*	...	...	...	...	...
Saudi Arabia	19,494	9,535	...	1,100*	0.01*	...	...	...	...	...
Sudan	27,899	13,787	...	140,000*	0.99*	...	...	...	...	...
Syrian Arab Republic	14,951	7,181	...	800*	0.01*	...	...	...	...	...
Tunisia	9,326	5,001	...	2,200*	0.04*	...	...	...	...	...
Turkey	62,774	34,593	...	2,000	0.01	...	...	...	...	...
United Arab Emirates	2,308	1,329	...	2,400*	0.18*	...	...	...	...	...
Yemen	16,294	7,243	...	900*	0.01*	...	...	...	...	...
sub-Saharan Africa	593,027	268,439	21,000,000	20,000,000	7.41	9,900,000	960,000	1,800,000	9,600,000	7,800,000
Angola	11,569	4,955	110,000	100,000	2.12	52,000	5,200	7,200	25,000	19,000
Benin	5,720	2,503	54,000	52,000	2.06	26,000	2,400	3,900	15,000	11,000
Botswana	1,518	743	190,000	190,000	25.10	93,000	7,300	15,000	43,000	28,000
Burkina Faso	11,087	4,843	370,000	350,000	7.17	170,000	22,000	42,000	250,000	200,000
Burundi	6,398	2,914	260,000	240,000	8.30	120,000	15,000	30,000	200,000	160,000
Cameroon	13,937	6,306	320,000	310,000	4.89	150,000	13,000	24,000	100,000	74,000
Central African Republic	3,416	1,582	180,000	170,000	10.77	85,000	7,300	17,000	92,000	65,000
Chad	6,702	3,051	87,000	83,000	2.72	42,000	4,200	10,000	70,000	55,000
Comoros	651	296	...	400*	0.14*	...	...	...	...	...
Congo	2,745	1,219	100,000	95,000	7.78	47,000	5,300	11,000	80,000	64,000
Côte d'Ivoire	14,300	6,611	700,000	670,000	10.06	330,000	32,000	72,000	420,000	320,000
Democratic Republic of Congo	48,040	20,774	950,000	900,000	4.35	450,000	49,000	93,000	470,000	410,000
Djibouti	634	306	33,000	32,000	10.30	16,000	1,300	2,200	7,000	3,900
Equatorial Guinea	420	188	2,400	2,300	1.21	1,100	120	280	2,000	1,600
Eritrea	3,409	1,559	...	49,000*	3.17*	...	...	...	...	...

Annex. HIV/AIDS estimates and indicators, end 1997

Country	Population 1997		Estimated number of people living with HIV/AIDS, end 1997					Estimated AIDS deaths		Orphans
	Total (thousands)	Adults 15-49 (thousands)	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)	Adults and children 1997	Adults and children cumulative	Orphans cumulative
Ethiopia	60,148	26,447	2,600,000	2,500,000	9.31	1,200,000	140,000	250,000	1,000,000	840,000
Gabon	1,138	512	23,000	22,000	4.25	11,000	800	1,700	7,100	4,800
Gambia	1,169	559	13,000	13,000	2.24	6,300	620	1,500	11,000	8,400
Ghana	18,338	8,418	210,000	200,000	2.38	100,000	10,000	24,000	170,000	130,000
Guinea	7,614	3,357	74,000	70,000	2.09	35,000	3,600	5,700	23,000	18,000
Guinea-Bissau	1,112	503	12,000	11,000	2.25	5,700	420	580	1,600	990
Kenya	28,414	13,381	1,600,000	1,600,000	11.64	780,000	66,000	140,000	600,000	440,000
Lesotho	2,131	985	85,000	82,000	8.35	41,000	3,100	5,200	15,000	9,500
Liberia	2,467	1,152	44,000	42,000	3.65	21,000	2,300	4,600	24,000	21,000
Madagascar	15,845	7,121	8,600	8,200	0.12	4,100	370	600	1,900	1,300
Malawi	10,086	4,474	710,000	670,000	14.92	330,000	42,000	80,000	450,000	360,000
Mali	11,480	5,057	89,000	84,000	1.67	42,000	4,800	8,300	40,000	33,000
Mauritania	2,392	1,135	6,100	5,900	0.52	2,900	250	480	1,900	1,400
Mauritius	1,141	649	...	500*	0.08*	...	...	...	...	...
Mozambique	18,265	8,178	1,200,000	1,200,000	14.17	580,000	54,000	83,000	250,000	170,000
Namibia	1,613	752	150,000	150,000	19.94	75,000	5,000	6,400	14,000	7,800
Niger	9,788	4,216	65,000	61,000	1.45	31,000	3,500	5,800	25,000	20,000
Nigeria	118,369	53,188	2,300,000	2,200,000	4.12	1,100,000	99,000	150,000	530,000	410,000
Reunion	664	365	...	160*	0.04*	...	...	...	...	...
Rwanda	5,883	2,710	370,000	350,000	12.75	170,000	22,000	36,000	170,000	120,000
Senegal	8,762	4,042	75,000	72,000	1.77	36,000	3,800	...	...	49,000
Sierra Leone	4,428	2,025	68,000	64,000	3.17	32,000	3,700	8,400	54,000	47,000
Somalia	10,217	4,454	...	11,000*	0.25*	...	...	...	...	...
South Africa	43,336	21,717	2,900,000	2,800,000	12.91	1,400,000	80,000	140,000	360,000	200,000
Swaziland	906	439	84,000	81,000	18.50	41,000	2,800	5,000	14,000	8,000
Togo	4,317	1,915	170,000	160,000	8.52	82,000	9,600	20,000	130,000	110,000
Uganda	20,791	9,099	930,000	870,000	9.51	430,000	67,000	160,000	1,800,000	1,700,000
United Rep. of Tanzania	31,507	14,347	1,400,000	1,400,000	9.42	680,000	68,000	150,000	940,000	730,000
Zambia	8,478	3,832	770,000	730,000	19.07	370,000	41,000	97,000	590,000	470,000
Zimbabwe	11,682	5,560	1,500,000	1,400,000	25.84	720,000	57,000	130,000	590,000	450,000
South & South-East Asia	1,859,821	954,510	5,800,000	5,700,000	0.61	1,500,000	81,000	250,000	730,000	200,000
Afghanistan	22,132	10,777	...	<100*	<0.005*	...	...	...	...	...
Bangladesh	122,013	61,360	21,000	21,000	0.03	3,100	270	1,300	4,200	810
Bhutan	1,862	860	...	<100*	<0.005*	...	...	...	...	...
Brunei Darussalam	307	173	...	300*	0.2*	...	...	...	...	...
Cambodia	10,516	4,994	130,000	120,000	2.40	60,000	5,400	6,300	15,000	7,300
India	960,178	494,756	4,100,000	4,100,000	0.82	1,000,000	48,000	140,000	350,000	120,000
Indonesia	203,480	109,979	52,000	51,000	0.05	13,000	960	1,600	3,900	1,000
Iran (Islamic Republic of)	71,518	32,664	...	1,000*	<0.005*	...	...	...	...	...
Lao People's Dem. Rep.	5,194	2,324	1,100	1,000	0.04	520	<100	<100	210	150
Malaysia	21,018	10,624	68,000	66,000	0.62	13,000	1,400	2,300	5,700	1,500
Maldives	273	120	...	<100*	0.05*	...	...	...	...	...
Myanmar	46,765	24,361	440,000	440,000	1.79	92,000	7,100	29,000	86,000	14,000
Nepal	22,591	10,404	26,000	25,000	0.24	10,000	580	840	1,700	750
Pakistan	143,831	68,870	64,000	62,000	0.09	12,000	1,800	4,500	15,000	5,000
Philippines	70,724	36,034	24,000	23,000	0.06	7,000	620	630	1,300	480
Singapore	3,439	2,030	3,100	3,100	0.15	610	<100	<100	<500	<100
Sri Lanka	18,273	10,025	6,900	6,700	0.07	2,000	190	400	1,700	450
Thailand	59,159	34,433	780,000	770,000	2.23	290,000	14,000	60,000	230,000	48,000
Viet Nam	76,548	39,722	88,000	86,000	0.22	17,000	1,100	2,700	7,200	1,900
Eastern Europe & Central Asia	373,424	193,385	190,000	180,000	0.09	38,000	4,700	<1000	5,400	<100
Armenia	3,642	1,951	<100	<100	0.01	...	...	...	...	...
Azerbaijan	7,655	4,054	<100	<100	<0.005	...	...	...	<100d	...
Belarus	10,339	5,262	9,000	9,000	0.17	...	...	...	<100d	...
Bosnia and Herzegovina	3,784	2,122	...	750*	0.04*	...	...	...	...	...
Bulgaria	8,427	4,157	...	300*	0.01*	...	...	...	...	...
Croatia	4,493	2,262	...	300*	0.01*	...	...	...	<100d	...
Czech Republic	10,237	5,371	2,000	2,000	0.04	...	...	...	<200d	...
Estonia	1,455	733	<100	<100	0.01	...	...	...	<100d	...
Georgia	5,434	2,726	<100	<100	<0.005	...	...	...	<100d	...
Hungary	9,990	5,102	2,000	2,000	0.04	...	...	...	200d	...

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June 24, 1998

Parts of Africa Showing H.I.V. in 1 in 4 Adults



By LAWRENCE K. ALTMAN

GENEVA -- In certain areas of Africa, one in four adults is infected with the virus that causes AIDS, and around the world the disease now rivals the greatest epidemics of history, according to a United Nations report issued today.

In the first country-by-country analysis of the disease, the United Nations said that last year 30 million people worldwide were infected with HIV, the AIDS virus, and that 21 million were in Africa.

Countries south of the Sahara account for the world's 21 highest rates of HIV among adults aged 15 to 49 years, the most sexually active segment of the population. In 13 of those countries, HIV has infected at least 10 percent of adults, and in Botswana and Zimbabwe, a quarter of adults are infected, a rate that even an expert described as "shocking."

The report, released ahead of the 12th international AIDS conference that begins here on Sunday, paints the gloomiest pictures of the HIV epidemic since it was first recognized in 1981.

AIDS is hitting Africa so fiercely that it now rivals the great epidemics of history -- the Black Death of the Middle Ages that killed 20 million people, or one-quarter of Europe's population, in four years and the influenza pandemic of 1918-1919 that killed 20 million people, including half a million Americans.

But where plague and influenza killed in days, death from untreated AIDS

takes about a decade, making it a more silent epidemic that officials have too easily ignored, AIDS officials noted.

"If HIV killed as rapidly as plague and influenza, the epidemic would be controlled by now," Dr. Peter Piot, the head of the U.N. AIDS Program, said in an interview.

The report contained a glimmer of good news, showing a slowing of infection rates in countries that have adopted strong prevention programs, like Senegal, Tanzania, Thailand and Uganda.

But Piot and other officials warned that South Africa, Namibia and other African countries could soon reach a 25 percent adult infection rate unless national leaders undertook similar programs.

Infection rates exceed one in three adults in some major African cities and reach 70 percent of women tested in some prenatal clinics. Many infected women pass the virus on to their babies.

The overwhelming majority of the Africans are doomed to die from AIDS, the officials said, because they live in countries that cannot afford the costly combinations of drugs that have helped keep the virus in check among infected people in developed countries.

The African figures compare to a worldwide adult HIV-infection rate of 1 percent for adults and 0.76 percent in the United States. Moreover, officials said, 90 percent of the African patients probably do not know they are infected because testing is not widely available.

Worldwide last year, 5.6 million people were newly infected while 2.3 million died from AIDS. AIDS is now on the verge of moving into the top five leading causes of death in the world, overtaking diarrheal diseases. The viral infection now kills as many people as malaria and is second only to tuberculosis, which itself is a common complication of AIDS and a source of infection to non-HIV-infected individuals.

Piot, a Belgian who has worked with AIDS in third world countries for more than 15 years, called the new HIV figures staggering and said he was "shocked" when he learned that 25 percent of an entire country's adults were infected. At first, both Piot and Dr. Bernhard Schwartlander, the U.N. epidemiologist who led the analysis, said they suspected a statistical error.

But checking found them accurate and erring on the side of underestimates, they said. It took the U.N. AIDS program more than a year to gather and verify the figures with each country, and the figures on AIDS are considered the most reliable of any international health statistics, Piot said. Health officials have been hampered since AIDS was first recognized in 1981 in getting a handle on such information because of the notoriously poor quality of health statistics in most of the world.

The U.N. researchers obtained data from published material, surveys conducted in clinics and health department data. Among the methods used was computer modeling, using census data and infection rates, to verify trends reported by the countries.

Piot said the epidemic could eventually be controlled if other countries matched successful prevention programs in Africa.

Uganda was the first country to respond to a massive burden of HIV infection, and the African country has cut HIV prevalence more than a quarter, to 9.5 percent in 1997 from 13 percent in 1994.

Thailand, which has experienced what the U.N. said was probably the best documented epidemic in the developing world, has cut its prevalence by nearly 15 percent -- to 2.3 percent in 1997 from 2.7 percent in 1994. A drop in new infections was noted especially among sex workers and their clients.

"Even in the industrialized world, reductions of this magnitude are virtually unheard of," Piot said.

Senegal instituted campaigns for safer sex that has kept its infection rate at about 2 percent. "Senegal acted before it had a major problem, but there are not enough of those countries," Piot said.

However, more than money will be needed to match such efforts elsewhere, Piot said. "The overriding need is political courage -- deciding to move ahead with effective approaches despite cultural constraints such as promotion of condom use, sex education in schools and widespread health education programs," Piot said.

As HIV is spread, it insinuates itself into communities little troubled in the past and strengthens its grip on areas where AIDS is already the leading cause of death.

In Botswana, the infection rate has more than doubled to 25.1 percent in 1997 from 10 percent in 1992. Surveys have found 43 percent of pregnant women infected in 1997 in the major urban center of Francistown. In 1995 in Harare, the capital of Zimbabwe, 32 percent of pregnant women were infected.

In one town on the Zimbabwe-South African border, 70 percent of women attending prenatal clinics in 1995 were found to be infected.

HIV rates are lower in Asia, Eastern Europe and South America. But an alarming trend is the doubling and tripling of transmission rates in some countries in these areas since 1994. "Because over half the world's population lives in the region, small differences in rates can make a huge difference in the absolute numbers of people infected," the U. N. report said.

In expressing alarm about the widening gap in infection and death rates between industrialized and developing countries, Piot said the gap "shines the spotlight on the have-nots of the epidemic."

The U.N. group attributed the gap to inadequate measures to stop transmission of HIV and to make available the combinations of anti-HIV drugs that help forestall development of deadly AIDS-related infections and cancers.

