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AIDS IN THE THIRD WORLD



A global disaster

PIETERMARITZBURG, HARARE, KAMPALA

The AIDS virus has infected 47m people, and shows no signs of slowing. It cannot be cured. Can it be curbed?

IN RICH countries AIDS is no longer a death sentence. Expensive drugs keep HIV-positive patients alive and healthy, perhaps indefinitely. Loud public-awareness campaigns keep the number of infected Americans, Japanese and West Europeans to relatively low levels. The sense of crisis is past.

In developing countries, by contrast, the disease is spreading like nerve gas in a gentle breeze. The poor cannot afford to spend \$10,000 a year on wonder-pills. Millions of Africans are dying. In the longer term, even greater numbers of Asians are at risk. For many poor countries, there is no greater or more immediate threat to public health and economic growth. Yet few political leaders treat it as a priority.

Since HIV was first identified in the 1970s, over 47m people have been infected, of whom 14m have died. Last year saw the biggest annual death toll yet: 2.5m. The disease now ranks fourth among the world's big killers, after respiratory infections,

diarrhoeal disorders and tuberculosis. It now claims many more lives each year than malaria, a growing menace, and is still nowhere near its peak. If India, China and other Asian countries do not take it seriously, the number of infections could reach "a new order of magnitude", says Peter Piot, head of the UN's AIDS programme.

The human immuno-deficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS), is thought to have crossed from chimpanzees to humans in the late 1940s or early 1950s in Congo. It took several years for the virus to break out of Congo's dense and sparsely populated jungles but, once it did, it marched with rebel armies through the continent's numerous war zones, rode with truckers from one rest-stop brothel to the next, and eventually flew, perhaps with an air steward, to America, where it was discovered in the early 1980s. As American homosexuals and drug injectors started to wake up to the dangers of bath-houses and needle-sharing,

AIDS was already devastating Africa.

So far, the worst-hit areas are east and southern Africa. In Botswana, Namibia, Swaziland and Zimbabwe, between a fifth and a quarter of people aged 15-49 are afflicted with HIV or AIDS. In Botswana, children born early in the next decade will have a life expectancy of 40; without AIDS, it would have been nearer 70. Of the 25 monitoring sites in Zimbabwe where pregnant women are tested for HIV, only two in 1997 showed prevalence below 10%. At the remaining 23 sites, 20-50% of women were infected. About a third of these women will pass the virus on to their babies.

The region's giant, South Africa, was largely protected by its isolation from the rest of the world during the apartheid years. Now it is host to one in ten of the world's new infections—more than any other country. In the country's most populous province, KwaZulu-Natal, perhaps a third of sexually active adults are HIV-positive.

Asia is the next disaster-in-waiting. Already, 7m Asians are infected. India's 930m people look increasingly vulnerable. The Indian countryside, which most people imagined relatively AIDS-free, turns out not to be. A recent study in Tamil Nadu found over 2% of rural people to be HIV-positive: 500,000 people in one of India's smallest states. Since 10% had other sexually transmitted diseases (STDs), the avenue for further infections is clearly open. A survey of female STD patients in Poona, in Maharashtra, found that over 90% had never had sex with anyone but their husband; and yet 13.6% had HIV. China is not far behind.

No one knows what AIDS will do to poor countries' economies, for nowhere has the epidemic run its course. An optimistic assessment, by Alan Whiteside of the University of Natal, suggests that the effect of AIDS on measurable GDP will be slight. Even at high prevalence, Mr. Whiteside thinks it will slow growth by no more than 0.6% a year. This is because so many people in poor countries do not contribute much to the formal economy. To put it even more crudely, where there is a huge oversupply of unskilled labour, the dead can easily be replaced. Some people argue that those who survive the epidemic will benefit from a tighter job market. After the Black Death killed a third of the population of medieval Europe, labour scarcity forced landowners to pay their workers better.

Other researchers are more pessimistic. AIDS takes longer to kill than did the plague, so the cost of caring for the sick will be more crippling. Modern governments, unlike medieval ones, tax the healthy to

help look after the ailing, so the burden will fall on everyone. And AIDS, because it is sexually transmitted, tends to hit the most energetic and productive members of society. A recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GDP will be 14.5% smaller in 2005 than it would have been without AIDS, and that income per person will be 10% lower.

The cost of the disease

In general, the more advanced the economy, the worse it will be affected by a large number of AIDS deaths. South Africa, with its advanced industries, already suffers a shortage of skilled manpower, and cannot afford to lose more. In better-off developing countries, people have more savings to fall

ous, AIDS could break budgets and hobble the provision of services. In South Africa, an estimated 15% of civil servants are HIV-positive, but government departments have made little effort to plan for the coming surge in sickness. Education, too, will suffer. In Botswana, 2-5% of teachers die each year from AIDS. Many more take extended sick leave.

At a macro level, the impact of AIDS is felt gradually. But at a household level, the blow is sudden and catastrophic. When a breadwinner develops AIDS, his (or her) family is impoverished twice over: his income vanishes, and his relations must devote time and money to nursing him. Daughters are often forced to drop out of school to help. Worse, HIV tends not to strike just one member of a family. Husbands give it to wives, mothers to babies. This correspondent's driver in Kampala lost his mother, his father, two brothers and their wives to AIDS. His story is not rare.

Obstacles to prevention

The best hope for halting the epidemic is a cheap vaccine. Efforts are under way, but a vaccine for a virus that mutates as rapidly as HIV will be hugely difficult and expensive to invent. For poor countries, the only practical course is to concentrate on prevention. But this, too, will be hard, for a plethora of reasons.

- Sex is fun... Many feel that condoms make it less so. Zimbabweans ask: "Would you eat a sweet with its wrapper on?"

- ... and discussion of it often taboo. In Kenya, Christian and Islamic groups have publicly burned anti-AIDS leaflets and condoms, as a protest against what they see as the encouragement of promiscuity. A study in Thailand found that infected women were only a fifth as likely to have discussed sex openly with their partners as were uninfected women.

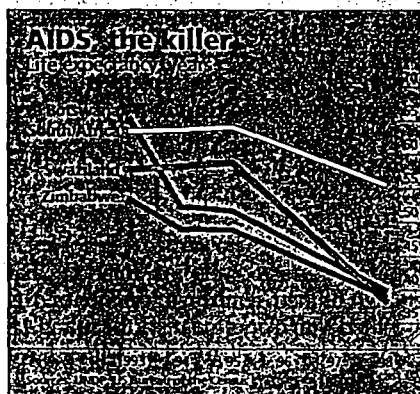
- Myths abound. Some young African women believe that without regular infusions of sperm, they will not grow up to be beautiful. Ugandan men use this myth to seduce schoolgirls. In much of southern Africa, HIV-infected men believe that they can rid themselves of the virus by passing it on to a virgin.

- Poverty. Those who cannot afford television find other ways of passing the evening. People cannot afford antibiotics, so the untreated sores from STDs provide easy openings for HIV.

- Migrant labour. Since wages are much higher in South Africa than in the surrounding region, outsiders flock in to find work. Migrant miners (including South Africans forced to live far from their homes) spend most of the year in single-sex dormitories surrounded by prostitutes. Living with a one-in-40 chance of being killed by a rockfall, they are inured to risk. When they go home, they often infect their wives.

- War. Refugees, whether from genocide in Rwanda or state persecution in Myanmar, spread HIV as they flee. Soldiers, with their regular pay and disdain for risk, are more likely than civilians to contract HIV from prostitutes. When they go to war, they infect others. In Africa the problem is dire. In Congo, where no fewer than seven armies are embroiled, the government has accused Ugandan troops (which are helping the Congolese rebels) of deliberately spreading AIDS. Unlikely, but with estimated HIV prevalence in the seven armies ranging from 50% for the Angolans to an incredible 80% for the Zimbabweans, the effect is much the same.

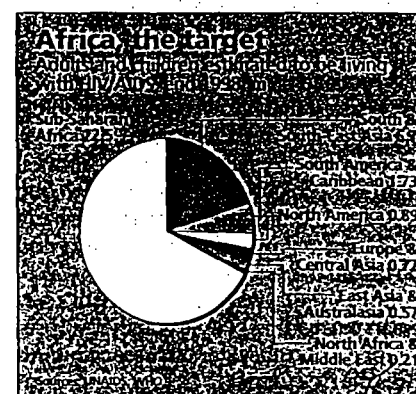
- Sexism. In most poor countries, it is hard for a woman to ask her partner to use a condom. Wives who insist risk being beaten



back on when they need to pay medical bills. Where people have health and life insurance, those industries will be hit by bigger claims. Insurers protect themselves by charging more or refusing policies to HIV-positive customers. In Zimbabwe, life-insurance premiums quadrupled in two years because of AIDS. Higher premiums force more people to seek treatment in public hospitals: in South Africa, HIV and AIDS could account for between 35% and 84% of public-health expenditure by 2005, according to one projection.

Little research has been done into the effects of AIDS on private business, but the anecdotal evidence is scary. In some countries, firms have had to limit the number of days employees may take off to attend funerals. Zambia is suffering power shortages because so many engineers have died. Farmers in Zimbabwe are finding it hard to irrigate their fields because the brass fittings on their water pipes are stolen for coffin handles. In South Africa, where employers above a certain size are obliged to offer generous benefits and paid sick leave, companies will find many of their staff, as they sicken, becoming more expensive and less productive. Yet few firms are trying to raise awareness of AIDS among their workers, or considering how they will cope.

In the public sector, where pensions and health benefits are often more gener-



up. Rape is common, especially where wars rage. Forced sex is a particularly effective means of HIV transmission, because of the extra blood.

- Drinking. Asia and Africa make many excellent beers. They are also home to a lot of people for whom alcohol is the quickest escape from the stresses of acute poverty. Drunken lovers are less likely to remember to use condoms.

How to fight the virus

Pessimists look at that list and despair. But three success stories show that the hurdles to prevention are not impossibly high.

First, **Thailand**. One secret of Thailand's success has been timely, accurate information-gathering. HIV was first detected in Thailand in the mid-1980s, among male homosexuals. The health ministry immediately began to monitor other high-risk groups, particularly the country's many heroin addicts and prostitutes. In the first half of 1988, HIV prevalence among drug injectors tested at one Bangkok hospital leapt from 1% to 30%. Shortly afterwards, infections soared among prostitutes.

The response was swift. A survey of Thai sexual behaviour was conducted. The results, which showed men indulging in a phenomenal amount of unprotected commercial sex, were publicised. Thais were warned that a major epidemic would strike

AIDS IN THE THIRD WORLD

if their habits did not change. A "100% condom use" campaign persuaded prostitutes to insist on protection 90% of the time with non-regular customers.

By the mid-1990s, the government was spending \$80m a year on AIDS education and palliative care. In 1990-93, the proportion of adult men reporting non-marital sex was halved, from 28% to 15%; for women, it fell from 1.7% to 0.4%. Brothel visits slumped. Only 10% of men reported seeing a prostitute in 1993, down from 22% in 1990. Among army conscripts in northern Thailand, a group both highly sexed and well-monitored, the proportion admitting to paying for sex fell from 57% in 1991 to 24% in 1995. The proportion claiming to have used condoms at their last commercial entanglement rose from 61% in 1991 to 93% in 1995.

People lie about sex, so reported good behaviour does not necessarily mean actual good behaviour. But tumbling infections suggest that not everyone was fibbing. The number of sexually transmitted diseases reported from government clinics fell from over 400,000 in 1986 to under 50,000 in 1995. Among northern conscripts, HIV prevalence fell by half between 1993 and 1995, from over 7% to under 3.5%.

Most striking was the government's success in persuading people that they were at risk long before they started to see acquaintances die from AIDS. There was no attempt to play down the spread of HIV to avoid scaring off tourists, as happened in Kenya. Thais were repeatedly warned of the dangers, told how to avoid them, and left to make their own choices. Most decided that a long life was preferable to a fast one.

Second, Uganda. Thailand shows what is possible in a well-educated, fairly prosperous country. Uganda shows that there is hope even for countries that are poor and

barely literate. President Yoweri Museveni recognised the threat shortly after becoming president in 1986, and deluged the country with anti-AIDS warnings.

The key to Uganda's success is twofold. First, Mr Museveni made every government department take the problem seriously, and implement its own plan to fight the virus. Accurate surveys of sexual behaviour were done for only \$20,000-30,000 each. Second, he recognised that his government could do only a limited amount, so he gave free rein to scores of non-governmental organisations (NGOs), usually foreign-financed, to do whatever it took to educate people about risky sex.

The Straight Talk Foundation, for example, goes beyond simple warnings about AIDS and deals with the confusing complexities of sex. Its staff run role-playing exercises in Uganda's schools to teach adolescents how to deal with romantic situations. Its newsletter, distributed free, covers everything from nocturnal emissions to what to do if raped. Visiting AIDS workers from South Africa and Zimbabwe asked the foundation's director, Catharine Watson, how she won government permission to hand out such explicit material, and were astonished to hear that she had not felt the need to ask.

The climate of free debate has led Ugandans to delay their sexual activity, to have fewer partners, and to use more condoms. Between 1991 and 1996, HIV prevalence among women in urban ante-natal clinics fell by half, from roughly 30% to 15%.

Third, Senegal. If Uganda shows how a poor country can reverse the track of an epidemic, Senegal shows how to stop it from taking off in the first place. This West African country was fortunate to be several thousand miles from HIV's origin. In the mid-1980s, when other parts of Africa were already blighted, Senegal was still relatively AIDS-free. In concert with non-governmental organisations and the press and broadcasters, the government set up a national AIDS-control programme to keep it that way.

In Senegal's brothels, which had been regulated since the early 1970s, condom use was firmly encouraged. The country's blood supply was screened early and effectively. Vigorous education resulted in 95% of Senegalese adults knowing how to avoid the virus. Condom sales soared from 800,000 in 1988 to 7m in 1997. Senegalese levels of infection have remained stable and low for a decade—at around 1.2% among pregnant women.

Contrast these three with South Africa. On December 1st, World AIDS Day, President Nelson Mandela told the people of KwaZulu-Natal that HIV would devastate their communities if not checked. The speech was remarkable not for its quality—Mr Mandela is always able to move audiences—but for its rarity. Unlike Mr Museveni, South Africa's leader seldom uses his authority to encourage safer sex. It is a tragic omission. Whereas the potholed streets of Kampala are lined with signs promoting fidelity and condoms, this correspondent has, in eight months in South Africa, seen only two anti-AIDS posters, both in the UN's AIDS office in Pretoria.

How to dither and die

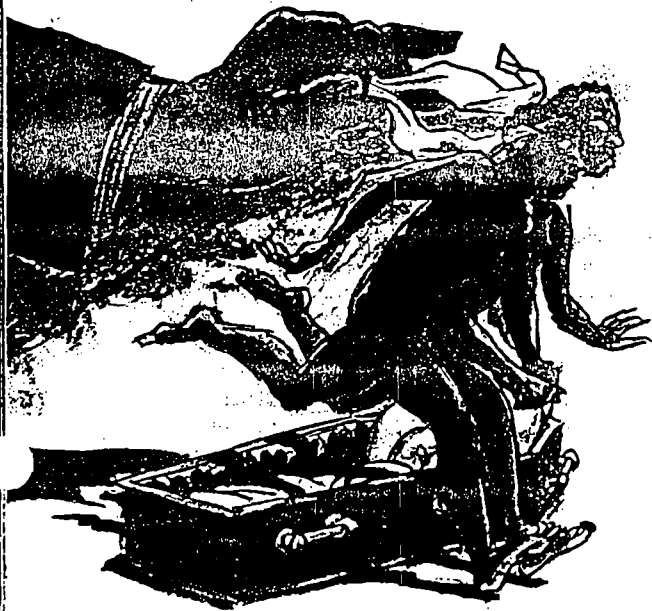
South Africa has resources and skills on a scale that Uganda can only marvel at. It even has an excellent AIDS prevention plan, accepted by the new cabinet in 1994. But the plan was never implemented. The government likes to consult every conceivable "stakeholder", so new plans are eternally drafted and redrafted. Local authorities cannot act without orders from the central government. NGOs, many of them dependent on the powers-that-be for their finance, waste months making sure that enough of their senior management posts are filled with blacks to satisfy the ruling African National Congress. And they have minimal freedom to experiment.

"There's an idea that if you disagree with the government, you are betraying the liberation struggle," says Mary Crewe, head of the Greater Johannesburg AIDS project. As a result, soldiers in the South African army are so ignorant that they snip the tips off their free condoms, and HIV has spread through South Africa as fast, according to Dr Neil McKerrow of Grey's Hospital in Pietermaritzburg, as if no preventive measures at all had been taken.

Such bungling is not unique to South Africa. Most governments have been slow to recognise the threat from AIDS. From Bulawayo to Beijing, apathy and embarrassment have hamstrung preventive efforts.

In anarchic countries, such as Congo and Angola, there have been almost no preventive efforts. Many people believe that the cause—a bid to restrain one of the most basic human instincts—is hopeless. As a Zimbabwean novelist, Chenjerai Hove, puts it with disturbing fatalism: "Since our women dress to kill, we are all going to die." But if the sexual drive is basic, so is the desire to live. If governments in poor countries wake up to the need to persuade their citizens that unprotected sex is Russian roulette, Mr Hove could be proved wrong.

This article is indebted to a number of UNAIDS reports, including AIDS epidemic update (December 1998), AIDS in Africa (November 1998), and "A measure of success in Uganda" (May 1998).



Presidential Mission on Children Orphaned by AIDS in sub-Saharan Africa: Findings and Recommendations

A Report to the President
June 14, 1999

Africa
findings -
SLT to POTUS

Sandra L. Thurman

Director
Office of National AIDS Policy
736 Jackson Place
Washington, DC 20503



"We have seen the faces of children and families living in a world with AIDS. Their spirit, their determination, and their resilience inspire all of us to join the fight. We are one world, and these children are our children. Their destiny is our destiny. Each of us can make a difference. Each of us can help save lives. Let us wage a holy war together. And for the sake of our children, let us pray we win."