Last year, deaths from HIV left 1.6 million children without at least one parent. From the time the epidemic was first recognized in 1981 to the beginning of 1998, 8.2 million children lost their mothers to AIDS. Many also lost their fathers as well. In East Africa, 40 percent of children 15 or younger have lost their mother or both parents.

"As the number of orphans grows and the number of potential caregivers shrinks, traditional coping mechanisms stretch to the breaking point," the report said.

The U.N. AIDS program cited four reasons why the infection rates are so high in Africa.

One is that more women of childbearing age are HIV infected in Africa than elsewhere. A second is that African women have more children on average than those in other continents. Thus, one infected woman may pass the virus on to a higher average number of children.

A third reason is that nearly all children in Africa are breastfed, which is thought to account for between a third and a half of all HIV transmission from mother to child.

A fourth reason is that new drugs are less readily available than in industrialized world. Also, other sexually transmitted diseases are known to speed transmission of AIDS and may go untreated in poor countries.

The U.N. said it saw early warning signs that epidemics of similar magnitude could occur among Asian countries, where HIV has been a relative latecomer. However, the report said the figures for Asia are less reliable than elsewhere because only a few Asian countries have developed sophisticated systems for monitoring the spread of the virus.

India has the largest number of HIV-infected people -- 4 million -- in the world.

One survey in Pondicherry found four percent of pregnant women infected. The prevalence of infection among truck drivers in Madras quadrupled to 6.2 percent in 1996 from 1.5 percent in 1995. In Manipure state, 73 percent of the patients in a clinic for injecting drug users were infected in 1996.

Although HIV has infected less than 1 percent of adults in India, the figure is 10 times higher than in neighboring China.

Two major epidemics are occurring in China, the U.N. said. One is among injecting drug users. The other is among heterosexuals in the prosperous eastern seaboard where prostitution is re-emerging as the gap grows between rich and poor. The incidence of sexually transmitted diseases has soared in recent years. Health officials regard the trend in sexually transmitted diseases as a warning sign of HIV rates because sexually transmitted diseases can enhance its spread.

The U.N. report also includes the first country-by-country information about the availability and use of condoms. But on condom use, the report's tables contain many blanks -- purposeful by challenging national leaders to take tougher stands on controlling HIV infection, Piot said.

With a vaccine against HIV a distant hope, Piot said that "AIDS is with us to stay for a long time."

Other Places of Interest on The Web

- [Official Webcast of the World AIDS Conference.](#)
 - [ASD Online, the World Health Organization's Office of HIV/AIDS and Sexually Transmitted Diseases.](#)
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September 18, 1998

In Zambia, the Abandoned Generation



Dead Zones Series

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- [Zimbabwe's Descent Into AIDS Abyss: Little Hope, Much Despair](#) (Aug. 6)

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By SUZANNE DALEY

LUSAKA, Zambia -- It was only two weeks after their mother died from AIDS that their aunt took them to the bus station. She said she did not want to take care of them anymore. She told them to go to Lusaka, find a police station and ask for an orphanage.

The children, Calvin Katoya and Jackson Kabaso, who would like to be soccer stars someday, did as they were told, riding the bus an hour from the small town of Kabwe, then asking strangers where to go. But the police could not help them. As the days went by, the boys, 12 and 15, slept in the rusting, abandoned cars nearby. They had no money or food.

DEAD ZONES
Children of the
Plague

Edith and Khuzini Banda lived with their aunt for about year after their mother died in 1994. But then the aunt said her home was too crowded. She sent the girls -- then only 13 and 14 -- to live alone in their mother's house. The girls make do by renting out half the two-room house for \$15 a month, and begging from the neighbors when food runs out.

Swept Aside by an

The two keep their cinder-block room tidy, decorated with magazine layouts of models

Epidemic

The number of children who have become **orphans** as a result of **AIDS** since the beginning of the epidemic.

Country 

Number of Orphans:
Children under 15 who have lost their mother or both parents to **AIDS** between 1970 and 1997.

Map: Orphaned by AIDS

Source: UNAIDS, "Report on the Global H.I.V./AIDS Epidemic"

and Hollywood stars. They hope the headmaster will be lenient about their school fees, which are eight months over due.

Sometimes, said Edith Banda, she is jealous of those who still have parents. "It would be nice to have someone who cares about us," she said.

The **AIDS** epidemic has been raging in Zambia for nearly two decades, and as the deaths pile up, so do the orphaned children. It is much the same in many other parts of Africa. In rural areas of East Africa, four of every 10 children who have lost one parent by age 15 have lost that parent to **AIDS**, according to U.N. figures. In 1997 alone, the disease orphaned 1.7 million children, more than 90 percent of them in Africa south of the Sahara.

But it is Zambia, a landlocked county in southern Africa that has never embraced birth control, that has the highest proportion of orphaned children in the world, according

to the United Nations. Here, an estimated 23 percent of all children under 15 are missing one or both parents, many of them dead from **AIDS**, and the numbers are expected to keep rising.

For now, most of the children have been absorbed into extended families. Almost 75 percent of all households are taking care of at least one orphan. But in this country, where half of all households are living in extreme poverty, the strain of caring for extra children is beginning to take its toll. Many children are being squeezed out. In 1991 Lusaka had 35,000 children living on the street. Today there are more than 90,000.

Zambian officials believe the number of adults infected with HIV, the virus that causes **AIDS**, will not decline before 2010, which means that the orphan population will not peak until 2020. Recent U.N. reports estimate that there are now nearly half a million orphaned by the disease in Zambia. That number is expected at least to double in the coming decade, further straining the country's meager resources.

The Orphans: Even Within Families, Many Are Outcasts

Experts say that already the **orphans** are suffering. When there is not enough to eat, **orphans** often get less than the other children in the household. They are also often the last to get shoes and the last to go to school. In the rural areas, girls are being married off at 12 or 13, far younger than the usual age of 18. The reason: the family no longer has to feed the girl and, in keeping with local custom, can claim a bride price.

Advocates for the children say the **orphans** are more likely to be forced to work long hours, to suffer from beatings and to experience sexual abuse.

"When you start talking about the rising number of **orphans**, you are quickly talking about a rise in all these related issues -- child labor, child abuse and sexual abuse," said Stephan Dahlgren, a project officer with Unicef based in Zambia. "The more vulnerable children you have, the more the problems escalate."

Despite the huge number of people infected with HIV in Zambia, there is little planning for death. Most people are never tested for **AIDS** and would not admit to it even if they did find out they are infected. Only among the educated elite is this beginning to change.

The Shelters: Help for Children Hardened by Life

Zambian health authorities believe that the prevalence of HIV here will peak this year because recent surveys report significant behavioral changes. But even that seems like bitter news: The infection rate in urban areas is expected to plateau at 28 percent. In rural areas, experts calculate, it will be 22 percent, giving Zambia one of the world's highest infection rates.

As is the case elsewhere in Africa, the vast majority of infected Zambians are between 15 and 40, meaning that they are dying when they should be in their most productive years. This, combined with wide-scale layoffs as the government tries to retool a socialist economy by selling off state-owned businesses, has made it all the more difficult for families to absorb the growing number of **orphans**. Children, orphaned or not, have hard lives in Zambia. Nearly half are stunted from a lack of food, about 20 percent severely so.

"Everybody knows about **AIDS**," Dahlgren said. "If you go into a small village and ask a chief about **AIDS**, he knows all about it. But when it comes down to 'What is this disease that so and so died from?' then it's tuberculosis or malaria."

Many **orphans** are losing both their parents and all their inheritance at the same time. Relatives quickly swoop in and grab property, be it cooking pots or farm land, and the children have little to say about it. In theory, they could appeal to the courts, but few Zambians have the wherewithal and the money to do so.

Florence and Veronica Phiri once lived comfortably with their parents in the modest house they owned. Their father was an electrician. But in 1994 both parents died within months of each other. The girls were 8 and 6.

Within weeks, their father's family took over the house and sent the girls to live with an aunt in a rural village. There, the girls said, they were beaten

and had to work long hours fetching water and collecting wood.

Two years later, their mother's relatives intervened and brought the girls back to Lusaka to live with their maternal grandmother, who sells vegetables in the market. Florence and Veronica and four cousins who are also **orphans** spend most days playing in the dusty streets in front of their grandmother's dilapidated house.

Florence and Veronica have nothing that ever belonged to their parents and do not expect they ever will. At her grandmother's, Florence said, some days there is no food.

But she is still glad to be there. "It is much better than before," she said, shyly adjusting her ragged clothes.

This year a community group donated money for her school fees, a school uniform and shoes. But Veronica will have to wait; there was not enough money for her.

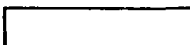
Elsewhere in this city, as the sun sets, casting shadows over the modern government-sponsored high rises, entire families settle in for the night on the sidewalks. Scattered among them are the ragged street children, many of whom make money as prostitutes and look for any means to get high.

The Hard Numbers

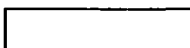
In countries across Africa, tuberculosis, hepatitis, malaria, measles and cholera -- all wholly preventable -- have surged mercilessly.

Country 

AIDS: Percentage of adult population infected with H.I.V.



Tuberculosis: Number of tuberculosis cases per 10,000 residents.



Malaria: Number of

Workers at the Fountain of Hope, a nonprofit organization that works with the street children, say the children have even found a way of getting a powerful high from fermented human feces, a substance known as jekem.

In the daylight, many idle the hours away kicking a soccer ball around outside the Fountain of Hope headquarters. The organization is trying to offer them a special four-year education program that will ready them for school exams. But the street children here are like street children everywhere -- hardened and focused on immediate survival.

The stories the children tell of fear, rejection and loneliness are numbingly similar. Simon Phiri, who is 14 but looks about 10, can not even remember when his parents died. Slumped in a chair, he peels the dirt from his palms as he talks sullenly about his short life. For a while, he said, he stayed with his mother's best friend. But after a while, he left.

malaria cases per 10,000 residents.

"They were always insulting me," he said.
"They always ate when I went out and never saved me anything."

A Continental Crisis

Cases of malaria, tuberculosis and other diseases have surged across Africa as national health systems have become overwhelmed.

He said he has spent many nights sleeping in the aisles of the local market place. But now he sleeps on the floor of a friend's older brother's house. He must get his own food, though, and he has no money for soap. He earns money doing odd jobs in the market, he said. The counselors said that he has a sexually transmitted disease. Nearly half the boys do.

Disease

Source: W.H.O.

Simon has not been to school in at least four years, though he hopes to be an accountant when he grows up. "I would like to work in an office," he said, suddenly brightening.

Finding homes for the street children is not really a possibility, say center employees. There are only a handful of very small orphanages in Zambia, including the Kabwata Orphanage, where Calvin and Jackson ended up after three days without food. Eventually the police contacted Lorraine Miyanda, who runs the place, and she bent the rules to admit the boys. Usually the orphanage will not take children over the age of 10.

But Ms. Miyanda said she has little hope that anyone will ever take the boys into a new home. In many African countries there is little tradition of taking in children who are not blood relatives and formal adoption is extremely rare. Child advocates say that this may be a particular problem in the future because of the way AIDS tends to devastate whole families, particularly in villages.

"The extended family in Africa is far better than in the West about taking in relatives.," said Mark Loudon, a South African who is writing a book on AIDS orphans. "There is no formality about taking care of cousins. They slip right into saying 'Mom.' In Africa you have 30 Moms. The problem is that AIDS doesn't usually take just one woman in a family; it tends to take all the wives of the brothers because the brothers tend to behave similarly."

The Caring Adults: Grandmothers Help, but When They Go ...

In the last few years, dozens of fledgling organizations have sprung up in Zambia to try to help the children. But there is virtually no government money available and many of the organizations are staffed only by volunteers.

"It's not that the government is unsympathetic," said Louis Mwewa, the coordinator of Children in Need, an umbrella organization that tried to

represent the groups. "But we are a poor country and they do not have money."

In Matero, one of Lusaka's poorer neighborhoods, where small houses with tin roofs stretch for miles, overwhelmed grandmothers and households that are a collection of siblings living on their own are easy to find. In one house, Brenda Tembo, 52, cares for 14 of her grandchildren.

On a recent afternoon, no one in her household had eaten yet: there was no food in the house. Mrs. Tembo was waiting for someone to buy tomatoes from her vegetable stand before buying corn meal, which would feed more of them for less. Five children in the household should be in school, but there is no money for tuition.

There is barely enough room for all the children to lie down on the floor at night. The homemade plywood table and the three rickety chairs must be put outside when it is bedtime. "I am not alone like this," she said, pointing across the dirt road at another house. "Right over there, it is the same."

While the grandmothers struggle with the burden of feeding and clothing the children, some child advocates are more worried about those who are growing up in the households run by siblings, where chaos sometimes reigns.

Like the Banda girls, the Zulu siblings survive on the rent they receive from their parents' house in a neighborhood called Kuanda Square. The seven children live in the back in a tumbledown two-room structure. But recently the oldest boy got married and set up his own household, leaving less money for the rest of the children, who range in age from 19 to 11. The 19-year-old is known in the neighborhood as a drinker who regularly beats the younger ones.

On a recent visit, there was no food in the dank-smelling house. Shoes and dirty clothes were strewn about. With the 19-year-old sitting silently nearby, no one complained of any difficulties. All but the youngest appeared to have found some way of making money, from working as a maid to selling sugar cane in the market. But each keeps that money for himself or herself, the children said. The 11-year-old appears to survive on the generosity of the others, but it was clear they expected her to do most of the housework.

"Sometimes the laundry is difficult," the girl admitted, twisting the hem of her skirt nervously.

By 1991 the needs of the **orphans** in the Matero neighborhood had become so apparent that some local women banded together to try to help. They have registered 2,047 **orphans** in the neighborhood and assigned someone to look in on each household and help solve problems that crop up. To raise money for school fees, they make doormats, bake bread, sew and batik fabrics. Six days a week, they also give about 60 of the children a free meal, with the help of the local Catholic church.

So far this year the group, called Kwasha Mukwena, has promised to pay the school fees for 279 children -- fees that range from less than \$10 for the younger children to about \$30 for the oldest. But they have only raised the money to pay fees for 132.

As the lunch hour drew near recently, **orphans** began arriving in the carefully swept church yard. In the back, over an open fire, the women had made a vegetable and peanut stew to be eaten with a corn porridge. The children, in tattered clothing, were painfully obedient. Some, as young as five, carefully carried full plates to the room where even the toddlers ate without spilling a drop.

A dozen children also carried plastic boxes -- a signal to the workers that they were having a particularly hard time. Before eating, these children put half their food in their boxes. Either they knew they would get no supper and were saving for later, or they had been told to bring food home for other children in the household or face punishment.