Bishop Desmond Tutu

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Summary

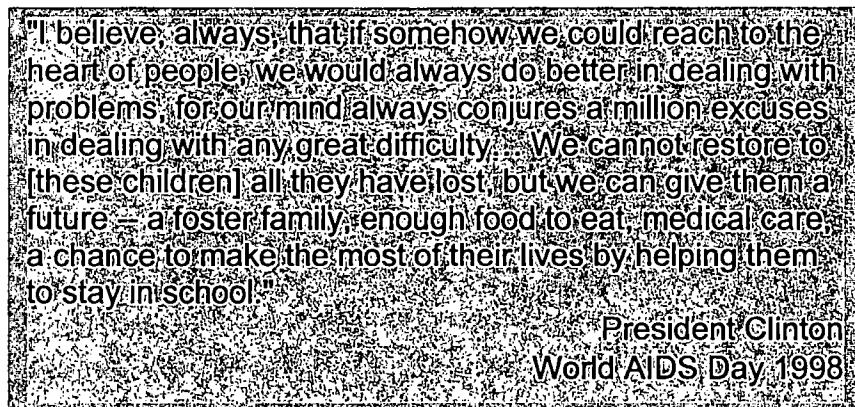
1. In the next decade, 40 million children will be orphaned as a result of losing one or both parents to AIDS.
2. AIDS is wiping out decades of progress on a variety of development fronts, including per capita GNP, infant mortality, and life expectancy.
3. AIDS is not just taking lives, it is threatening economies, stability, and civil society.
4. As goes Africa, so will go India, Asia, and the new Soviet states, and by 2005, more than 100 million people worldwide will be HIV positive.
5. Leadership and resources can help, and has helped, to turn the tide.

Background

This past World AIDS Day, you highlighted the growing global tragedy of children orphaned by AIDS in sub-Saharan Africa. At that time, you directed me to lead a fact-finding mission to the region and to report back to you with recommendations for productive action. From March 27 through April 5, I led a Presidential Delegation to Zambia, Uganda, and South Africa. I was accompanied by Representatives Jackson-Lee, Kilpatrick, and Lee, and senior staff from the offices of Senators Hatch, Helms, and Kennedy, and Representative Pelosi. Also joining us was a select group of individuals from outside of government including Mayor David Dinkins, Bishop Felton May, and William Harris. [Attachment A: Manifest]

The goals of the trip were:

- to heighten awareness
- promote leadership, and
- identify promising interventions.



Information for this report was gathered from meetings with African presidents, government ministers, donors, experts, providers, and consumers. In addition, site visits were made to a wide variety of community-based programs serving children and families affected by AIDS. Both the meetings and the visits provided an important perspective on the problem, actions taken, lessons learned, and barriers to further progress. (See Attachment B: Groups Visited)

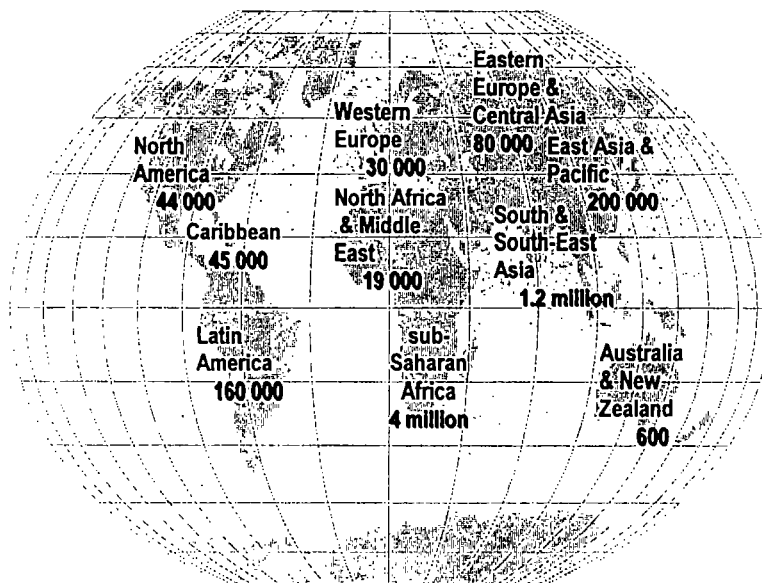
Findings

AIDS is ravaging sub-Saharan Africa, shattering families and placing extraordinary burdens on the extended family and village systems that have been the backbone of African child rearing tradition.

AIDS in sub-Saharan Africa, notes the UN, is the "worst infectious disease catastrophe since the bubonic plague." While sub-Saharan Africa accounts for only one tenth of the global population, it carries 80-95% of the AIDS burden. In the region, 21.5 million adults and 1 million children are already living with HIV, and every day 11,000 additional people are infected--one every 8 seconds.

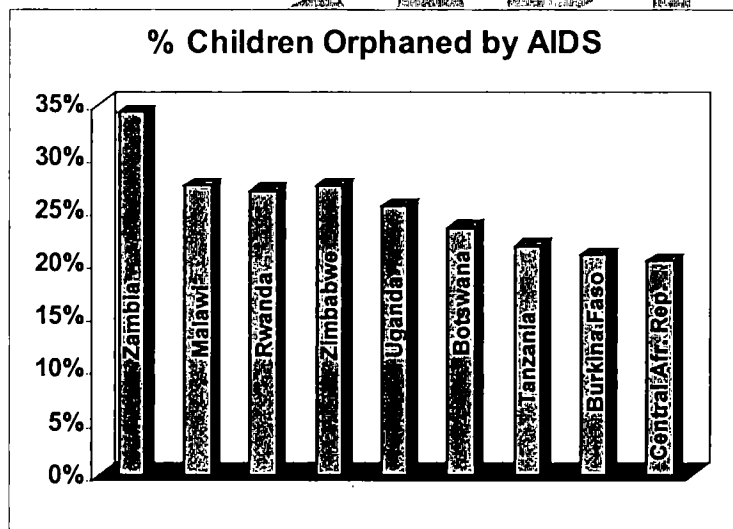
Since your press conference on World AIDS Day, 300,000 people in South Africa alone have become HIV infected, 200,000 of whom are teenagers. Half of all new infections in southern Africa occur in South Africa. Some 12 million people in the region have died of AIDS--a quarter of them children--and each day AIDS buries another 5,500. By 2005, the daily death toll will reach nearly 13,000.

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



While numbers vary from country to country, in nine sub-Saharan Africa countries, between one-fifth and one-third of all children will be orphaned by AIDS by the end of this year.

Further, throughout the region, one-quarter of all children are already living with an HIV+ parent. During the next decade, more than 38 million children in sub-Saharan Africa will be orphaned by AIDS, causing unprecedented threats to child welfare. This vulnerability includes decreased access to food, education, health care, housing, and clothing and increased psychosocial distress brought on by death, isolation, and stigma. These children are also at extraordinary risk of physical and sexual abuse as well as child labor exploitation. This "slow burn disaster" is not expected to peak until at least 2030, leaving an entire generation in jeopardy.



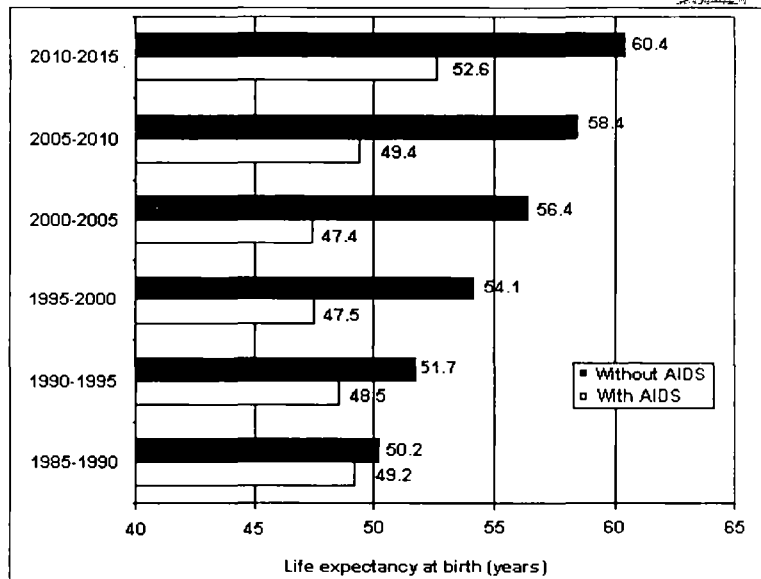
In 9 Sub-Saharan African countries, one-fifth to one-third of all children under the age of 15 will be orphaned by the year 2000

AIDS is wiping out decades of progress on a host of development objectives. After hundreds of millions of dollars of donor investment and well-documented results, AIDS is now turning back the development clock to the 1960s. In the coming decade in sub-Saharan Africa, infant¹ mortality will double and child² mortality will triple. In addition,

¹ Infants are defined as those less than 1 year old

² Children are defined as those ages 1 to 5

despite steady increases in access to education, children caught in the crossfire of this epidemic will continue to drop out of school to act as substitute labor or to care for their dying parents, and far too few will find their way back. Finally, according to the US Census Bureau, AIDS has already reduced life expectancy in Zimbabwe by a quarter of a century and in Zambia from 56 to 37 years old. In the next few years, AIDS will reduce life expectancy in South Africa by a third, from 60 years old to 40.



The Impact of AIDS on Life Expectancy in Selected African Countries

AIDS is not only causing unfathomable human suffering, it is jeopardizing the economies, stability, and civil society of many sub-Saharan African nations.

AIDS is a trade and investment issue. At the recent meeting with African trade and finance ministers, Professor Jeffrey Sachs, director of the Harvard Institute for International Development, stated that, "a frontal attack on AIDS in Africa may now be the single most important strategy for economic development." According to the *Economist*, "a recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996" and "Kenya's GNP will be 14.5% smaller in 2005 than it would have been without AIDS, and the per capita income will be 10% lower."

AIDS has hit professionals hard in sub-Saharan Africa, particularly civil servants, engineers, teachers, miners, and military personnel. According to a World Bank study, 34% of people with post-secondary education were HIV positive, compared to 18% of those with primary education, and civil servants were more than three times more likely to be HIV positive than farmers. Finally, increased benefits and training costs, and disruption due to sick and bereavement leave are seriously affecting both the private and public sectors. Companies like British Petroleum and Barclay Bank told us that they are now hiring two employees for every one skilled job, assuming that one will die of AIDS.

AIDS is a security issue. According to the *Economist*, "the estimated HIV prevalence in the seven armies embroiled in the Congo range from 50% for the Angolans to 80% in Zimbabweans." Recent reports confirm that 40% of the South African military is also already HIV positive. US military and intelligence officials have raised this as a serious stability concern. According to a DCI classified document: "Extremely high levels of HIV infection among senior officers lead to rapid turnover in those positions. In countries where the military plays a central or strong role in government, such rapid turnover could weaken central government authority or bring to the fore a military commander opposed to the government. In countries in political transition, instability in the military and security forces could slow or even reverse the process."

AIDS is a crime issue. A South African anti-crime institute has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. The assumption is that as the number of disaffected and undereducated young people increases, many sub-Saharan African countries may face serious threats to their social stability. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa alone, will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs to survive. This not only seriously affects stability but also promotes the spread of HIV.

In Lusaka, Zambia alone, estimates are that 100,000 children are living on the streets. Most have been orphaned by AIDS. It is projected that by the year 2000, one million children in Zambia, or one out of every



three children, will be orphaned by AIDS. Hundreds and hundreds of these children, ages 4 to 15, spend their nights on Cairo Road, sleeping in gutters and in tress, hoping to remain out of the "line of fire". Some are new to the streets, others have called it home for years. The longer they stay, the harder they get. In an effort to survive, too many are bought by crime, sex, and drug operations. While none would actually "chose" this life, once they "belong to the streets", it is difficult to turn back. It is likely that HIV infection is spreading like wildfire among these children. Given this reality, it is amazing that as the dawn breaks, so many of them gather at the

gate of the Fountain of Hope for school. While this school is really only a collection of outdoor benches around blackboards, the attention of the children to their studies and their desire to learn is inspiring.

As goes Africa, so will go India, Asia, and the new Soviet states, and by 2005, more than 100 million people worldwide will be HIV positive.

Asia is slated to mirror Africa in the number of AIDS deaths by the year 2005. As the world's most populous continent, containing 60 percent of the global population, Asia will soon come to dominate the HIV picture with one out of every four infections worldwide by the end of the century. Already, current trends suggest that Asia may have surpassed Africa with the highest number of new infections per year.

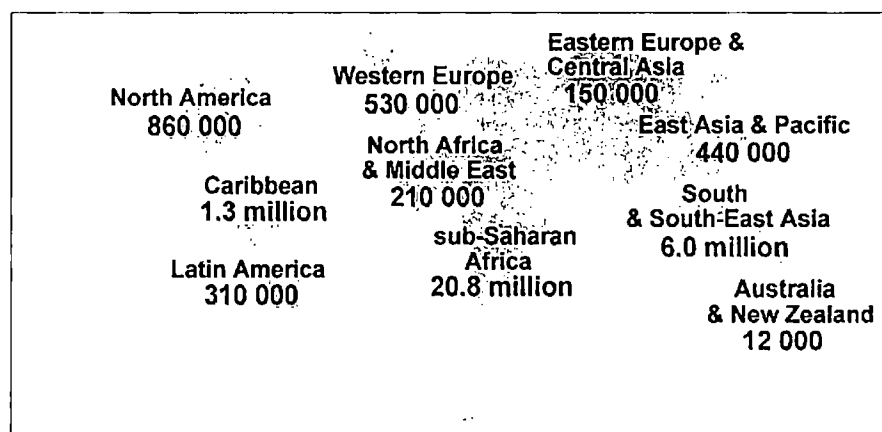
India is the growing hot spot of the epidemic, with the largest number of HIV infected people in the world - an estimated 5 to 7 million. While the number of deaths remains low in comparison to the rest of the developing world, infection rates are increasing rapidly and will continue this devastating trend in coming years. Surveillance of the disease is particularly difficult as cultural norms and discrimination of those identified as HIV positive keep many victims silent and out of the public consciousness. As a result, AIDS cases in India remain under-diagnosed, under-reported and poorly treated.

In addition, gender inequalities in South-East Asia as a whole continue to fuel the skyrocketing numbers.

The new Soviet states have registered astronomical growth in HIV infection rates over the past few years. In fact, the former socialist economies of Eastern Europe and Central Asia have seen infection rates increase six-fold. In the Ukraine alone, there are an estimated four times as many infections as there were in the whole Eastern European region just three years ago.

The spread of HIV poses a very real threat to the success of the new Soviet States. IV drug use now accounts for 80% of new infections in the Russian Federation and the growing number of new users continues to threaten prevention efforts in the region. With HIV gaining these new footholds in the communities of Eastern Europe, the potential for continued spread through drugs and sex is undeniable.

Political leadership remains critical in controlling the AIDS crisis in Asia. For example, significant strides have been made in Thailand where the government has recognized the growing crisis and successfully launched large-scale programs to counter the impact. Successful efforts to control the epidemic in Asia will require sustained commitment from political leadership to implement initiatives that address both prevention and treatment within their populations.



**An Estimated 30.6 Million Adults and Children
Are Living With HIV/AIDS,
Most in Developing Countries**

Determined leadership and sustained investment have made, and can continue to make, an extraordinary difference -- and save millions of lives.

Leadership matters. Amidst the tragedy of AIDS, there is opportunity. Uganda has shown that even a country with limited resources and a low literacy level can turn the tide on this burgeoning epidemic. President Museveni demonstrated bold leadership early on by making every government ministry take the problem seriously, requiring them to develop and implement a plan to reduce stigma and transmission, and care for those who became sick. As a result, Uganda created an "enabling environment" for donors to assist in this effort. Over the past decade, the US invested \$56 million in HIV prevention, care and support in Uganda and HIV rates among pregnant women dropped from 30% in 1991 to 15% in 1995 to 8% in 1998.

Effective solutions are community-based and multi-sectoral. In the longstanding African tradition, communities across the continent are searching for creative ways to support "the village" in its efforts to raise its children. Unfortunately, the growing number of young deaths and orphaned children already overwhelms many of these small villages.

With support of non-governmental organizations (NGOs), communities are mobilizing to deal with school fees, food assistance, immunization and oral re-hydration, counseling, and the range of other services these children need. Through FINCA and other micro-finance programs, women are receiving loans, starting small businesses, and with increased household incomes, taking in children orphaned by AIDS.

These efforts are low cost strategies designed to empower women (many of whom are HIV positive), protect children, and support extended families and communities in caring for their own. This community-based approach is universally preferred to the use of orphanages, a solution that can never keep pace with this burgeoning epidemic. For a small fraction of the cost of one orphanage bed, many more vulnerable children can receive care in a family setting. The problem is, only a very tiny fraction of those children in need receive even this modest level of support.

Bernadette Nakayima is a remarkable woman from a small village called Kyahusome outside of Maskaka, Uganda. Bernadette has lost 10 of her 11 adult children to AIDS. Today, at age 70, she is caring for



her 35 grandchildren. With loans from a village banking system, she has begun growing sweet potatoes, beans, and maize, raising goats and pigs, and trading in fish, sugar, and cooking oil. With the money she earns, she is now able to send 15 of her grandchildren to school, provide modest treatment for

the 5 who are now HIV+, and begin construction on a house big enough to sleep them all. In her spare time, she participates in an organization called "United Women's Effort to Save Orphans" – founded by the first lady of Uganda, Mrs. Museveni – linking in solidarity thousands of women allied in the same great struggle.