"It is not that people are so cruel," said Patricia Ngoma, who volunteers with the program. "But they have nothing themselves."

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International

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Aids orphans eat lunch at the Motaru Catholic church where a womans group, Kwasha Mukwena, run a community based program where they feed orphans every day.



Credit: João Silva/Sygma, for The New York Times
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August 6, 1998

Zimbabwe's Descent Into AIDS Abyss: Little Hope, Much Despair

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By MICHAEL SPECTER

T SHOLOTSHO, Zimbabwe -- They loaded Mcdonald Mafu into the donkey cart about 10 minutes after the doctor signed his papers. He had been dead for two days -- one less than he lived -- but it took his mother a while to make it to the district hospital so far from her home.

The whole transaction lasted about two minutes. Dr. Bart Vander Plaetse took a piece of paper with the words "Notice of the Death of a Person" printed on top. He wrote down the dead boy's name and for his age he scribbled in a fraction: 1/52. Since he had no idea of the cause of death, the doctor listed ARI -- acute respiratory infection.

"That's what we say when we can't say something else," Vander Plaetse explained with a sad shrug. "It'll let his mother bury him."

The Hard Numbers

In countries across Africa, tuberculosis, hepatitis, malaria, measles and cholera -- all wholly preventable -- have

The next sounds floating through the doctor's window were the thud of a cow bell and the whack of a whip as two donkeys hauled the body to the burial ground across the road. Macdonald's mother and grandmother sat in the cart with the cardboard box that held their boy. Several women walked behind softly singing funeral

surged mercilessly.

songs.

Country

AIDS: Percentage of adult population infected with H.I.V.

There were no men at the service: McDonald's father died a few months ago. His grandfather died last year. A brother died the year before. And three uncles are also gone.

Tuberculosis: Number of tuberculosis cases per 10,000 residents.

"You almost can't keep track of it all," said Vander Plaetse, a gentle, 32 year-old internist from Belgium, who is one of two doctors serving this rural area of 140,000 people not far from the border of Botswana. "There are just so many sick people," he said. "We want to control it all and we try. But it's getting harder. There are times when it seems like it's getting out from under us."

Malaria: Number of malaria cases per 10,000 residents.

Zimbabwe has suddenly turned into the deadly center of the AIDS epidemic. Recent studies now suggest that it may have the highest infection rate on earth.

A Continental Crisis

Cases of malaria, tuberculosis and other diseases have surged across Africa as national health systems have become overwhelmed.

The optimism of the West is a cruel fantasy in Zimbabwe. There is no treatment, no cure, little hope and -- in almost every country in Africa -- far more pressing problems to face each day.

Disease

Source: W.H.O.

The savage virus has left few people untouched: it has devastated families, communities and cities. But seen through the weary and often bloodshot eyes of the beleaguered doctors and nurses who must attend to the sick people around them, AIDS is just another word for dying -- and it's just

another disease.

People here call it "iyoyo" -- "that thing." And in the spare but spotless clinics of Zimbabwe -- where aspirin is available only a third of the time -- "that thing" may not even be the one that matters most. With an average of less than \$10 to spend on each person's health every year, most African nations have no money for tests, for fancy drugs or for complicated support networks.

Despite the magnitude of the epidemic, the great majority of people in Africa have no idea if they are infected with HIV, the virus that causes AIDS, and most don't want to know.

Zimbabwe, formerly Rhodesia, once had a health system that was the envy of southern Africa. Yet, fueled by AIDS and also by increasing poverty and

instability, illness has begun to overcome the country. Tuberculosis, hepatitis, malaria, measles and cholera -- all wholly preventable -- have surged mercilessly. So have infant mortality, stillbirths and sexually transmitted diseases.

In 1996, during the last heavy rains, this region in the center of Zimbabwe reported 82,000 cases of malaria -- which means that more than half the local population got sick. The hospital here was so overwhelmed by people desperate for help that nurses couldn't even make their way down the teeming halls.

In 1989, 100 people died of malaria in Zimbabwe. Last year the figure was 2,800. Reported cases of tuberculosis -- the sentinel illness of poverty and social decline -- have risen from 5,000 a year in 1986 to 35,000 last year. This year it is worse.

The Hard Numbers

If the effects of it all are sometimes impossible to believe, they are also impossible to ignore: Average life expectancy in Zimbabwe -- often considered the most reliable barometer of a nation's health -- was 61 in 1993. By the end of the century, however, it will fall to 49.

In 10 years, if trends continue, United Nations officials say, it will probably be closer to 40 -- which would push development here -- and in many other sub-Saharan countries -- back nearly a century.

"AIDS is the basic fact of all our lives," said Vander Plaetse, whose work day runs from dawn to dusk and includes dealing with everything from setting bones to major surgery. "But it is not the only fact. And to be honest, it is not a fact we can do that much about.

"It may sound callous," said Vander Plaetse, who seems incapable of any such emotion, "but there may be better ways to spend our time and money than treating a complicated disease we will never have the money or the drugs or the ability to cure."

It is an understandable comment from a man who couldn't send his nurses out in the community in July to give vaccines because the Health Ministry had no money left to buy gas in the car.

"Oh, that's OK," he said softly. "Last year we had no radio contact with any other clinic for two months because we couldn't pay a \$300 phone bill. It's hard to focus on the big picture when that's happening."

It would probably be hard in any case, because numbers like this are almost too great to have meaning: 4 million people were newly infected with the AIDS virus in the countries of sub-Saharan Africa last year alone.

The epidemic has already killed 10 million people in sub-Saharan Africa --

90 percent of the world's AIDS deaths -- and because there is so little hope of access to the best drugs, at least 20 million more will almost certainly die.

In Zimbabwe, doctors and nurses all know the bad news and they all worry about it. They face AIDS -- in one way or another all day, every day: when they see a man with genital herpes, when they draw blood or stick themselves with a needle, when they deliver a baby, when any patient starts to cough, or wheeze or breaks out in a rash.

And particularly when people die -- of fevers and wasting and pneumonia or TB.

Two years ago 500 people died each week in Zimbabwe; last year the figure was 650. Now it's close to 750. They either die after a "short illness," or they die after a "long illness." The newspapers don't print ages in obituaries. They don't have to. The words "loving son," and "remarkable daughter," -- repeated in nearly every other notice -- tell the story clearly enough.

Tsholotsho is a two-hour drive from Bulawayo, the nearest big city. Most patients walk -- sometimes for days across dried river beds and dusty roads -- to get here. The squat brick hospital is a wide open building at the end of the only paved road in the region.

On this day, Vander Plaetse will sweep from one room to the next -- setting bones, operating on an elderly woman with internal bleeding, checking the health of pregnant women, seeing dozens of patients with skin rashes, eye diseases, malaria and tuberculosis. He has a chart for everyone and his nurses are disciplined and extremely well trained.

A woman in a bright red dress, wrapped in a yellow polyester blanket, appears. She is wearing tennis shoes and says she is losing weight, bleeding and having dizzy spells.

He examines her but it's hard to guess her problem.

"Does your neck hurt you?" he asked, after examining her swollen glands. She shrugs.

"Tell her we will give her tablets," Vander Plaetse says to a nurse who helps him negotiate the roughest spots of the Shona language. "We will give her pills to help her retain water. And we will give her some vitamins."

It's not much, but there is not much else he has to offer. The woman might have malaria or pneumonia or diarrhea or TB or dysentery. Or all of them, or AIDS.

She looks at the pills she is handed as if they were pythons. Then she walks out. The next patient is coughing too hard to talk. Vander Plaetse decided to let him sit in the hall for a few moments, until he feels better. He never

came back.

The Harried Clinics

"I t's hard to worry about something that is going to kill you one day when so many other problems are going to kill you tomorrow," said Dr. Ruth Labode, the frank and energetic medical director for the region that includes Tsholotsho and Bulawayo, the industrial city of 900,000 that is the country's second largest city. "Have you ever sat down with a man who is trying to feed his hungry children and had a talk about safe sex? It's not easy."

Dr. Labode has a poster on a wall outside her office that lists the "standard case definition" of bubonic plague. It is not a historical artifact. She talks about leprosy, malaria, diarrhea, TB.

"We have too many hungry people," she concludes. "And of course AIDS makes it all worse."

At this year's international AIDS conference in Geneva there was particularly grim news about Zimbabwe and neighboring Botswana. At least in part because statistics here are better than in many other developing countries, experts say that as many as 25 percent of all adults may now be infected with HIV. In some places -- including tourist crossroads like Victoria Falls -- the rate is closer to 40 percent.

It would be a staggering figure anywhere, but particularly in a country that can afford to spend only \$11 per person each year on health care.

"I don't like to think about AIDS," said Sithozile Nkala, a nurse at the district hospital in Tsholotsho. "It's not because I am afraid or because I think we can run away from it. But the only way I can do my job is to see every patient and try to just help them. If I say to somebody you have AIDS -- and we almost never know because we don't have money for tests -- they just go home."

"That's why I don't think you can write about the effect of AIDS on the health care system," she said. "Most people just stay home to die. And we encourage that because really there is very little we can do here for them except to try and make them comfortable. And people at home can do that better than we can."

Miss Nkala is 28 and she came from a small village more than 200 miles from Tsholotsho. She said that most people don't want to know if they are infected with HIV, and it is common lore among nurses that those who do find out often give up and die much more quickly than if they had lived on in ignorance.

When Miss Nkala is not tending to patients she is folding uniforms, or towels or wrapping sterile instruments in paper. She is unusual because she

has been at the hospital for three years and has no plans to leave.

Burnout has been high here -- in part because treating people who can't be cured is never easy. And in part because since Zimbabwe trains nurses and doctors well but can afford to pay them only a pittance, they can make more money in South Africa when they are done with school, and many of them do.

Like most regional health care centers, the hospital here is down 50 percent of its nurses, and recruiting is hard.

"It's the biggest problem we have," Vander Plaetse said. "Because nurses do nearly everything here. Without them there is no health care."

The Unlikely Optimist

Dr. Bornapate Nkomo hates it when people start talking about "hopeless" Africa. "It's a code," he said. "It means let's forget them. They can't be helped. Let's move on to something else."

Nkomo is in charge of treating sexually transmitted diseases in Bulawayo. He is a careful man who spent seven years in Czechoslovakia (when that country still existed). One year was devoted to language study and the next six were for medical school.

The Khambi Road Clinic is the only sexually transmitted disease center in Bulawayo and Nkomo runs it. Its pale green waiting rooms overflow with people waiting quietly for help.

There is only one doctor and few major drugs, but the clinic is clean, efficient and well lit.

Nkomo can see 130 people a day -- although most days he sees far fewer. Sexually transmitted diseases have long been taken as the best marker for the prevalence of HIV; in addition to being a sign of risky sexual behavior, the diseases themselves often make it far easier to become infected. Last year 70 percent of the patients tested in one clinic in Harare were infected with HIV. No similar study has been conducted here -- but Nkomo assumes the figures can't be much different.

"You have to assume that almost everybody who walks in the door is going to get AIDS," he said. "But you can't dwell on it. Because if you do then you just walk out and go home for good."

He has no intention of doing that. A thin man with a wispy string of beard, he manages to be both an optimist and a realist.

This day he will see a variety of people: a boy with a broken ankle and a woman with a skin rash and a man who has a strange swelling in his feet. One woman comes in with elevated blood pressure -- but Nkomo will be

able to do little for her because there are no drugs available at the moment for her condition.

Zimbabwe has a list of drugs that doctors consider essential for treating the most common and commonly cured illnesses -- and most basic medicines are usually available. But it takes aggressive pharmacists, luck and good connections to keep a well-stocked clinic. Today there is no aspirin, no acyclovir (for treatment of herpes, one of the most common sexually transmitted infections), and penicillin won't be in until this afternoon.

"I want more drugs and I want donors to help buy them for us," Nkomo said. He has recently returned from three months' work at a clinic in Liverpool and it pains him greatly to see how easily most of his clients could be treated for many of their illnesses.

"Why shouldn't we want to treat AIDS?" he asks. "What kind of doctor would I be if I sat here quietly and watched everyone in England taking drugs that will save their lives and knowing that we are all going to die?"

A 23-year-old man comes into the office. He is shy, embarrassed and silent.

"You got to tell me what's bothering you if I'm going to treat it," Nkomo said, quietly. "That's what I am here for."

The patient has reason to believe he has a sexually transmitted disease and upon examination it is clear that he is right.

"When did you last meet someone?" the doctor asked, using a common euphemism here for having sex. The answer was last week.

"Did you use a condom?" he asked. The answer was a quiet no.

"Is she your regular partner?" he continued. No again. "When did you meet someone before her?" The week before. The same questions followed with the same answers.

"Do you know about AIDS?" he asks. Yes, the patient replies, dazed but slightly angry.

"Don't you care?" Nkomo asks, his voice rising sharply. "Do you want to die?" Of course not, the patient replied. Sometimes I just forget.

Nkomo gives the man a lecture and tells him condoms are always free at his clinic. He shows him how to use the condoms -- there is a wooden pole on his desk for demonstrations. And he warns the young man that sex these days is not a game.

As soon as the patient is gone Nkomo takes both hands and slams them on the desk.

"Sometimes this is so painful," he whispered. "What can I do for these people? I want to be out there fighting for them. Most of the time I believe we will turn the tide. But sometimes I ask myself if we are all just going to disappear."

The Ailing Nurse

Mildred passes for what is considered middle class in this part of Africa. She is a highly trained nurse who earns about \$100 a month but recently she became too sick to work. She has fevers and headaches and no appetite.

Her husband, who has spent his life working on the railroads, seems healthy, and neither has taken an AIDS test.

For the last month she and her husband have been on a drug hunt -- desperately trying to find a way to acquire enough antiretroviral medicine to keep her alive. The couple have three children and live in a lovely brick house in a suburb of Bulawayo that once was dominated by the whites who ruled Rhodesia.

They invited a reporter into their home with great reluctance and with the hope that publicity -- however vague and indirect -- might somehow help them. When asked how she became infected, she replied at first that she wasn't. When pressed she conceded she must be.

"I can't explain it," she said, fighting back the tears. "I can't explain it at all. I never had any extra love. I have always worked hard. I don't deserve to die and I know I don't have to."

There are many drugs in Zimbabwe to treat the secondary infections caused by AIDS -- the pneumonias and fungal infections and other ailments that come when a person's immune system is too weak to do its job. But the latest therapies to treat the virus itself are not available and there are very few people who could afford them if they were. So this couple recently went to South Africa to see if they could buy a stay of execution.

"We got to a clinic and the doctor told us it would be about \$1,000 a month for the drugs," the husband said, moaning softly. "That was some sort of discount price. I make \$200 a month. We could afford the drugs for maybe one month or two. And that is nothing. It would only make us poor. So we are waiting now for God to help us. We are hoping God will help us all."