A focus on children can be a catalyst. The only way to slow the number of children orphaned by AIDS is to reduce the transmission of HIV. Until there is an available vaccine, this means more aggressive prevention efforts. In addition, the delivery of nutritional counseling and low cost treatments for opportunistic infections, STDs, and TB to parents with AIDS can help them to live longer and better lives and enable them to plan for the future of their children. Finally, community mobilization to save orphans empowers those involved and enables them to believe that they can change their circumstances for the better. It brings home the very real consequences of HIV, something that is too often denied due to the long latency period and the "conspiracy of silence" that surrounds this illness. These additional benefits of orphan work have far reaching implications for the epidemic, and for development at large.

Recommendations

[NOTE: These recommendations are currently under consideration by the emergency working group and will be further delineated once agreement has been reached.]

Throughout our travel in Africa, it was clear that your "Partnership with Africa" is making hope a reality, even at the village level. From Kampala to Cape Town, people across Africa know of this historic alliance, and many were anxious to show their gratitude. Unfortunately, AIDS threatens to decimate this partnership, as it has decimated everything in its path. To protect and defend this legacy of growth and opportunity, and the children and families who depend on it, an aggressive AIDS initiative, involving concrete action both at home and abroad is needed.

Given the magnitude of the AIDS pandemic and its devastating impact on economic development, trade, regional stability, and civil society in Africa today, and in India tomorrow, we established a Global AIDS Emergency Working Group. Included were the National Security Council, Office of Management and Budget, Office of the Vice President, USAID, Peace Corps and the Departments of Defense, State, Treasury, Commerce, and HHS. The Office of National AIDS Policy coordinated this effort, and together we make the following specific recommendations for an invigorated US response:

New funding

The global AIDS budget of the US Agency for International Development (USAID) is currently funded at approximately \$127 million, \$74 million of which is being spent in sub-Saharan Africa. USAID estimates that funds from all donors and host countries combined reach less than 10% of the at-risk or in-need population in the region. In order to reach our goals of promoting economic growth and opportunity in Africa and achieving our other development objectives, an investment in the battle against AIDS that is more commensurate with the magnitude of the unfolding horror is essential.

It is our hope that viewing a new investment through the lenses of millions of children orphaned by AIDS, and as an element of free trade and political stability, will engender bipartisan support. Given the importance of a multi-sectoral response to AIDS, it is essential that this be new money, not be taken from other USAID development accounts. Such an approach would be counterproductive to our overall development goals.

Debt swap for AIDS

In keeping with your goal to “ensure that no country committed to reform is left with a debt burden that keeps it from meeting its people's needs and spurring economic growth,” the Administration will explore the creation of mechanisms for allowing African countries to shift some of their debt payment toward an increased domestic investment in fighting AIDS. Target countries would be those with a significant debt burden, a significant HIV prevalence, and a demonstrated governmental commitment to reform. Selected countries would be required to develop an AIDS action plan, with the debt swap agreement based on movement toward performance goals delineated in the plan. Zambia, Ghana, and Rwanda are likely demonstration sites.

Public-private partnerships

The Administration will promote a broad-based response to AIDS in Africa that engages multi-national corporations, labor, non-governmental organizations, universities, and the religious community. A few courageous leaders have stepped forward, but much more needs to be done. Such an effort will not only extend the reach of government funding, but will provide a much-needed source of expertise, training and technical assistance.

Speaking with one voice

The Administration will adopt its own multi-sectoral response and instruct all of its agents in dialogue with African leaders to include a discussion about the importance of leadership on AIDS to the full range of other development objectives.

Mobilizing other donors

The Administration will continue to raise the need for an enhanced global response to AIDS among the G-8 nations, and will recommend their engagement in an AIDS debt swap

program (as described above). We will also look for other opportunities to partner with other developed nations in areas of prevention, care, and research.

Encouraging African leadership

The Administration will promote an AIDS summit for African Presidents or an AIDS orphan summit for African First Ladies. For example, President and Mrs. Museveni of Uganda certainly have much they could share with their colleagues from other countries in the region. President Chiluba from Zambia, President Rawlings of Ghana, and Deputy President Mbeki have all demonstrated a growing interest in enhancing their response to AIDS. Support from the US in an Africa leaders summit would ensure a major turnout and would reinforce our high level partnership with Africa.

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Conclusion

We are living in wartime and the stakes are high. Tragically, we know the severity of the horror that lies ahead. Fortunately, we also know a great deal about what can be done to protect children, and to support families and communities in their battle against AIDS. Across Africa, valiant efforts are being made to stem the rising tide of HIV infection, to prolong the lives of those who are sick and to stitch together a tapestry of family or family-like support systems for the growing millions of children orphaned by AIDS. Partnerships between our government and other donors, host governments, non-governmental organizations, consumer organizations, and communities are generating hope and demonstrating promising results.

But the battle has just begun, and the worst is yet to come. We need to continue to seek ways to promote and reward leadership, and to remove barriers that impede a cooperative multi-sectoral response. We need to expand our vision, expand our capacity, and expand our resource base -- in the face of an ever expanding nightmare that just won't take no for an answer. Living in wartime means pushing forward on several fronts at the same time. As we seek to keep pace and perhaps even gain ground, the question of how best to "scale up" effective interventions looms large. While on the trip, we heard calls for caution, caution not to move too fast and caution not to overestimate absorptive capacity. This caution is wise and well taken, but the faces of the children crying out for our help beckon us all to find ways to do better, to be smarter, to move faster, and to develop whatever capacity we lack, as we gear up for the long haul.

Attachment A

Trip Manifest

PRESIDENTIAL MISSION TO AFRICA MARCH 27, 1999 – APRIL 5, 1999

MEMBERS OF CONGRESS

Rep. Carolyn Kilpatrick

*Foreign Operations Subcommittee, Appropriations, and
Congressional Black Caucus*

Rep. Barbara Lee

*Africa Subcommittee, International Relations, and
Congressional Black Caucus*

Rep. Sheila Jackson Lee

*Founder and Chair, Congressional Children's Caucus, and
Congressional Black Caucus*

CONGRESSIONAL STAFF

Bruce Artim, Health Staff, Senator Hatch

Mary Lynn Qurnell, Legislative Assistant, Senator Helms

Stephanie Robinson, General Counsel, Senator Kennedy

Carolyn Bartholomew, Legislative Director, Rep. Pelosi,

Minority Staff, Foreign Operations Subcommittee, Appropriations

NON-GOVERNMENTAL PARTICIPANTS

William Harris, President, Children's Education and Research Institute

Bishop Felton May, General Board of Global Ministries, United Methodist Church

David Dinkins, Chair, Black Leadership Coalition on AIDS

Dr. Jacob Gayle, World Bank

Rory Kennedy, Documentary filmmaker

Nick Doob, Documentary filmmaker

ADMINISTRATION OFFICIALS

Sandy Thurman, Director, Office of National AIDS Policy

Michael Iskowitz, Consultant, USAID

Dr. Paul DeLay, Director, HIV/AIDS Programs, USAID

Maria Sotiropoulos, Protocol Officer, State Department

Phil Drouin, Africa Bureau, State Department

Attachment B

Groups Visited

	Community Organizations	Government Officials
Zambia	▪ Family Health Trust ▪ Fountain of Hope ▪ Mulenga Compound ▪ Project Concern International ▪ Society of Women Against HIV/AIDS ▪ St. Anthony's Compound ▪ Twapia Windows Group	▪ President Jacob Titus Chiluba ▪ Dr. Inkandu Luao, Minister of Health ▪ Dr. Moses Sichone, GRZ (Government of the Republic of Zambia) HIV/AIDS Coordinator ▪ Ambassador Arlene Render
Uganda	▪ AIDS Development Foundation ▪ AIDS Information Center Program ▪ The AIDS Support Organization ▪ Foundation for International Community Assistance ▪ National Community of Women Living with AIDS	▪ President Museveni ▪ First Lady Janet Museveni ▪ Minister of Health, Dr. Philip Byaruhanga ▪ Ambassador Nancy J. Powell
South Africa	▪ Bethesda House ▪ CINDI (Children in Distress) ▪ Don McKenzie TB Hospital ▪ Edith Benson Babies Home ▪ Ethembeni Centre ▪ Grey's Hospital ▪ Highway Hospice ▪ Hope Worldwide-Jabavu Clinic ▪ King Edward Hospital ▪ Lilly of the Valley ▪ Makaphuthu Children's Home ▪ Project Gateway ▪ Streetwise Shelter	

Attachment C

US Government Agencies Engaged

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Attachment D

US Government Agency Reports

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CHILDREN ON THE BRINK

STRATEGIES TO SUPPORT CHILDREN ISOLATED BY HIV/AIDS

E X E C U T I V E R E P O R T



UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT



Children on the Brink: Strategies to Support a Generation Isolated by HIV/AIDS tells a powerful and deeply disturbing story of crisis proportions. More than 40 million children in 23 developing nations will likely have lost one or both of their parents by 2010. Most of these deaths will be the result of the HIV/AIDS pandemic and complicating illnesses. The human and social costs of these numbers are staggering.