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An Epidemic Spreads

While AIDS infections in the cities of Rwanda have hit a plateau, they are widespread throughout rural areas.

PREVALENCE OF H.I.V. BY AGE

Rural Areas			Urban Areas	
	1996	1997	1996	1997
12-15	1.7%	4.6%	4.2%	11.2%
16-25	1.8	9.9	17.0	24.2
26-40	2.8	14.1	17.2	30.0
40 and over	0.6	12.7	14.9	6.4

PREVALENCE OF H.I.V. BY MARITAL STATUS

Rural Areas		Urban Areas	
Single	7.7%	5.4%	
Married	12.1	10.8	
Common Law Union	12.5	25.4	
Divorced/Separated	11.0	26.3	
Widowed	14.5	21.6	

Source: Rwandan Government

*1996 figures included ages 6 to 12.

Credit: The New York Times

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May 28, 1998

AIDS Prolongs War Devastation in Rural Rwanda

Graphic

- [AIDS Epidemic Spreads Across Rwanda](#)

By JAMES C. MCKINLEY Jr.



GITARAMA, Rwanda -- Emiriene Nirere lay dying in a hospital here, a victim, she said, not only of the AIDS virus, but also of the Rwandan tradition that extols having many children.

Too weak to hold her head up, Ms. Nirere, 40, told how her husband had begun sleeping with several other women several years ago after it became clear they could not conceive a child in the first five years of their marriage. He died of an AIDS-related illness during the civil war in 1994. She is dying now.

"I could never get pregnant," she said, fiddling with the intravenous tube in her hand. "I think he wanted to have a child with another woman."

Ms. Nirere is a sign of things to come here in rural Rwanda, where people are facing a new catastrophe after living through civil war, massacres and a refugee crisis of monumental proportions.

Fanned by a decade of ethnic war and upheaval, a fast-growing AIDS epidemic has broken out of this Central African country's cities and is sweeping through the rural areas, health officials and aid workers say. Even if it is arrested now, the epidemic will take the life of 1 person out of 10 in the coming decade.

A new survey of 4,750 people released this month suggests that Rwanda's epidemic is one of the worst in East Africa, with an overall infection rate even higher than neighboring Uganda, where the disease first appeared in Africa in the early 1980s, epidemiologists say. Last November, United

Nations medical experts estimated that about two-thirds of the 30 million people infected worldwide with the virus live in sub-Saharan Africa.

The survey shows that about 11 percent of Rwandans are HIV positive. Although the epidemic seems to have hit a plateau in the cities, it has skyrocketed in the countryside, going from about 1.3 percent in 1986 to nearly 11 percent today.

Since most Rwandans live on small farms, the trend is alarming, health officials say. "It's a national problem," said Dr. Innocent Ntaganira, the head of the Rwandan AIDS-control program. "It is now going to spread in the rural areas and we have to do something to stop it."

There are many reasons for the rise in AIDS outside the cities, but most of them can be traced to the war and massacres in 1994, as well as the mass movements of refugees from the violence in the last four years. The upheaval broke down social taboos against promiscuity, and the ever-present threat of violence made it harder to persuade people to worry about a disease that takes years to show up.

During three months in 1994, more than 500,000 Tutsi and moderate Hutu were killed in a state-organized campaign of terror. About 2 million Hutu refugees marched into exile in neighboring countries, where they lived in U.N. refugee camps until late 1996, when they were forced to return en masse to Rwanda.

These events spread AIDS outside the capital city, where it had long been a serious problem, health officials say. Not only were the Hutu refugee camps notorious for prostitution and sexual promiscuity, but thousands of Tutsi women were raped by Hutu soldiers and militiamen during the massacres.

A guerrilla war between Hutu militias and the Tutsi-dominated army has continued to grind on in the countryside, with massacres taking place on both sides. The insecurity not only keeps health workers out of remote areas, but also hampers efforts to prevent AIDS.

"The priority for these people right now is not AIDS," Pascale Crussard, a nurse who directs Care's anti-AIDS program in Gitarama, said. "It's security. When people can die tomorrow from a machete wound, I'm not sure they think much about AIDS, from which they could die in 10 years."

The war and massacres also contributed to the rise of sexual promiscuity in recent years, as people whose families have been scattered or killed try to piece their lives together, find companionship and start new families, social workers here say.

In some communes, or villages, it has become common for several women to share a single male sexual partner who lives with none of them, health workers say. In others, polygamy is being practiced as it was in Rwandan culture before colonialism; indeed, of the married people surveyed, 23

percent of the women and 17 percent of the men said they were in polygamous households.

Rwandans do not talk openly about sex, and illiteracy is high in the country. In addition, most Rwandans are Catholic and the church has resisted programs to distribute condoms. Some Rwandan men in rural areas are also reluctant to accept condoms.

In addition, because Rwandans put a high value on having many children, many widows who lost their children and husbands during the war are choosing to have children out of wedlock since the war ended, often with a man who has other sexual partners, aid workers say.

Lying about 20 miles south of Gitarama, Ntongwe is typical of the rural communities where health officials believe AIDS is now spreading. According to a survey by CARE, about 70 percent of people living amid the bucolic hills there are women, of whom 46 percent are widows with young children. Three-fourths of the women have more than one sexual partner.

"There is nothing but widows in this village," said Eulerie Mukarugambwa, a 39-year-old mother of five whose husband was killed in the genocide. "There are not too many men. Women share men among themselves to have children."

Mukarugambwa, who is the head of the local women's association, said many of the widows in her community are determined to have children to replace family members lost in the genocide and war, even if it means risking AIDS. The desire for children is so strong, she said, many do not care if the man is faithful, she said.

"We think about AIDS only afterwards, after the sexual act," she said. "There are women here who lost children in the war and they just want to replace them."

Another widow, Kayisharaza Mediatrice Kayisharaza, a 37-year-old mother who has agreed to help aid workers teach other women here about AIDS, said some of the young couples in the community are beginning to use condoms because of the educational programs Care has mounted.

But she said most of the uneducated farmers in the community are still not taking the epidemic seriously. Even though at least two people are suspected to have died of AIDS-related illnesses in the last year, no one in the commune had gone to Gitarama to get a test for the virus, she said.

"People who have a little education take it more seriously," she said. "But for most of the people here, the war is a much bigger danger than AIDS."

At the Kabgayi Hospital, however, the costs of the epidemic are beginning to be felt. In a crowded tuberculosis ward, 18 of the 33 patients are confirmed to have the virus that causes AIDS. In one bed, Martha

Vwamwezi, a 32-year-old widow, was clinging to life, too weak to pull a blanket over herself.

Nearby, Odett Mukashema, a 33-year-old woman with tuberculosis who also lost her husband during the war, was bathing her baby boy, Josue, in a blue plastic tub. She had given birth to the baby out of wedlock, hospital officials said. Both of them have AIDS.

Back in Nirere's ward, there are at least two other women suffering from AIDS-related illnesses, a nurse says, but neither of them is willing to admit they have the virus or to talk about the disease to a reporter. The stigma is too great, a nurse says.

Lying nearly motionless on her black plastic mattress, Nirere says it is a mistake not to talk about their sickness. She says she had never heard of AIDS until her husband became sick and was tested at the same hospital where she is now fighting for life.

She cannot read, she says, and she has never used a condom in her life. Neither do many of her acquaintances in her home commune of Nyamabuye use them.

"Some do use condoms, but many just go to the bars and cabarets and they don't think about it," she said, smiling wanly for a moment. "The message I would give to these women is to use condoms, or don't do anything. They should stay at home."



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Post-Apartheid Agony: AIDS on the March

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By SUZANNE DALEY

I ZINGOLWENI, South Africa -- One day earlier, the workers from the South Coast Hospice had at least brought food. But this day they had only bad news to deliver.

They had not been able to find anyone willing to donate a coffin for Ennie Gambushe's daughter, Mercy, who had died of AIDS. Nor had they come up with the \$18 needed for a traditional burial.

Mrs. Gambushe, 64, with chronic arthritis that makes it difficult for her to stand up, absorbed the blow without saying a word. It was hardly her only concern: outside, dirty and dressed in rags, were the 15 grandchildren, none older than 12, that she was now responsible for.

Years after many other sub-Saharan countries, South Africa has finally begun to see its people die from AIDS. In almost every cluster of desperately poor huts tucked into the rolling hills



of KwaZulu/Natal Province, the slow wasting fatal disease that few will admit to is wreaking its havoc.



In Izingolweni, AIDS is bringing new misery to the very poor.

The epidemic in this country is now one of the fastest growing in the world. Experts say South Africa -- protected by apartheid's isolationism from major exposure to infection, and with a health system better than any other on the continent -- had a unique opportunity to prevent the kind of explosion of AIDS cases that has ravaged the rest of Africa.

But in the early 1990s the country was in the grip of negotiating a peaceful transition from white supremacist rule. With the possibility of civil war looming, no one paid much attention to halting unprotected sex.

Even now, many experts say, the government's efforts to combat the epidemic have been slow and marred by scandal.

Today almost three million South Africans -- about 12 percent of all adults -- are infected with HIV, the virus that causes AIDS, more than double the number only three years ago. The rate of infection is highest, at 20 percent, among women in their 20s.

Experts say that it may be only a few years before South Africa's infection rates will equal those of its neighbors Zimbabwe and Botswana, where 25 percent of all adults are infected.

For the time being, experts believe that the virus is most prevalent among South Africa's poor blacks. In some parts of Africa, the epidemic first roared through the urban elite. They had the money to travel and tended to have more sexual partners. But in South Africa, it is poor blacks -- because they search the country looking for jobs and often have sexual partners in their villages and where they work -- that have been hardest hit.

What impact the virus will have on South Africa's economy, the largest on the continent, remains an open question. But there is little doubt that it will bring new levels of misery to the very poor.

This is already evident in places like Izingolweni -- rural areas where the way of life was for decades dictated by apartheid laws. The able-bodied went off to work, forbidden from taking their families with them. But it is here that they came to marry, to celebrate holidays or when they were ill, old or dying.

Down the road from Mrs. Gambushe is an 11-year-old girl who alone nursed her dying parents last year, barely able to keep them clean and fed as their bodies, worn down by the HIV virus, shriveled from dysentery and tuberculosis.

There is a dying mother of nine who struggles with a husband who beats her because he believes she gave him the disease.

And there is a young man, rail thin, who worked for a while in the city of Durban, but who has come home to die now. He is not accepted by his family because they suspect he has AIDS and are afraid that they too will catch it. Though the young man is allowed his hut nearby, he must tend to himself. Many days he is too weak to fetch water from the river and the workers find him lying in filth.

Most of the time, such people receive few services. The South Coast Hospice originally began as a non-profit organization working out of a small house in a white neighborhood, catering largely to middle class people dying of cancer in the seaside town of Port Shepstone.

But 18 months ago, the group began trying to reach out to the black population dying of AIDS. At first, the hospice concentrated on delivering pain killers as it had for whites. But soon they were carting food, clothing and whatever else they could into the hills.

"What good does it do to bring pain killers when you find that the caregiver in the household doesn't have the strength to roll the patient over because she is starving," said Kathleen Defilippi, the director of the non-profit group. "So we didn't want to, but we had to get involved in handing out food parcels and whatever else was needed."

Mrs. Gambushe's difficulty in providing a coffin for her daughter is not unusual, the hospice workers said. Many these days are buried wrapped only in sheets despite the deeply held Zulu belief that those who are not put to rest properly will come back to haunt their families.

"A lot of times, we even have to give them the sheets," said Judy Ndaba, who visits patients four days a week. The fifth day, she receives counseling as do all the other workers, because what they see is so draining.

As the workers try to tend to patients they must often do so without acknowledging that the patient has AIDS. Here as elsewhere in the country patients are too ashamed and too frightened to tell anyone their diagnosis. Often enough, they die with their secret. Mrs. Gambushe, for instance, does not know that Mercy died of AIDS. Mercy did not want to tell her, and the health workers are bound to follow her wishes. Another of Mrs. Gambushe's daughters died last year, and she does not know why. It is the children of both daughters whom Mrs. Gambushe is now looking after.

Another patient, Nomusa Dlamini, who has been ill for three years, has also not told her family that she has AIDS. She does not fear only for herself. She worries that if her sisters knew, they would be too frightened to take care of her two young children after she dies.

Typically, even wives are afraid to tell their husbands they are infected with H.I.V. Because the women, run down by the hard lives they lead and the many children they bear, are most likely to show symptoms first, husbands will not believe that they have been faithful and sometimes throw them out of the house or beat them like Esther Xolo. Her husband now believes that their last two children are not his.

On a recent visit, Ms. Xolo burst into tears, begging the workers to talk to her husband, who has taken to living on his own and hoarding the food the workers take to the family.

Even though the disease is often not acknowledged, the villages have seen enough AIDS so that suspicion runs high.

Some patients live in virtual isolation because of it. Vusumuzi Tabhu, who has told no one he is suffering from AIDS, has gotten little help from his family since he came home last year. On a recent day he greeted the workers with a grin. He had been feeling better in the last few days and had done his laundry.

They teased him about having found a girlfriend, an exchange that he clearly enjoyed. But the workers say he suffers a great deal. Even when the workers bring him food, family members often take it from him. They, too, are hungry, and he is far too weak to stop them.

"You sometimes go into the household and you see that the person is isolated," said Dr. Terry Gilpin, the director of nearby Murchison Hospital. "You'll see that the sick person's plate and utensils are in the corner away from everyone else. You see it a lot. People are ignorant about the disease."

Murchison, like many other hospitals in the province, is already overwhelmed by the numbers of AIDS patients. Most nights, 15 patients sleep on the floor. While infection rates are rising throughout South Africa, the hardest-hit area is KwaZulu/Natal, which includes a port city and many truck routes connecting it to neighboring countries. What Lies Ahead? 'Great Misery' Since there are no similar models to study, economists say it is impossible to predict what is likely to happen to South Africa's economy.

Some predict that the bigger corporations will be able to adapt to a decline in the labor pool. Most are already in the process of shedding employees as they mechanize, computerize and in general try to become more competitive.

In addition, the growing mobility of the international labor pool means that South Africa could go outside the country to fill gaps that arise.

But already it is clear that the measure of hardship in this society will rise sharply. Young people will be dying at a time when they are usually contributing to a family's income. And many will be leaving children

behind.

"The jury is still out on what the macro level impact will be," said Alan Whiteside, an economist at the University of Natal in Durban who studies such issues. "But at the micro level you will see great misery."

Despite South Africa's relatively advanced public health services, the country is still struggling financially and the Government is not even discussing providing treatment for AIDS itself. Few of the private medical insurance companies will pay either.

Peter Bassey of the National Association of People Living With H.I.V./AIDS says fewer than 1 percent of South Africa's infected are being treated with life-prolonging drugs like AZT. And most of those are paying for the drug themselves.

Nor are there any national programs to try to block the transmission from mother to child, either by offering AZT to infected pregnant women or by providing formula so they can avoid transmission through breast feeding.

The government has made progress, though, in dispensing condoms -- about 140 million last year -- and in offering treatment for other sexually transmitted diseases, which helps reduce the spread of AIDS.

Also, about one-tenth of the country's secondary school teachers have been trained to teach youngsters about the disease and how to avoid it.

Still, the Government's two most visible steps against AIDS were both headline-making fiascos.

The first was an ill-fated traveling musical, "Sarafina II," meant to warn the illiterate about the dangers of AIDS. As soon as it opened, AIDS experts called some of its dialogue dangerously inaccurate and its message unclear. The Health Minister And Her 2 Fiascos

It then turned out that the show had cost a relative fortune -- nearly \$3.3 million. Health Minister Nkosazana Zuma commissioned a friend to write it, bypassed bidding rules to give him the job and then lied to Parliament about the whole affair.

Then last year, Dr. Zuma announced that South African scientists had made a major breakthrough in the search for an AIDS cure. She invited researchers who claimed to have discovered the miracle cure -- a drug called Virodene administered by a skin patch -- to bypass the Medicines Control Council, the equivalent of the Food and Drug Administration, and take some of their cured patients before the Cabinet to plead for funding.

Medical experts, including the control council, were aghast when they found out that human trials had been performed secretly, especially when they learned that the Virodene contained a poisonous solvent. Since then, Dr.

Zuma has dismantled the council. She continues to back Virodene research.

These days the South Coast Hospice workers visit more than 300 patients a month, though they have yet to secure financing for next year and may have to shut down. The workers are particularly worried about the fate of the children they see.

The 11-year-old girl who nursed her parents, Kugu Sengane, spent most of last year alone with them and her toddler brother. Her relatives showed up only in the last few months -- ready, it seems, to take over the two shacks her parent built. These days the workers are worried about the girl. She seems afraid to speak in front of her aunts and appears to do most of the housework.

There is also little possibility that the 15 children in Mrs. Gambushe's care will go to school anytime soon. They will all be living on her pension now, less than \$80 a month. The school fees and mandatory books and uniforms amount to about \$120 a year for each child.

Sitting motionless on the straw mat inside her virtually empty house, Mrs. Gambushe answered questions about the future in a monotone.

"I don't know what I will do now," she said. "I don't know."

Other Places of Interest on The Web

- [Offical Webcast of the World AIDS Conference.](#)
 - [ASD Online, the World Health Organization's Office of HIV/AIDS and Sexually Transmitted Diseases.](#)
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USAID OFFICE OF POP.

International Development
Washington, D.C. 20523

FACSIMILE TRANSMITTAL COVER SHEET

DATE: 1 Sep 98

TO:

ATTENTION: Sandra Thurman

ORGANIZATION:

Office of NCH / AIDS PolicyFAX PHONE: 202 454 2439

OFFICE PHONE:

202-395-1441

FROM:

ORIGINATOR: Caroline Connolly

ORGANIZATION:

USAID/WASHINGTONFAX PHONE: (202) 216-3404

OFFICE PHONE:

202-712-4549

SUBJECT:

SOUTH AFRICA

NUMBER OF PAGES (including this cover sheet):

3

COMMENTS:

As attached.804 243-2359



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

Ms. Sandra L. Thurman
Director
Office of National AIDS Policy
The White House

1 September 1998

Dear Ms.  Thurman:

As you are well aware, South Africa has one of the fastest-growing HIV/AIDS epidemics in the world, with up to 2,000 new HIV infections a day and a national doubling time of 24 months. According to the annual national survey of women attending antenatal clinics, HIV prevalence has increased by a factor of 14 during the last six years. The national average prevalence among antenatal clinic attendees is more than 14%, with wide variations among the nine provinces - from 6% in the Western Cape to more than 26% in Kwazulu-Natal.

In response to this growing epidemic, the South African Business Council plans to launch "South Africa's Business Response to AIDS". The official launch of this program will take place in South Africa on October 28, 1998. The South African Business Council represents the major multinational corporations in South Africa, including Southern Life, Shell Oil, Old Mutual, Anglo-American, BMW, DeBeers, Metropolitan Life and Volkswagen. This venture is a major step in bridging the gap in the response to the epidemic between the public and private sectors.

The Council has requested, through the USAID Mission in South Africa, your participation to speak to the issues of how the Office of National AIDS Policy has engaged the business community in the United States to respond to the epidemic, the role of the business community and examples of successful programs.

In addition, the Council would like a Chief Executive Officer from a large US company that has developed a successful HIV/AIDS program to speak at the meeting. The USAID/South Africa Mission can fund this trip. I would very much appreciate your assistance in identifying and obtaining the appropriate CEO to speak at this conference.

- 2 -

The Mission would like to arrange field visits in South Africa for you and the CEO, if time permits in your schedules.

Caroline Connolly has been in touch with Sarah Holwinski in your office. Caroline will continue to work on this up to her posting to the Mission in South Africa in early October. She can be reached at 202-712-4549.

I hope that your schedule permits you to attend. This is a powerful organization poised to make a significant contribution in the area of HIV/AIDS in South Africa.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul", with a large, sweeping initial "P" and a trailing flourish.

Paul Delay
Chief
HIV/AIDS Division

Geneviève M. Clavreul
Phone: (626) 398-8585
Fax: (626) 398-5664

ON HOLD



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Waiting For Your Feedback

3 September, 1998

TO: Ms. Sandra Thurman

FAX: (202) 456-2438

1 Pages including this coversheet

PLEASE DELIVER TO MS. THURMAN; THANK YOU.

Sandy:

I am the process of "firming-up" my travel plans for my visit to Washington DC for later this month. I was hoping that we would have the opportunity to meet and continue our discussions, which we began in Geneva. By the way have you heard from or seen our friend Dr. Kozlov recently.

Please call me so we can touch base.

Geneviève

Changes in male sexual behaviour in response to the AIDS epidemic: evidence from a cohort study in urban Tanzania

Japheth Z.L. Ng'weshemi*, J. Ties Boerma*[†], Robert Pool*[†], Longin Barongo[‡], Kesheni Senkoro[‡], Mary Maswe*, Raphael Isingo[‡], Dick Schapink*[†], Soori Nnko[‡] and Martien W. Borgdorff[§]

Reproduced with permission of Rapid Science Publishers. Ng'weshemi J., Boerma T., Pool R., Barongo L., Senkoro K., Maswe M., Isingo R., Schapink D., Nnko S., and Borgdorff M. Changes in Male Sexual Behaviour in Response to the AIDS Epidemic: Evidence from a Cohort Study in Urban Tanzania. AIDS 1996; 10(12):1415-1420.

Objective: To examine changes in sexual behaviour among men in urban Tanzania.

Design: An observational cohort study among factory workers during 1991–1994.

Methods: Data from five follow-up visits with structured questionnaire-guided interviews and biomedical data were analysed to examine trends in sexual behaviour and sexually transmitted disease/HIV among 752 men. In-depth interviews were conducted to evaluate the magnitude of reporting bias.

Results: During the 2 years of observation, the proportion of men with more than one sexual partner during the month preceding the interview declined from 22.3 to 12.2%. The proportion of men reporting casual sex partners during the last month was almost halved: from 9.8 to 5.2%. The decline in the reporting of extramarital partners was gradual and pronounced. There were only minor changes in reported condom use, notably an increase in use with casual partners, and no changes in coital frequency. Data from in-depth interviews confirmed that reduction in sexual partners was the predominant change.

Conclusions: This study documents that, in response to the AIDS epidemic, changes in male sexual behaviour are taking place in urban areas in Africa. The predominant change among these men, who are predominantly married and aged over 25 years, is a reduction of the number of sexual partners, although condom use remains low.

AIDS 1996, 10:1415–1420

Keywords: Sexual behaviour change, cohort study, urban males, Tanzania

Introduction

The main mode of transmission of HIV in Africa is heterosexual contact [1,2]. Because no curative intervention or vaccine is available, most AIDS control efforts focus on changing sexual behaviour and control of sexually transmitted diseases (STD) among adolescents and adults. In a survey of 23 developing countries, the leading aims of HIV prevention programmes were promotion of condom use (95%), reduction of the number of sexual partners (91% of countries), prevention of STD (96%) and promotion of monogamy (80%) [2].

Hitherto, very few evaluations of the impact of interventions aiming for behavioural change among the general population in Africa have been conducted [1,3]. Consequently, there is only limited evidence of sexual behaviour change in Africa, mostly in discordant couples [4,5] or specific high risk groups, such as prostitutes [2]. Multiple cross-sectional surveys focusing on a limited number of indicators can be used to measure trends in sexual behaviour in the general population [6]. The most important indicators of changes in sexual behaviour are incidence of STD and HIV, reported number of sexual

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Note: The views expressed in this paper are solely those of the authors.

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partners and condom use. Longitudinal studies present a better opportunity to assess changes in sexual behaviour. For instance, evaluation of reliability of responses is possible through checks in consistency across repeat measures in the same persons [6]. In our study, we present data on trends in sexual behaviour from a cohort study of factory workers and their spouses in a town in Tanzania during 1992–1994.

Methods

The study population includes workers at a large urban textile factory in Mwanza in northwest Tanzania that had a workforce of approximately 2000 workers in 1991. Enrolment started in October 1991 and continued until August 1994 and included workers and their spouses, whereas follow-up continued until April 1996. A study clinic was established at the factory. All study participants were invited for follow-up visits 4 months after their previous visit. If they failed to attend, reminders were sent on four subsequent occasions, including personal attempts to motivate the participant to attend. After 1 year of non-attendance participants were excluded from the study. During intake and follow-up visits, a standardized interview, physical examination and laboratory investigations were performed. Free medical treatment was provided to all study participants at intake, follow-up visits and any time they presented in between. Referrals to hospitals were made when necessary.

Four types of sexual partners were distinguished: spouse; a partner one lives with but is not married to (cohabiting); a regular partner one is not married to and does not live with; and a casual partner [7]. The latter was defined as any sexual partner not considered a regular partner by the respondent. The limitations of these definitions are discussed elsewhere [8].

During each follow-up visit the respondent was asked about events since the last interview. These included marriage or separation, and sexual encounters with casual partners. In addition, the respondent was asked whether he or she had a regular partner at that time. For each type of partner, questions were posed about sexual behaviour during the month preceding the interview, frequency of sexual intercourse and condom use. In addition, the respondent was asked whether he or she had had sexual intercourse during menses, anal intercourse, genital ulcers, genital discharge and had used alcohol since the last interview. The amount of alcohol used during the last drinking session was also recorded.

This analysis was based on 752 men, who had made at least four follow-up visits to the project clinic by January 1995 — five visits in total. Virtually all men had been enrolled prior to January 1993. In total, 1433 men had registered for the study by January 1993 and could have completed five visits by January 1995. Some of these

men dropped out of the study due to death (1.5% of all enrolled) or other reasons (38.9%), others are still on follow-up, but have not yet reached their fifth visit (7.1%). Economic instability has contributed to high drop-out rates. Since 1993 the factory has been repeatedly closed and re-opened, and was closed completely in late 1994. The majority of drop-outs were temporary workers, who made only one visit to the study clinic.

The intervention to reduce HIV transmission had four components. First, there was free and effective treatment of STD at the study clinic. In addition, at every follow-up visit a blood sample was tested by rapid plasma reagin test, and if positive the client was treated for syphilis. Second, condoms were freely available at the study clinic and in the factory. Third, voluntary HIV counselling services were available, although these were not used extensively. By early 1994 only 10% of the study participants were aware of their HIV status. Fourth, several health education activities were initiated in the factory. These included workshops for factory workers to provide information about AIDS, drama performance, and training and follow-up of peer educators (from 1993). The intensity of these health education and promotion activities was moderate in 1992 and strengthened in 1993. The coverage of the peer educator programme was very limited, however, due to the economic problems at the factory. By early 1994 only 20% of the study participants reported ever having discussed AIDS with a peer educator.

Double data entry was carried out for all questionnaires, using DBase IV (Borland International, Scotts Valley, California, USA). Stata version 3.1 was used for all analyses (Stata Corporation, College Station, Texas, USA). The χ^2 test was used to assess whether the trends in proportions were significantly different from no change over time, (paired) t-test was used for comparison of means and the Poisson distribution for calculation of confidence intervals for incidence rates.

In addition to the quantitative data, a qualitative study was carried out in an attempt to evaluate the effect of reporting biases. From the 752 men, 32 were randomly selected for in-depth interviews, including 19 men who had reduced their number of sexual partners and 13 men who had not changed their sexual behaviour. The in-depth interviews covered the 5 years preceding the interview and were conducted by a experienced female field worker, recorded and transcribed verbatim, and analysed by discourse analysis. In addition, 10 wives of the selected men were interviewed about changes in their husband's behaviour. These wives were also enrolled in the factory cohort study. Biomedical data on STD/HIV incidence were used to validate the reports.

After a preliminary analysis of the first group of men it was noted that levels of agreement between the quantitative and qualitative interviews were high. We decided to further challenge the data by randomly selecting

another 13 men who were either incident cases of HIV or clinical STD during the second half of the study period, a technique that may be labelled as a reverse record study [9]. These included eight men who, according to the follow-up data, had reduced the number of sexual partners and five men who had not changed their behaviour. A detailed report of the methodology used in the qualitative study has been documented by Pool *et al.* [10].

Results

Table 1 presents the background characteristics at intake interview of the 752 men who had made five follow-up visits to the project's clinic, and compares these data with those of the men dropped out of the study. Most men in the study group were aged 25 years or older (85%) and had completed primary education but had not received subsequent education. Monthly household income for 80% of the study participants was below US\$ 30. The dropouts were younger (33% aged under 25 years) and more likely to be single (36.7%) than men remaining in the study. There were no differences between the two groups of men with regard to number of sexual partners. However, condom use was more commonly reported by those lost to follow-up than the study group (6.1 and 3.2% condom use among sexually active men in the last month, respectively; $P = 0.021$).

Of 628 men who were married at the first interview 1.6% were divorced at the time of the fifth interview. Among 102 single men, 36.3 and 4.9% reported themselves to be married and divorced, respectively, at visit 5. Almost one-half of the 22 divorced or separated men reported themselves as married at the end of the study period (47.8%). Overall, the proportion of men who were married increased from 83.4 to 88.4%, including a slight increase in the proportion of men in a polygamous marriage (from 4.3 to 5.6% of all men; $P > 0.05$).