In countries across Africa, Asia and Latin America, HIV/AIDS is unraveling years of progress in economic and social development. Life expectancy — which has been steadily on the rise for the last three decades — will drop to 40 years or less in nine sub-Saharan African countries by 2010. In all 23 countries included in this study, AIDS-related mortality will eliminate the gains made in child survival over the past 20 years. In Zambia and Zimbabwe, infant mortality rates will likely nearly double, and child mortality rates will triple. The economies of the developing nations in this study will all struggle to deal with the immense economic dislocation and costs of illness, death and lost opportunity. And while the bulk of countries in this study are in Africa, this report should also serve as a grave reminder of similar storm clouds gathering now in Asia and Latin America, and of the terrible toll the HIV/AIDS crisis will claim on those regions' children.

This report provides a compelling demographic portrait of an immense problem. However, more important than the numbers contained in this study is the human story they tell. Forty million children losing one or both of their parents are 40 million children more likely to be forced into child labor; 40 million children who may never have an opportunity to attend school; and 40 million children more at risk of contracting HIV. This study should serve as a call to action for developed and developing nations alike. We cannot risk losing an entire generation of children to despair, ill health and hopelessness.

J. Brian Atwood
Administrator, U.S. Agency for International Development

Cover Photo: FAO Photo, Uganda 1994

Since his father died of AIDS 18 months ago, and his mother ran away to find a new life, Ismail, 18, looks after his eight brothers and sisters, including a three-year-old sick with AIDS. His paternal aunts are trying to take the land away from Ismail and his siblings, and they often take the plantain bananas Ismail grows as a staple to feed the family. The region around Ismail's town of Rakai in Uganda was initially the hardest hit by AIDS, but the virus has now spread throughout the country, and the death toll is mounting around the nation.

OVERVIEW

In many of the sub-Saharan African countries included in this study, the HIV/AIDS epidemic began early and is now severe, with the percentage of the population infected with HIV reaching more than 30 percent in some urban areas. The Asian countries that are most seriously affected by HIV/AIDS are home to over 20 percent of the world's population, and it is likely that by 2020 the largest number of children to lose parents to HIV/AIDS will be in South and Southeast Asia. The sheer size of the population at risk for HIV/AIDS in Asia means that the problem of parental deaths there will eventually eclipse that of sub-Saharan Africa. The number of children likely to lose their parents due to HIV/AIDS will also continue to grow in Latin America and the Caribbean, where the epidemic also started later.

Unfortunately, data is unavailable to make accurate projections of the number of children to lose parents to HIV/AIDS in most Asian countries where the epidemic impact is likely to be severe, such as India, Burma, Cambodia and Vietnam. This lack of data

underscores the importance of understanding how children and households are being affected and can best be assisted in sub-Saharan Africa so that these lessons can be applied when the problem of parental deaths becomes more severe in Asia and elsewhere.

According to the U.S. Census Bureau, 15.6 million children will have lost their mothers or both of their parents in the 23 countries studied in this report by 2000. Largely as a result of the HIV/AIDS epidemic, the number of those children who will likely lose their mothers or both parents in these 23 countries will increase to 22.9 million by 2010.

As stark as these figures may be, they do not fully convey the impact of HIV/AIDS on children and families in these countries. In order to develop a fuller picture of this impact, the U.S. Agency for International Development (USAID) expanded Census Bureau estimates to also include the number of children who will likely lose their *fathers* in these countries. Tracking the projected growth in the number of paternal deaths provides a fuller understanding of the impact of HIV/AIDS on children, for several reasons:

- Single mothers are the most impoverished members of these societies, and their ability to support children without the assistance of the father is very limited.
- In many societies, children whose fathers die of AIDS often lose their mothers soon after due to illness or social forces.
- In most of these countries, the social safety net provides only minimal assistance to widows and their children.

When paternal deaths are included, the total number of children who will lose one or both of their parents from all causes in these 23 countries is projected to increase from 24.7 million in 2000 to 41.7 million in 2010.

The loss of a parent obviously has profound significance to a child. The death of a mother, in particular, has dramatic consequences. Children lose

THE 23 COUNTRIES IN THIS STUDY

Nineteen of the countries in this study were included because the percentage of the population infected with HIV was estimated to be greater than 5 percent. Four additional countries were included: two where infection rates are approaching 5 percent; and two for which sufficient data existed to estimate AIDS mortality and the rate of loss of parents.

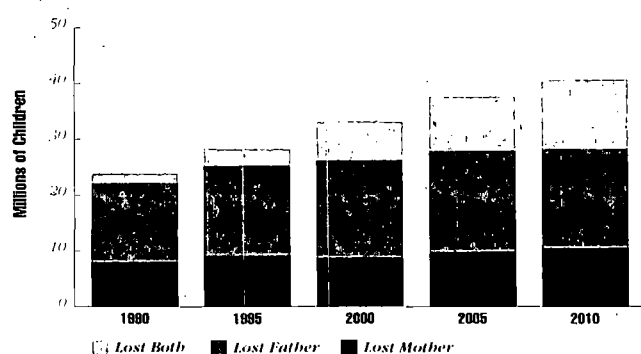
**Botswana
Burkina Faso
Cameroon
Congo
Dem. Rep. of Congo
Guyana
Kenya
Malawi
Rwanda
Thailand
Uganda
Zimbabwe**

**Brazil
Burundi
Central African Rep.
Côte d'Ivoire
Ethiopia
Haiti
Lesotho
Nigeria
Tanzania
South Africa
Zambia**

THIS OUTGROWTH of the HIV/AIDS epidemic may create a lost generation — a sea of youth who are disadvantaged, vulnerable, undereducated and lacking both hope and opportunity.

love and nurturing, and their households often break up, with siblings sent to different members of the extended family. Loss of a father frequently means the loss of income and subsequent economic deprivation. In any case, loss of a parent poses tremendous challenges for a child. These children may suffer depression, malnutrition, lack of immunizations or health care, increased demands for labor, loss of schooling, forfeiture of inheritance, forced migration, homelessness, vagrancy, starvation, crime and increased exposure to HIV infection.

Loss of Parent Estimates for 23 Study Countries



The growing number of children who will lose parents will, in turn, have a profound impact on their societies. With children who have lost parents eventually comprising up to a third of the population under age 15 in some countries, this outgrowth of the HIV/AIDS epidemic will create a lost generation — a sea of youth who are disadvantaged, vulnerable, undereducated and lacking both hope and opportunity. The creation of such a large and disaffected demographic “youth explosion” could propel some of these societies to significant unrest and destabilization over the long term. The threat to the prospects for economic growth and development in the most seriously affected countries is considerable. New approaches — including policy innovations for women and children

— must be developed within the next few years to nurture and develop local efforts to assist families and communities affected by the crisis.

It is important to note that while HIV/AIDS causes serious problems for children, singling out these children for assistance can sometimes stigmatize the intended beneficiaries. The needs of individual children who lose parents to AIDS are not necessarily greater than those of children who have lost parents to other causes, and they may begin long before their parents become ill or die from AIDS. Interventions to respond to children who have lost parents to AIDS must target communities and must include all children affected by HIV/AIDS, not just those whose parents have been infected with HIV or have died from AIDS.

The Demographic Effects of HIV/AIDS

Countries may experience the most severe demographic effects of HIV/AIDS years after the height of the epidemic. The demographic effects detailed below are now apparent in sub-Saharan Africa, where the epidemic began early, and will occur in the next decade for countries in Asia and Latin America.

IN ALL 23 COUNTRIES included in this study, AIDS-related mortality will eliminate the gains made in child survival over the past 20 years.

Life expectancy. Life expectancy will drop to 40 years or less in nine sub-Saharan African countries by 2010. Botswana, Zambia, and Zimbabwe would have had life expectancies of 60-70 years without HIV/AIDS, but will have life expectancies of only around 30 years with HIV/AIDS. Other countries that were making more modest but significant improvements in life expectancy will also see severe reductions.

Death rates. Crude death rates may be more than 1.5 times their present levels for the 23 countries overall, but the effects will vary by country. For example, crude death rates are projected to increase by half in Ethiopia but will more than double in Tanzania and Uganda. In the hardest-hit countries, including Zambia,

Zimbabwe and Malawi, crude death rates may increase by three to six times.

Infant and child mortality. In all 23 countries included in this study, AIDS-related mortality will eliminate the gains made in child survival over the past 20 years. The increases in infant and child mortality are expected to be most pronounced in those countries that have made the greatest progress in reducing infant and child mortality. In Zambia and Zimbabwe, infant mortality rates are expected to nearly double and child mortality rates to triple. In Kenya and Uganda, infant mortality rates are projected to increase by 50 percent and child mortality rates to double.