Sexual partners

The mean interval between two subsequent visits was 5.5 months and the mean period of observation was 22 months. The trends in multiple partnerships during the month preceding the interview are shown in Table 2.

Table 1. Percentage distribution of background characteristics among study group and among those lost to follow-up (dropouts).

Variable	Study participants (n = 752)	Dropouts (n = 681)
Age (years)		
< 25	15.4	33.0
25–34	32.9	33.5
35–44	39.2	23.8
≥ 45	12.5	9.7
Education		
None	0.9	1.2
1–4 years	9.4	7.1
5–7 years	80.6	77.8
Secondary plus	10.0	13.9
Marital status		
Single	13.6	36.7
Married (monogamous)	79.2	56.0
Married (polygamous)	4.3	4.0
Divorced/separated	2.9	3.3
Income (US\$ per month)		
< 15	24.3	36.0
15–30	56.1	43.3
30–60	16.8	13.2
> 60	2.8	1.6
Missing	–	5.9
Sexual partners in last month		
≥ 3	4.7	5.1
2	17.6	16.2
1	57.6	51.4
None	20.2	27.3
Had casual partner in last month		
Yes	8.8	8.8
No	91.2	91.2
Used condom in last month		
Yes	3.2*	6.1†
No	96.8	93.9
Total	100.0	100.0

*Six hundred sexually active men; †495 sexually active men.

The proportion reporting no sexual partner during the last month was lower during the later rounds, partly because more men were married. One in five men reported no sexual partner at visit 1. During visits 2–5, 14–17% of respondents had no sexual activity during the month preceding the interview.

More importantly, Table 2 clearly shows a reduction in the number of sexual partners during the 2-year period. The proportion of men reporting more than one sexual partner in the last month declined from 22.3 to 12.2%. The proportion of men reporting more than two sexual partners declined from 4.7 to 2.0%. The proportion of men reporting casual sexual partners during the last month was almost halved, from 9.8 to 5.2%.

Table 2. Number and type of sexual partners during month preceding the interview by follow-up visit (752 men).

No. sexual partners	Follow-up round					P*
	1	2	3	4	5	
≥ 3	4.7	4.1	3.1	2.3	2.0	0.012
2	17.6	14.0	12.2	10.6	10.2	< 0.001
1	57.6	68.4	67.3	70.2	72.9	< 0.001
No sex	20.2	13.6	17.4	16.9	14.9	0.007
Total	100.0	100.0	100.0	100.0	100.0	
Casual partner	8.8	6.8	5.2	4.4	4.6	0.001

Values are percentages. *Based on χ^2 test for trend.

Table 3. Proportion of men reporting to have used condom use during the month prior to the interview by type of partner and follow-up round (in parentheses number of men).

Type of sexual partner	Follow-up round [% (no. men)]*					P†
	1	2	3	4	5	
Casual	7.6 (66)	23.5 (51)	41.0 (39)	25.8 (31)	27.3 (22)	0.002
Regular	5.4 (167)	8.4 (143)	8.3 (108)	12.4 (89)	8.6 (70)	0.427
Cohabiting	0.4 (504)	1.2 (572)	1.3 (546)	1.1 (567)	0.9 (587)	0.603
Used in the last month	2.5 (752)	4.3 (752)	3.9 (752)	3.7 (752)	3.1 (752)	0.377

*Do not add up to 752 as some men had multiple, and some no, partners in the last month. †Based on χ^2 test for trend.

The decline in the reporting of extramarital partners was also gradual and pronounced. The proportion of married men reporting a regular non-cohabiting partner decreased from 20.1 to 6.5% ($P < 0.01$), and the proportion reporting a casual partner decreased from 8.0 to 2.7% ($P < 0.001$).

Frequency of intercourse

The reported mean frequency of sexual intercourse in the month prior to the interview was 5.6, 5.4, 4.9, 5.0 and 5.2 times during interview rounds 1–5, respectively. There was a pronounced reduction in the frequency of sexual intercourse with non-cohabiting partners, mostly regular partners. In round 1, 18% of sexual acts were with a non-cohabiting partner (0.9 out of 5.6 acts); in round 5 this was only 6% (0.3 out of 5.2 acts). Sex with casual partners contributed very little to the total frequency of intercourse.

Condom use

In general, condom use during the 4 months preceding the interview remained low (Table 3). At the last interview, only 3.1% of respondents reported having used a condom during the month prior to the interview. Analysis of condom use in the last month by type of sexual partner shows that minor changes had taken place. Condom use during sexual intercourse with spouses was very low throughout. Condom use with regular non-cohabiting partners was somewhat higher after five visits, although nine out of 10 respondents still did not use a condom with regular partners. Condom use with casual partners, however, was reported more frequently, increasing from 8% in round 1 to a high of 41% in round 3, and then declining to 26–27% in the subsequent rounds.

Sexual practices and alcohol use

Sex during menses and anal sex were rarely reported for the periods between the interviews. Only 6% of men reported ever having had sex during menses. Anal intercourse was reported by three men during the second round. During the first interview, 56.2% of men thought that there were people who had anal intercourse.

Alcohol consumption patterns did not change much during the 2-year period. About one in four men drank alcohol between the rounds. When asked to recall the amount of alcohol consumed the last time they drank, a fairly large proportion of respondents mentioned large quantities of alcohol. For instance, during round 5, 9% of men had drunk more than 2.5 l beer or more than 0.5 l strong liquor on the last drinking occasion. There was no consistent change in alcohol use over time.

Behaviour change

Table 4 shows the trends in sexual behaviour at the beginning (first two interviews) and the end of the study period (last two interviews). With regard to the number of sexual partners in the last month 61.7% of all men reported low risk behaviour (defined as none or one sexual partner) at both the beginning and the end, 19.0% had changed from high (more than one partner) to low risk, 12.2% continued high risk behaviour, and 7.1% changed from low to high risk behaviour.

Uni- and multivariate analyses were carried out to assess which men had high risk behaviour and who had changed sexual behaviour (data not shown). The analyses included the following background variables: age, education, marital status, income, religion, place of birth, duration of stay in town, HIV status and alcohol use. Excluding men in a polygamous union, having multiple sexual partners during the last month was significantly ($P < 0.05$) associated with age (20–29 years compared with ≥ 40 years), place of birth (urban versus rural), and alcohol use (moderate and excessive use, compared with no use) in a logistic regression controlling for all other variables listed above. No characteristic was significantly associated with changing from high to low risk behaviour among those who initially had high risk behaviour. The reverse, however, was significantly associated with age and excessive alcohol use. Men were more likely to change from low to high risk behaviour if they were younger than 30 years or 30–39 years (than those 40

Table 4. Percentage distribution of changes in sexual behaviour comparing the beginning and the end of the study period.

High risk	Low risk	n	High→high	High→low	Low→high	Low→low	Total
> 1 partner	0–1 sexual partner in last month	752	12.2	19.0	7.1	61.7	100.0
Extramarital partner	No extramarital partner	639	10.0	23.5	5.8	60.7	100.0

years and over) and if they had used excessive amounts of alcohol during the month preceding the interview (than those not using alcohol).

In-depth interviews

Among 16 (84%) of the 19 men who had reduced the number of sexual partners, qualitative and clinical data confirmed the change. For two men, the reduction in sexual partners was contradicted by either the in-depth interview or the spouse. In a third case, fewer sexual partners were reported in the in-depth interview than initially in the follow-up interviews.

All data sources agreed for 11 (85%) of the 13 men who had not changed. Two men who had reported consistent low risk behaviour during the follow-up rounds reported multiple sexual partners during the in-depth interviews.

Not surprisingly, results were less convincing among the 13 selected cases incident for HIV or clinical STD. For five of the eight men who had changed their behaviour, reports from all sources were consistent, whereas two men had evidence of underreporting in follow-up interviews compared with the in-depth interview. One man reported fewer sexual partners during the in-depth interview than in the follow-up interviews. Among two of the five men who had not changed their behaviour, the different sources of data were in agreement, both showing continuing high risk behaviour. The three men with inconsistent reports all had reported continuing high risk behaviour during the follow-up interviews, but the numbers and type of sexual partners were different from the in-depth interview. In two cases more sexual partners were reported during the in-depth than in the follow-up interviews, and in one case more were reported during follow-up.

HIV incidence and STD symptoms

The proportion of men reporting an STD during the first half (from intake to the third visit) and the second half of the study period declined slightly, but not significantly. During the first half, 4.5% of men reported a genital ulcer during the past 4 months, compared with 2.9% during the second half ($P = 0.10$). The corresponding figures for genital discharge in the last 4 months were 8.9% and 8.2%, respectively ($P = 0.65$). The incidence of the clinical diagnosis of genital discharge syndrome was 10.6 per 100 person-years of observation (PYO) during the first half and 9.0 per 100 PYO in the second half of the study period ($P = 0.35$).

HIV prevalence was 8.9% at the first interview. During the first half of the study period, HIV annual incidence was 1.77 per 100 PYO (11 seroconverters with 621 PYO). During the second half, incidence was 0.66 per 100 PYO (four seroconverters with 603 PYO). The incidence rate ratio was 0.37 (95% confidence interval, 0.09–1.26).

Discussion

Data from cross-sectional surveys and anthropological studies suggest that multiple and extramarital sexual contacts are common and contribute significantly to the spread of HIV/AIDS in many parts of Africa [11,12]. In most surveys, respondents mentioned reduction of sexual partners as the most important means of AIDS prevention rather than use of condoms [13]. Some have argued that this is not likely to be true and consider increased condom use more likely than a decrease in the number of sexual partners [13]. Others have noted the overall negative attitude to condoms prevailing in much of Africa, especially regarding their use for non-commercial sex, and consider reduction in the number of partners more likely [14].

The main behavioural change documented by the study is a reduction of the number of sexual partners. The proportion of men with more than one sexual partner during the last month was almost halved during the 2-year period of investigation. This decline was due to fewer extramarital non-cohabiting sexual partners and fewer casual partners. There were only minor changes in reported condom use, notably an increase in use with casual partners. The cohort data do not show a decline in sexual activity, but there is a shift towards more sexual activity with one partner and within marriage. There was a moderate decline in the incidence of reported STD, notably genital ulcers, and clinically diagnosed STD, and a larger (although not significant at $P = 0.05$) decline in HIV incidence.

Our study has several limitations. First, the study population differs from the overall adult population in Mwanza town, because young (aged < 30 years) and unmarried men were underrepresented in the factory population and were also more likely to drop out of the study. This implies that our results cannot be generalized to the whole adult male population, but are more typical for married men older than 25–30 years. In fact, it appeared that those lost to follow-up, although they did not have more sexual partners than the study group, may be more likely to use condoms than the study participants.

Second, the observed reduction in number of sexual partners may be a reporting bias due to the interventions promoting fewer sexual partners. Lack of change in other indicators such as condom use, which were at least equally strongly promoted, and in other aspects of sexual behaviour (frequency of intercourse, marital sexual activity, abstinence), supports the claim that much of the reduction in sexual partners is genuine. Additional confidence in the data was obtained by a detailed qualitative study on a subsample of men, from which it can be concluded that the data are sufficiently valid to consider the decline in number of sexual partners a genuine change [10].

Third, it may be argued that most of the changes in sexual behaviour are due to the ageing of the study population. During visit 5 the respondents were on average almost 2 years older than during visit 1. The magnitude of the reduction in sexual partners, however, exceeds the effect of ageing of the population. Data on frequency of sexual intercourse also suggested no change over time. Because we are dealing with a closed cohort, however, part of the changes in HIV and STD incidence may be due to lack of replacement of subjects at high risk: those men with high risk behaviour become infected and are not replaced [15].

Fourth, it is difficult to attribute the changes to either specific interventions in the factory or to general changes in the urban population. Although the factory workers were more exposed to AIDS education activities than the general population of Mwanza, there was not a large difference between the factory and the Mwanza urban population in terms of AIDS knowledge. Knowledge of AIDS is high throughout Tanzania. A national survey in 1994 showed that 99% of urban men in Tanzania had heard of AIDS, 90% knew of ways to avoid AIDS, 89% knew that a healthy-looking person can have AIDS, and 63% knew a person with AIDS [16]. In our population, 99% of the men knew about the sexual transmission of AIDS, 90% knew a healthy person can be infected with HIV, and 79% personally knew an HIV-infected person. Condom availability was clearly better for the factory population than for most other urban dwellers, but did not lead to a significant increase in use. The peer educators may have had some impact, but most of them were active from mid-1993. Their work was hampered due to the repeated (temporary) closures of the factory. Only 13% of male workers said they had discussed AIDS with a peer educator. Therefore, the exposure to interventions was only slightly higher among the study population compared with the general population of the town. The main difference was their participation in the study with regular follow-up visits and STD treatment free of charge.

It is relevant to know who changed their sexual behaviour during the study period. In the factory population only two variables were associated with behavioural change: age and alcohol use. Men under 30 years were more likely to have multiple sexual partners, and to change from low to high risk behaviour than older men. Men who used alcohol, and particularly men who had used excessive amounts of alcohol during the last drinking session were also more likely to have multiple sexual partners and to change from low to high risk behaviour. The association between alcohol use and high risk sexual behaviour may need more attention in educational campaigns aimed at reducing HIV transmission.

Recently, Caldwell [17] argued that the most important change in sub-Saharan Africa has been 'a very substantial rise in condom use'. He was rather pessimistic about reductions in the numbers of sexual partners. Our data

show that among this population of mostly married men aged 25–30 years or older, condom use is a less likely to change than the number sexual partners. Among these men, a remarkable and consistent reduction in the number of regular non-cohabiting and casual partners occurred during the period 1992–1994.

Acknowledgement

We thank the Principal Secretary, Ministry of Health, and the Director General, National Institute for Medical Research, Tanzania, for permission to publish the results of this study. We are indebted to the factory workers who participated in the study and to the TANESA staff who collected the data.

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SCHEDULING REQUEST

Date: 11/11/98

☐ ACCEPT

☐ REJECT

☐ PENDING

TO: Stephanie Streett, Assistant to the President and Director of Scheduling

FROM: Bruce Reed, Assistant to the President for Domestic Policy
Minyon Moore, Assistant to the President and Director of Public Liaison
Sandra L. Thurman, Director, Office of National AIDS Policy

REQUEST: Announcement of international AIDS orphan initiative on World AIDS Day

PURPOSE: Commemoration of World AIDS Day and to affirm the Administration's commitment to the global battle against HIV and AIDS

BACKGROUND: To commemorate the 10th anniversary of World AIDS Day the President will launch a \$10-20 million international initiative designed to develop and implement effective models for caring for children orphaned by AIDS and for children at highest risk of infection by HIV.

\$10 million, administered by USAID, will be used to (1) identify and enhance model programs to support communities in caring for children and families affected by AIDS, (2) initiate these model programs in areas of most acute need and where they do not currently exist; and (3) develop an action plan for expanding and sustaining effective community-based programs proportionate to the magnitude of the problem. An additional \$10 million may be provided by the National Institutes of Health to enhance these activities and document their effectiveness.

In addition, the President will direct Sandra Thurman, Director of the Office of National AIDS Policy, to lead a delegation in January that will report to him on the extent of the problem and provide recommendations for additional action. This delegation will include representatives from Congress, foundations, and the media.

The increasing number of AIDS orphans has reached crisis proportions in many of the world's poorest countries. The U.S. Agency for International Development (USAID) estimates that there will be 40 million orphans by the year 2010. To date, over 8.2 million children had been orphaned by AIDS; 90% of these children are from sub-saharan Africa.

The President is scheduled to meet with the Advisory Council on HIV/AIDS on December 18th. The Council is going to make a strong request to the President for increased leadership on and funding for the

international AIDS epidemic. This initiative provides a timely opportunity to provide such leadership.

World AIDS Day is sponsored by the World Health Organization. The 1998 World AIDS Day theme, "Force for Change: World AIDS Campaign with Young People" challenges governments and non-governmental organizations around the world to children and youth who are most severely impact by this epidemic.

PREVIOUS

PARTICIPATION: A Presidential Proclamation has been released on World AIDS Day every year. In 1993 the President spoke at Georgetown University. In 1994 the Office of National AIDS Policy arranged an Oval Office meeting with the President and HIV positive youth. In 1995, a Presidential video message was produced and the historic White House Conference on HIV/AIDS was held. In 1996 the President met with NIH, CDC, and HHS representatives for a scientific research briefing in the Oval Office. In 1997, the President signed the World AIDS Day Proclamation and an Executive Order that urged Federal agencies serving youth to improve access the HIV prevention and care services.

DATE & TIME: Tuesday, December 1, 1997 (World AIDS Day)

DURATION: Twenty minutes (event)
Five minutes (briefing)

LOCATION: Roosevelt Room

PARTICIPANTS: The President
Sandra Thurman, Director Office of National AIDS Policy
Brian Atwood, Director, USAID
Affected individual

There will be an additional 40 non-speaking guests that will include representatives of international child survival and relief organizations, representatives from Congress, members of the President's Advisory Council on HIV/AIDS, HIV/AIDS advocates, children and families.

OUTLINE OF EVENT:

The President will announce the initiative with brief remarks. Other speakers will include Sandra Thurman, Brian Atwood, and a parent or child with a related personal story.

REMARKS: Yes

MEDIA: Open press.

FIRST LADY: No.

VICE

PRESIDENT: Optional.

RECOMMENDED

BY: Bruce Reed, Minyon Moore, Sandra Thurman

CONTACT: Todd Summers 6-2444 or Christa Robinson 6-5165

FAX MESSAGE



U.S. Agency for International Development
HIV-AIDS Division, Office of Health and Nutrition
Global Bureau

Mailing address: G/PHN/HN/HIV-AIDS
3.07-075M, 3rd Flr, RRB
Washington, DC 20523-3700
U.S.A.

To: Sarah Holwinski
Sandra Thurman
White House ONAP

Phone:

FAX: 202 456 2439

cc:

From: Paul R. DeLay, M.D.,
D.T.M. & H. (Lond)
Chief, HIV/AIDS Division

Phone: 202 712 0683

FAX: 202 216 3046

Pages: 9

Date: 11/20

Subject:

Here are the 1998 UNAP
figures from UNAIDS

Chilling numbers for infants
infected

These are "embargoed" until
Nov 24

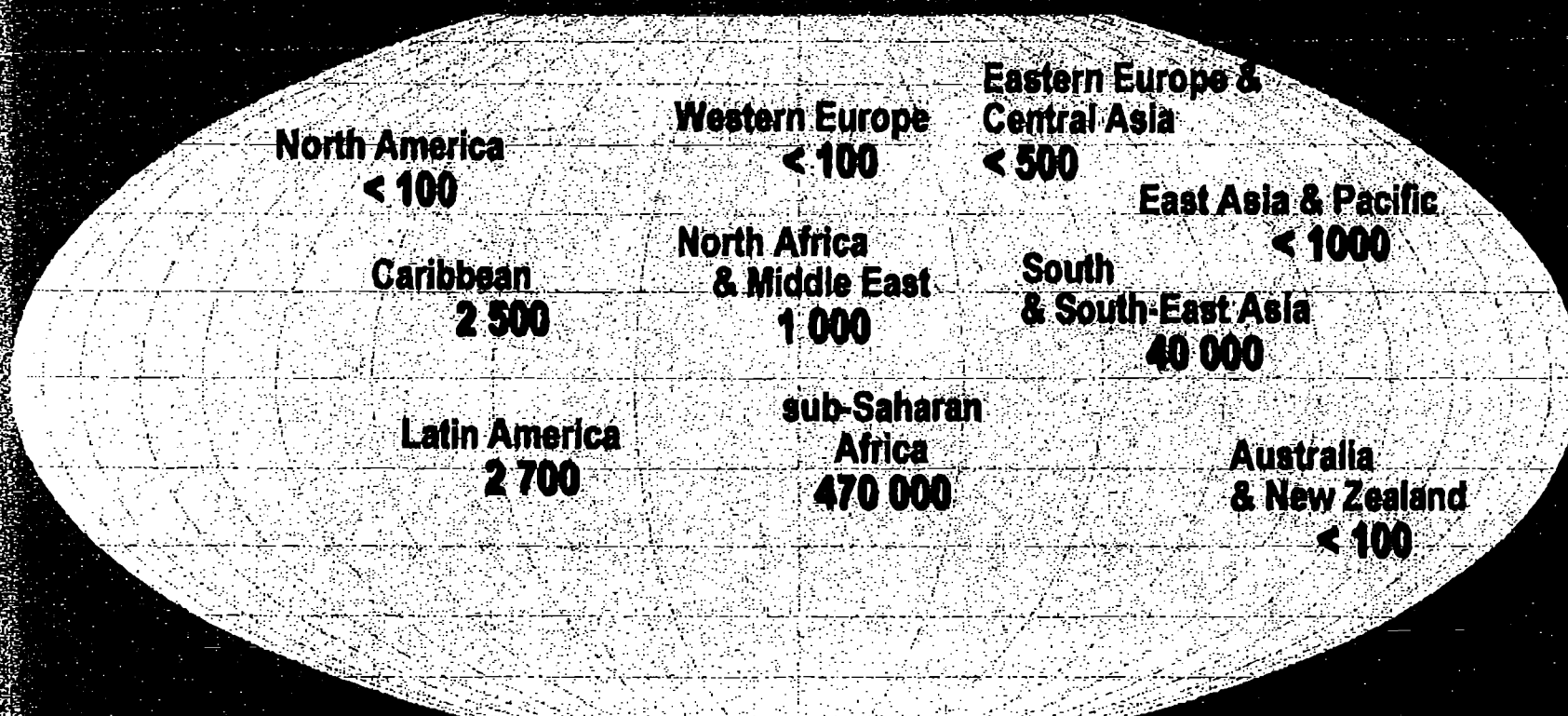
[FAX page: 1]

Paul

Estimated number of new HIV infections in young people

- About 7 000 young people aged 10–24 get infected with HIV every day, that is five young persons every minute
- About 1.7 million young people in Africa get infected with HIV every year
- Close to 700 000 young people get infected with HIV every year in Asia and the Pacific

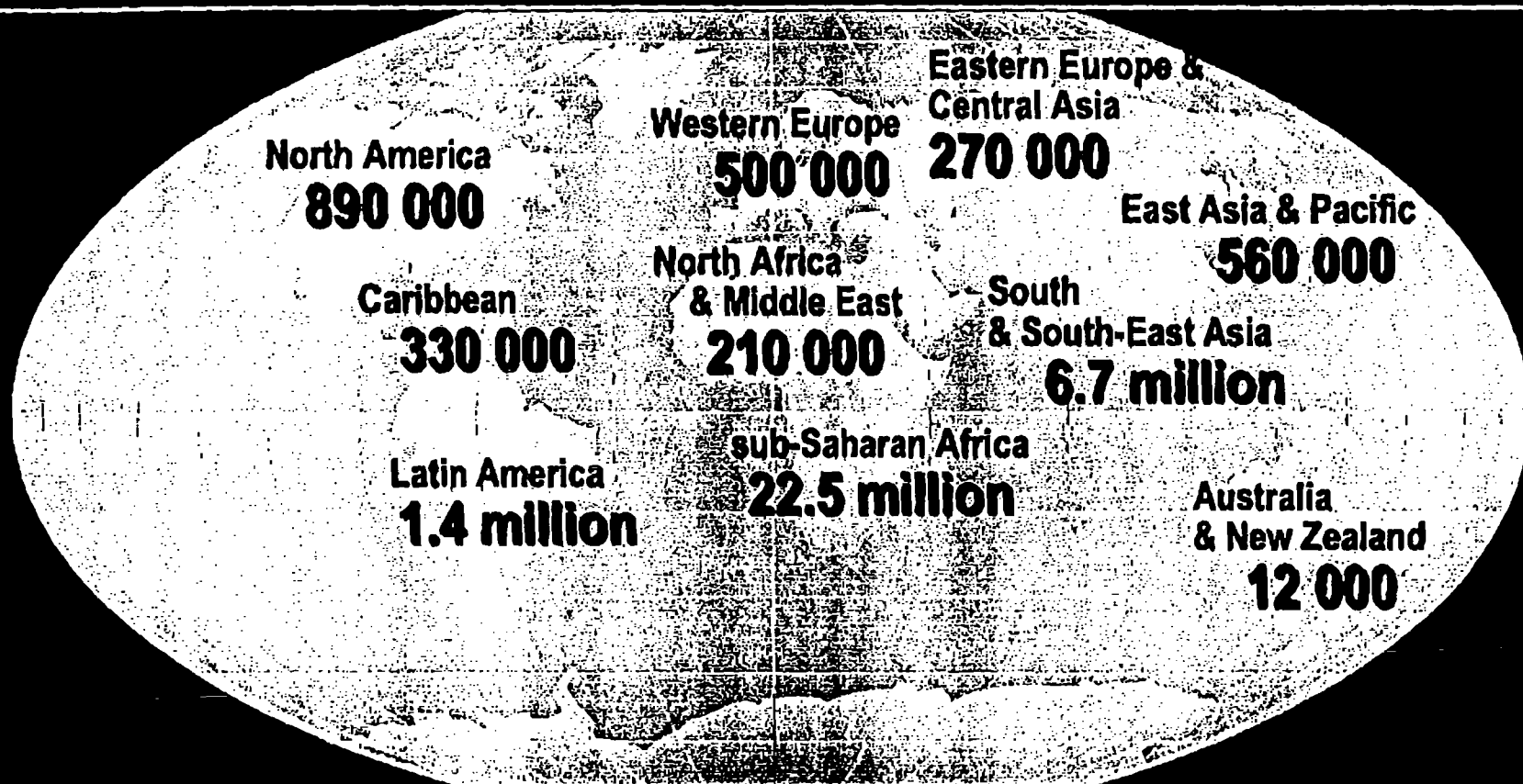
Estimated deaths in children (<15 years) from HIV/AIDS during 1998