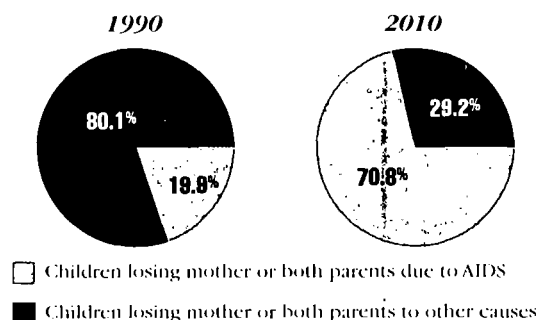
Population growth rates. AIDS will reduce population growth rates to less than half of their expected levels by 2010, and they may remain low or negative for many years. In most countries, total population growth will remain positive because fertility rates will remain high. However, in three countries, Botswana, Guyana and Zimbabwe, fertility rates may drop sufficiently to result in negative population growth by 2010.

Age distribution. In sub-Saharan Africa children under age 5 will continue to outnumber adults over age 44. According to the Census Bureau, there will be 12 times as many children under age 15 as adults over age 64 in sub-Saharan Africa. The proportion of the world's children under age 15 who live developing countries will near 90 percent in 2020. As a consequence, increased adult deaths caused by the epidemic may exacerbate the significant demographic "youth explosion" in the countries in this study.

The Socio-Economic Effects of HIV/AIDS

HIV/AIDS will cause fundamental social and economic changes in the 23 study countries that will affect the demand for labor, the availability of social services, access to health care, educational opportunities and the rates of poverty at the household level. The World Bank's 1993 World Development Report noted that HIV infections were a leading cause of disability and death and predicted an annual slowing of income growth per capita by 0.6 percent in the 10 worst-affected countries

Children's Loss of Mothers or Both Parents to AIDS versus Other Causes



in sub-Saharan Africa. The epidemic will continue to have a profound impact at the local level on families, communities and small-scale industries. The effects of HIV/AIDS will be uneven among households and communities, but will encompass the following areas:

The well-being of individuals and households. The costs of HIV/AIDS-related illness and death can be enough to send a household into permanent poverty or from poverty into destitution. Per capita and household income will decline as more families are thrown into poverty by the costs of illness, health and hospital care and support of orphans. The loss of women's labor in the home and in agriculture will create critical deficits in food supplies and potentially in exports.

Demand for labor. HIV/AIDS causes illness and death among adults in the most productive age groups. Costs of absenteeism and reduced productivity may be higher than the costs of eventual deaths. HIV/AIDS will significantly slow the growth of the labor force and will create labor shortages in certain markets. A study in Uganda estimated that there would be 2 million fewer people in the working age groups by 2010, 12 percent less than without HIV/AIDS.

Urban poverty. Higher HIV infection rates in urban areas will aggravate the situation of the urban poor more than the rural poor, who have broader household and community support systems and can fall back, to some extent, on household food production as their incomes decline.

Agricultural production. Household food production will become less labor-intensive and probably less nutritious. Commercial production by small-holders and plantations will be jeopardized as labor is diverted to the immediate demands of food crop production.

Social services. Increases in HIV/AIDS-related illness and death will likely cause a decline in school attendance as declining household incomes put pressure on children to help meet household needs for labor and income. A 1992 World Bank study in Tanzania suggested that HIV/AIDS may reduce the number of primary school children by 22 percent and the number of secondary school children by 14 percent from the level that could be expected without HIV/AIDS. HIV/AIDS also will reduce the number of teachers available, just as it will reduce the number of skilled workers in the health care and social services. HIV/AIDS-related illnesses will continue to swamp hospital beds and budgets in many of the countries in this study.

The Impact of HIV/AIDS on Children

The problems children face as a result of HIV/AIDS begin long before their parents die as they live with sick relatives in households stressed by the drain on their resources. Children are left emotionally and physically vulnerable by the illness or death of one or both parents. They may suffer lingering emotional problems from attending to dying parents and seeing their parents die. In countries with even only moderately severe HIV infection rates, up to 25 percent of children born to healthy women may have at least one HIV-infected parent by their fifth birthdays.

Subsequently, children who have lost parents are more likely to be removed from school because their households need new sources of income and labor. Children are increasingly forced to assume adult roles

IN COUNTRIES with even only moderately severe HIV-infection rates, up to 25 percent of children born to healthy women may have at least one HIV-infected parent by their fifth birthday.

in the home and in external labor markets. Strains on households and families may result in increases in child abuse and neglect in countries where social welfare systems may already be weak or marginal. Girls may face pressure to marry at younger ages. These children also will experience higher mortality rates and suffer from decreased nutrition.

HIV/AIDS also causes the dissolution of families. Children may be fostered or adopted prior to the death of a parent. Orphans are cared for by grandparents, uncles, aunts or siblings. Female orphans may be preferred for adoption over male orphans because they can provide domestic labor, sexual diversion and, in many places, a bride price. In short, children in households affected by HIV/AIDS face loss of their family and their identity, severe emotional distress, increased malnutrition, the loss of health care, the increased likelihood they will be forced into child labor, reduced opportunities for education, the loss of their inheritance, forced migration, homelessness and increased exposure to HIV infection.

APPROPRIATE PROGRAMS must be effective, cost-effective and sustainable over the long term.

The Impact of HIV/AIDS on Families

HIV/AIDS places new demands on family resources and reduces the time adults can spend on income-generating activities or subsistence agriculture. Medicines, treatments and other care often consume a significant share of the family income. When HIV infections result in disability, households are less able to care for children and the elderly. The demands for children's labor for domestic chores, income-generating work or care for an ailing household member increase. Households with HIV/AIDS typically spend a full year's income meeting treatment and funeral costs. Many families are impoverished by HIV/AIDS, particularly those with little savings or reserves. Female-headed households are especially vulnerable.

The problems caused by HIV/AIDS are shared by all

members of a household. The locus of care for HIV/AIDS patients is the family because of poverty or a lack of access to institutional care, personal preference and cultural norms. Changes in family composition and increased poverty have limited the ability of many families to provide care for sick family members. Most HIV/AIDS patients now care for themselves or are assisted by female relatives. These caretakers often lack medicine or treatments. The demands of caring for sick household members may lead them to neglect themselves and other household members. Labor-intensive, small-holder farms generally decline as a result of HIV/AIDS because illness reduces the quantity of household labor and limits the amount of income available for farm investment. HIV/AIDS deaths may result in changes in land ownership and utilization, reduced food stores and the sale of livestock holdings. The overall result may be diminished nutrition for adults and children. AIDS deaths lead to a redistribution of household assets, often with the disenfranchisement of women and children. Widows may have difficulty remarrying or finding potential husbands willing to assume responsibility for their children.

THE RESPONSE

It is impossible to overemphasize or exaggerate the scope and complexity of challenges faced by children affected by HIV/AIDS and by the families, communities and governments responsible for them. The coordination, effectiveness and impact of HIV/AIDS programs must be improved. Appropriate programs must be effective, cost-effective and sustainable over the long term.

The first and most important responses to the problems caused by HIV/AIDS comes from the affected children, families and communities themselves. The efforts of governments, nongovernmental organizations (NGOs) and donors are significant largely to the extent that

REDUCING "property grabbing" by protecting women's and children's property and inheritance rights is vital.

THE CHANGES experienced by children, families and communities vary around the world. In Africa, despite widespread poverty, children benefit from broad support mechanisms that may provide a stronger safety net than in other regions. This support system includes multi-generational families, single mothers living in sub-households, customs for exchanging children among kin and the sharing of child support and child rearing. Many of these patterns and customs differ in Asia and Latin America.

they help children, families and communities cope more easily with these problems. Recent experience suggests that six basic intervention strategies can help national governments, NGOs and donors target their efforts.

1. Strengthen the Capacity of Families to Cope with Their Problems

When a household begins to feel the effects of HIV/AIDS, extended family relationships are its first safety net. Although families are under great stress, the extended family has not collapsed under the weight of the HIV/AIDS pandemic. Most families are still providing some level of care for the overwhelming majority of affected children. Even in the most severely affected countries, the overwhelming majority of children who lose parents are living with extended family members.

The reality of caregiving for HIV/AIDS in developing countries places the greatest stress on females in the family, both adults and children. Action is needed to empower women and maximize their access to economic resources. Many of the problems faced by households affected by HIV/AIDS are fundamentally economic. These households are generally struggling to make ends meet and suffer setbacks when a member is sick or dies with HIV/AIDS or when they take in foster children. Arranging access to credit or ways to generate additional income can help families overcome such setbacks. In addition, reducing the labor demands on household members can free them to undertake other productive activities. Such labor-

saving efforts could include measures such as supporting community-based child care or extending piped water to villages.

Reducing “property grabbing” by protecting women’s and children’s property and inheritance rights is vital. This can be done, for example, by informing affected communities about ways women’s and children’s inheritance rights can be enhanced and by supporting legal services for widows and orphans. Measures should also be taken to reduce the health risks to children in households affected by HIV/AIDS. These may include developing home-based health services, supporting child nutrition programs, making special efforts to include these children in immunization programs and other health outreach efforts and targeting especially vulnerable children with HIV prevention programs.