Total: 510 000

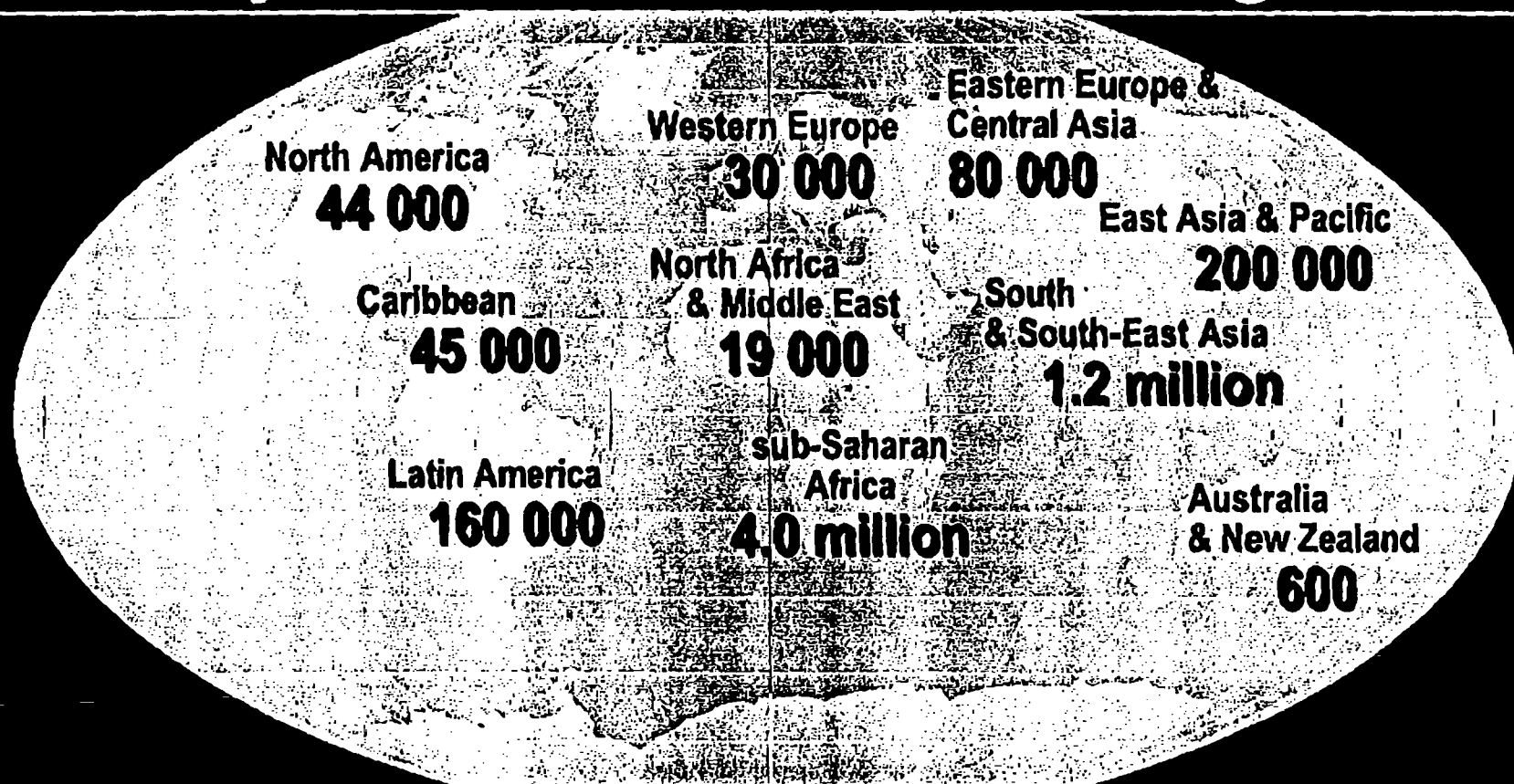


Adults and children estimated to be living with HIV/AIDS as of end 1998



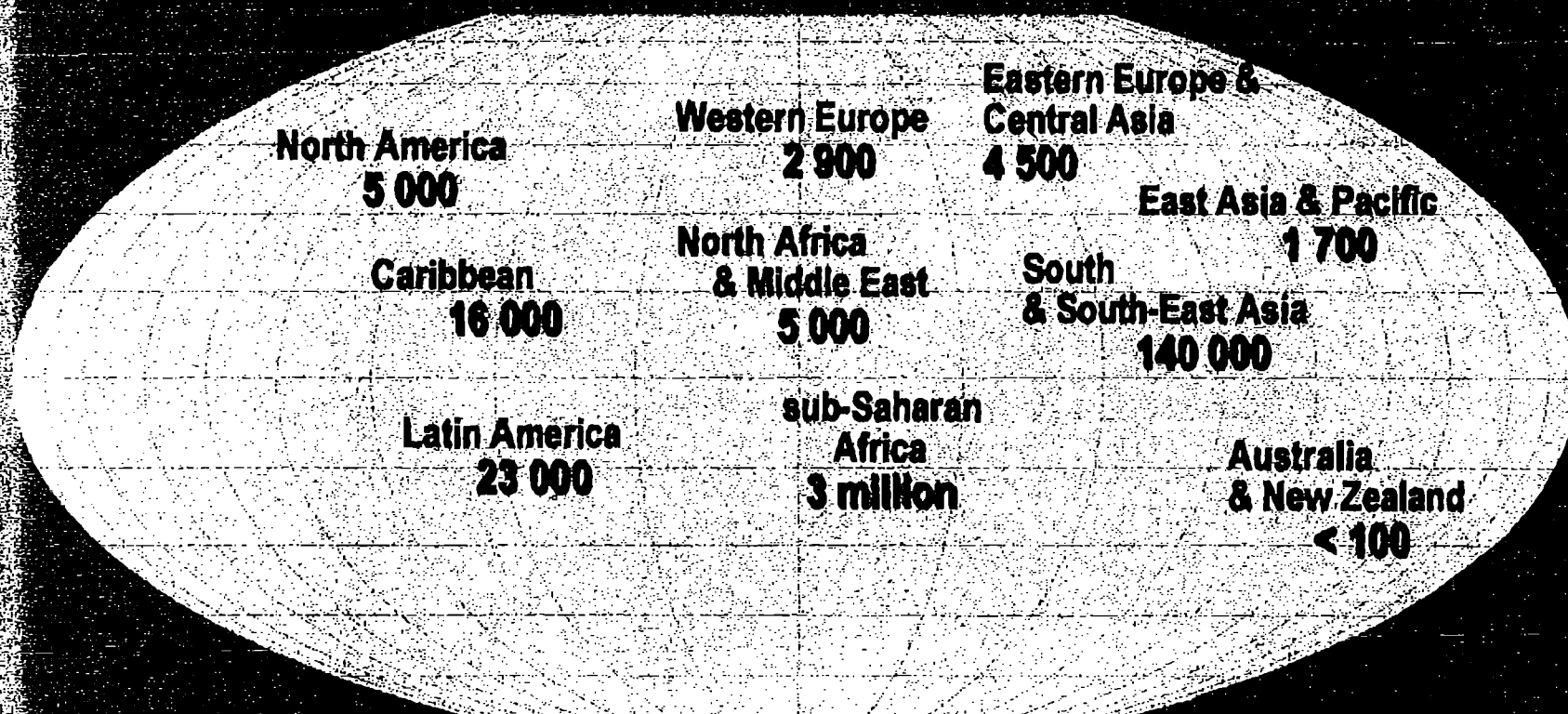
Total: 33.4 million

Estimated number of adults and children newly infected with HIV during 1998



Total: 5.8 million

Estimated deaths in children (<15 years) due to HIV/AIDS from the beginning of the epidemic to end 1998



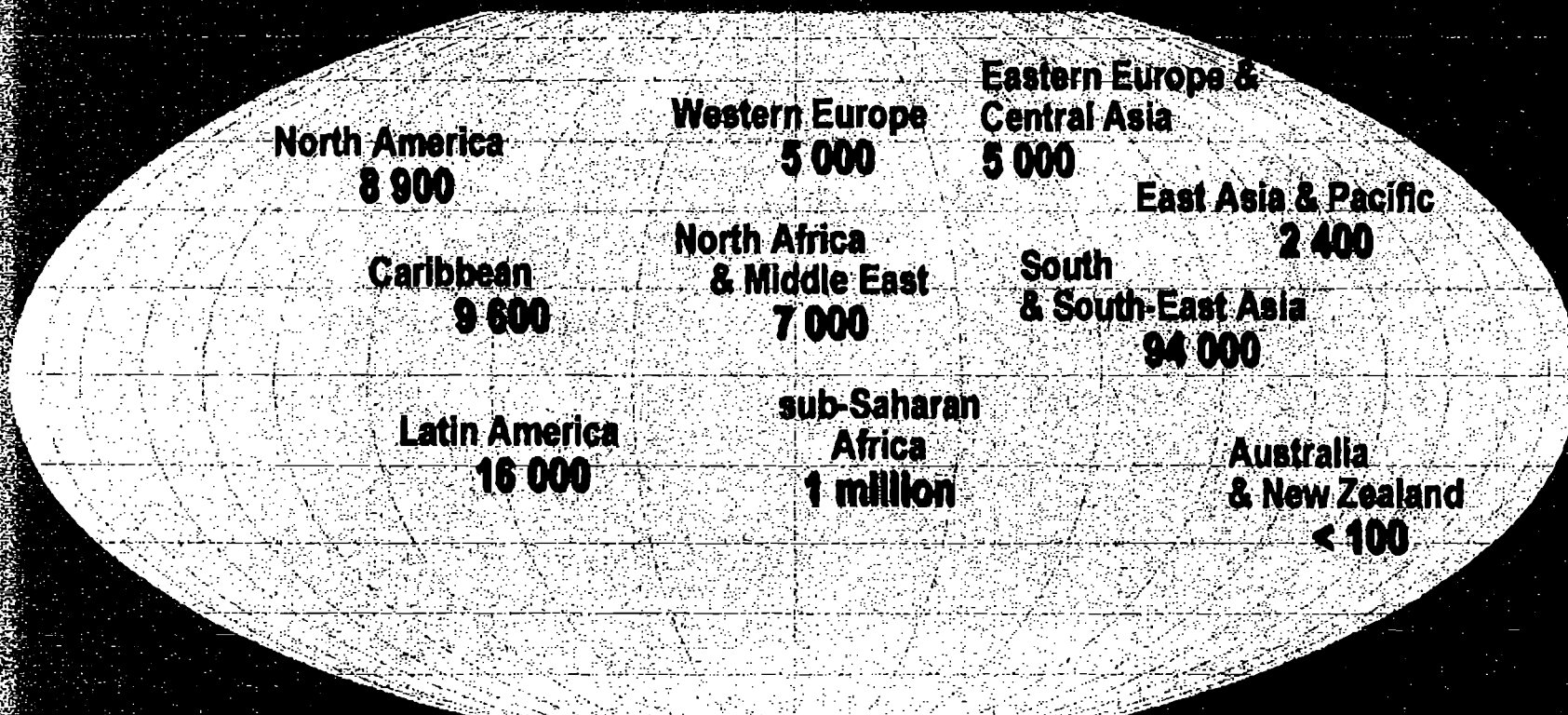
Total: 3.2 million

98036-E-4 - 15 July 1998



World Health
Organization

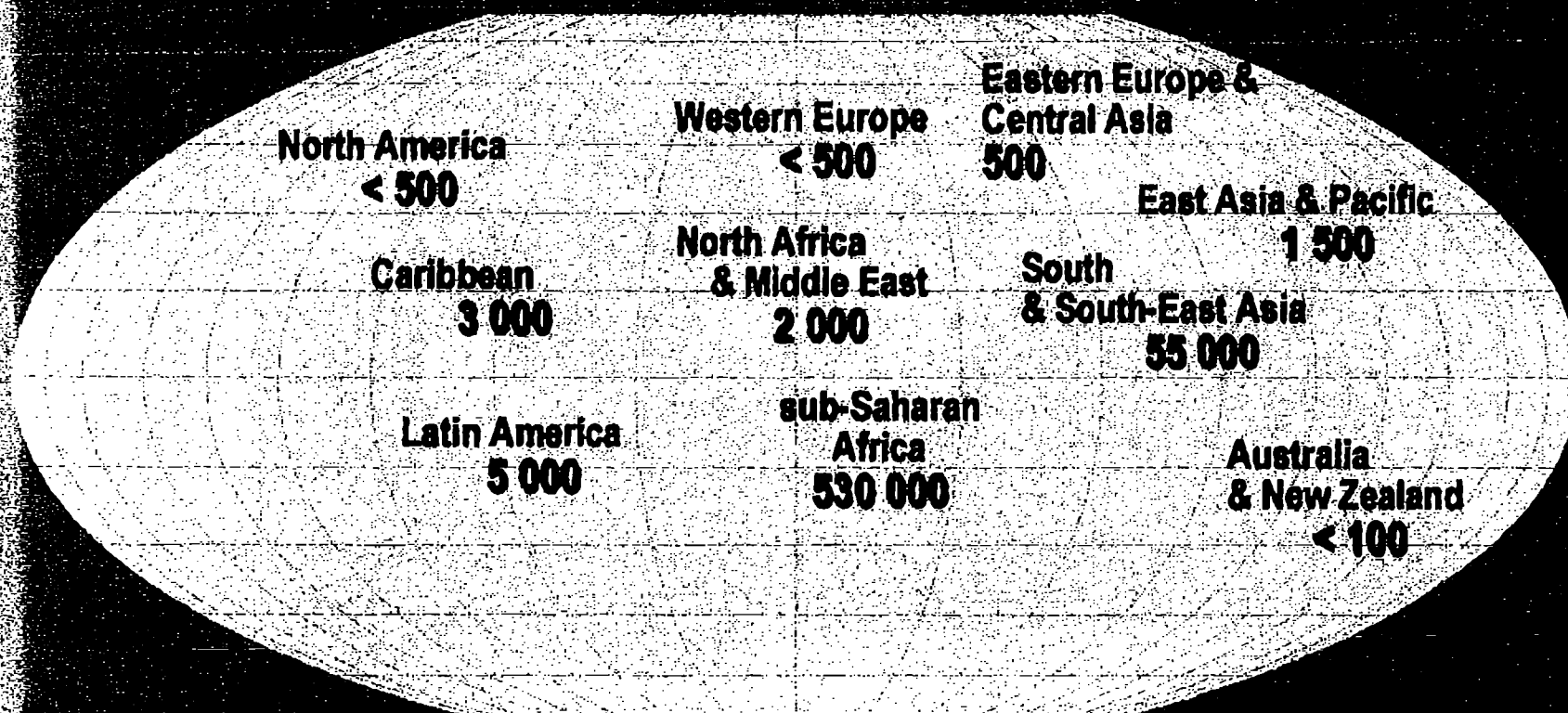
Children (<15 years) estimated to be living with HIV/AIDS as of end 1998



Total: 1.2 million

98036-E-2 - 15 July 1998

Estimated number of children (<15 years) newly infected with HIV during 1998



Total: 590 000

End-1998 global estimates Adults and children

People living with HIV/AIDS 33.4 million

New HIV infections in 1998 5.8 million

Deaths due to HIV/AIDS in 1998 2.5 million

Cumulative number of deaths due to
HIV/AIDS 13.9 million



WAD-EN 1998





AIDS Policy Center
For Children, Youth & Families

MEMO

TO: Sandy Thurman

FROM: David Harvey and Clark Moore

RE: World AIDS Day

DATE: November 20, 1998

We are very enthusiastic about your plans to focus attention on AIDS and orphans on World AIDS Day. As you are well aware, the statistics on AIDS and orphans are staggering: in 1997, UNAIDS estimated that 8.2 million children ages 14 and under had been orphaned by AIDS. An estimated 70,000 of these children were living in North America. The U.S. Agency for International Development estimated in 1997 that more than 40 million children in the 23 countries which have been hit hardest by HIV will be orphaned by the year 2000. The National Abandoned Infants Resource center has predicted that by 2000, as many as 125,000 children in the United States will have lost their mothers to AIDS.

AIDS Policy Center is eager to assist your office with preparations for World AIDS Day events at the White House. As you know, most of our member organizations provide services to children and families affected by HIV/AIDS, including children who have lost one or both parents to AIDS. We are happy to help facilitate the participation of families with orphaned children and their health care providers in your ceremony, from geographic areas of your choosing. We are also available to help respond to press inquiries.

The World AIDS Day event will be an opportunity to call attention to important public policy issues related to AIDS and orphans. One such issue is need for standby and joint guardianship laws. Standby guardianship laws enable parents with HIV to designate a guardian for their child in the event of the parent's mental incapacitation, physical debilitation, or death. Joint guardianship laws permit terminally ill parents to share guardianship with at least one other person. Although the Adoption and Safe Families Act of 1997 established "the sense of Congress that the States should have in effect laws and procedures that permit any parent . . . to designate a standby guardian," many states have not enacted such laws.

We would also be happy to help in any way with your planned visit to Africa to examine the issue of HIV/AIDS and orphans. As you may know, AIDS Policy Center has increasingly been involved in international HIV/AIDS policy. We would be happy to call upon our contacts in the international community to assist you as you plan the visit.

Suggested Contacts on HIV/AIDS and Orphans

Child Welfare League of America

440 First Street NW, Third Floor

Washington, DC 20001-2085

(202) 942-0291

Contact: Mr. Bruce Hershfield, HIV/AIDS Program Director

Children with AIDS Project of America (CWA)

4141 Bethany Home Road

Phoenix, AZ 85019

(602) 973-4319 or (800) 866-AIDS

The National Resource Center for Permanency Planning

Hunter School of Social Work

129 East 79th Street

New York, NY 10012

(212) 452-7053

The Orphan Project: Families and Children in the HIV Epidemic

121 Avenue of the Americas, Sixth floor

New York, New York 10013

(212) 925-5290

Jeff : ENC
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