HOUSEHOLDS WITH HIV/AIDS typically spend a full year’s income meeting treatment and funeral costs.

2. Stimulate and Strengthen Community-Based Responses

For children whose families cannot adequately provide for their basic needs, the community is the second safety net. In many areas, communities have joined together to support and assist families and children affected by HIV/AIDS. Left on their own, with no external assistance, some communities have devised identification and assistance programs of varying sophistication to help needy families in their midst. While being the least visible, many of these community-based responses may be the most cost-effective interventions.

Frequently, the most vulnerable children and families are the least likely to make their needs known to the community. An active effort is required to identify them and to mobilize local resources to respond to their most urgent needs. Many of the community-based programs to assist those affected by HIV/AIDS are

SENSITIZING POLICE and other public officials to the situation of children who work on the street and to any laws that protect them and promoting enforcement of child labor laws is also vital.

developed and run by community-based organizations. These organizations are generally democratic, representing the interests of their members and accountable to them. They are formed as a response to shared experiences, and they generally do not rely on outside sources for funding. These groups form a powerful constituency for governments, nongovernmental organizations and donors.

Many of the communities hardest hit by HIV/AIDS have fashioned similar responses to HIV/AIDS and the needs of families and children. The community responses have included systems to enumerate and assess the needs of families and children, means of targeting assistance to those most in need, ad hoc monitoring systems of vulnerable children, labor sharing, broader access to credit, protection of the legal rights of women and children, efforts to help orphans support themselves, repair of deteriorating houses, apprenticeships to teach adolescents marketable skills and efforts to change local laws and practices that burden needy families and children.

3. Ensure that Governments Protect the Most Vulnerable Children and Provide Essential Services

The most vulnerable children are those who fall through the safety nets of both family and community. These children need a third line of response. National governments have the ultimate responsibility for ensuring that children are protected and cared for if they are on their own or if those with whom they live are unable to adequately care for them.

MANY OF THE COMMUNITIES hardest hit by HIV/AIDS have fashioned similar responses to HIV/AIDS and the needs of families and children.

This responsibility requires governments to intervene to protect abused or neglected children. Children who lose both parents are especially vulnerable. Most foster families provide the best care they can, but some have exploited or abused orphans they have taken in. Governments also have a responsibility to provide services on many levels that improve the welfare of children by ensuring access to safe water and health services, enabling all children to attend school and empowering families to support themselves economically.

ENABLING CHILDREN to stay in school and to learn vocational skills improves their ability to provide for their own needs, now and in the future.

Adoption and foster care mechanisms are needed to help children who require special placement. Building these mechanisms involves strengthening and expanding governmental or NGO programs, supporting measures to ensure rapid placement of abandoned infants and supporting screening procedures to ensure that children are placed in institutional care only when no better options are possible. Many children who have lost parents to AIDS have to work to survive. Sensitizing police and other public officials to the situation of children who work on the street and to any laws that protect them and promoting enforcement of child labor laws are vital.

Government leadership is also needed to encourage all elements of society to collaborate in developing realistic strategies to meet the needs of children and families affected by HIV/AIDS. These strategies can directly target the problems caused by HIV/AIDS, or they can seek to have a much wider social impact, such as providing free primary education or improving water and sanitation systems in vulnerable communities. The strategies should include attempts to harness private, as well as public and charitable, resources.

4. Build the Capacity of Children to Support Themselves

Children who have lost parents often must support themselves and their younger siblings earlier than other children. HIV/AIDS catches children in a double bind. At a point where children face a premature need for education and training that will help them support themselves, economic pressures and the need to replace lost adult labor often force them to drop out of school. Girls are often forced to drop out first, causing long-term losses for the society.

Enabling children to stay in school and to learn vocational skills improves their ability to provide for their own needs, now and in the future. Interventions to help children continue their education must address the specific factors that cause them to drop out and may include paying school expenses or vocational training fees, supporting apprenticeships with local artisans, constructing school facilities in exchange for guaranteed admission of children without parents and developing informed education for part-time students. It is also important to decrease households' dependence on children's work by boosting the income-generating capacity of poor households in areas seriously affected by HIV/AIDS.

5. Create an Enabling Environment for Affected Children and Families

The significance of efforts by governments, NGOs, donors, religious bodies and other entities will depend largely on the extent to which they make it easier for children, families and communities to cope with the effects of HIV/AIDS. In addition to the strategies for direct intervention described above, all parties must work together toward the overarching goal of creating an enabling environment for those affected.

Stigma and discrimination impede efforts to prevent the spread of HIV/AIDS and improve care and support of those with HIV/AIDS. The process of reducing stigma and discrimination is largely one of reducing fear, ensuring basic legal protection and transforming

MANY SUB-SAHARAN African countries, responsibility for children's welfare is often assigned to the most understaffed and under-funded government agencies.

the public perception of HIV/AIDS. Providing information and challenging myths can help reduce fear. Laws to protect the rights of those with HIV/AIDS and their families regarding health services, employment, housing, and schools can directly enhance their ability to cope. In some countries, public attitudes have been changed when political leaders or popular public figures have spoke openly about HIV/AIDS.

Sufficient financial resources must be mobilized and allocated to support essential policies and priorities. In many sub-Saharan African countries, responsibility for children's welfare is often assigned to the most understaffed and under-funded government agencies. Resource-strapped governments also rely on funding and assistance from donors and NGOs to provide many health, educational and social services. The private sector's commitment to respond should be nurtured. Many countries have work-site HIV/AIDS prevention programs with nascent care components. In some countries, concerned employers are developing survivor support programs which include health, education and vocational training. Private philanthropy can also be a source of support for local programs.

Laws and policies should be changed, where necessary, to reduce the vulnerability of children and families. At a minimum, laws and governmental policies and activities should promote women's and children's rights and status, allow women to own land and hold jobs, promote the responsibility of males for maintaining and supporting families, support increased activity and coordination among nongovernmental organizations, increase multi-sectoral responses to

USAID WORKS with more than 500 private voluntary and nongovernmental organizations in 40 countries to implement HIV prevention programs.

HIV/AIDS, encourage private sector investment in HIV/AIDS prevention and care and redirect national investment to improve health care and educational opportunities for those affected by HIV/AIDS.

6. Monitor the Impact of HIV/AIDS on Children and Families

Because an HIV/AIDS epidemic is constantly evolving, monitoring its effects provides essential information to guide policy and program development. Systems that regularly collect and disseminate information on the health and socio-economic impact of HIV/AIDS on families and children are particularly important.

Accurate information is essential for targeting assistance to children in the most seriously affected areas. There is a need to enhance mechanisms for collecting and analyzing data on the impact of HIV/AIDS on children, families and communities — their coping strategies, the factors that contribute to the spread of HIV/AIDS and existing programs and services. Estimates and projections of parent loss are particularly valuable. When community members assist in collecting data, they become more familiar with the scale and nature of the problems created by HIV/AIDS and are usually motivated to take charge and find solutions. This data must be updated regularly to reflect the changing face of the epidemic and the impact of interventions.

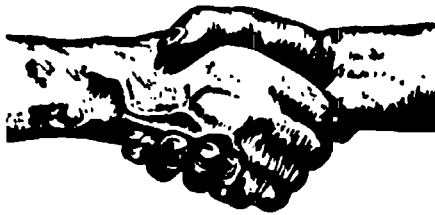
PREVENTION

Prevention remains a crucial element in combating HIV/AIDS. Without more effective prevention programs, the international community will never get the upper hand in the battle to protect children and families from the impact of HIV/AIDS. For the past decade, USAID has played a leading role in combating the HIV/AIDS epidemic. USAID works with more than 500 private voluntary and nongovernmental organizations in 40 countries to implement HIV prevention programs. The Agency has reached more than 15 million people with comprehensive HIV prevention education.

USAID has committed more than \$700 million to HIV/AIDS programs during the past eight years. This commitment has enabled the Agency to establish effective partnerships with international organizations, donors, national governments and nongovernmental organizations, develop innovative approaches to HIV/AIDS prevention and build community capacity to slow the spread of the epidemic. Given the threat the epidemic poses to sustainable development, USAID has made reducing transmission of HIV and other sexually transmitted diseases one of its strategic objectives. To achieve this objective, the Agency:

- Implements HIV/AIDS prevention programs using proven strategies to prevent transmission.
- Encourages policy reform to address social, cultural, regulatory and economic barriers to controlling HIV/AIDS and other sexually transmitted infections (STIs).
- Develops and tests new strategies and methods for preventing transmission and mitigating the impact of the HIV/AIDS pandemic.

Given the lack of an effective HIV/AIDS vaccine or treatment, USAID's strategy focuses on prevention. In recent years, however, the Agency has supported efforts to identify models of care and support for people living with HIV/AIDS and their families.



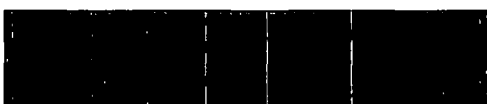
Working Paper:

Accelerating the Implementation of HIV/AIDS Prevention and Mitigation Programs in Africa

Draft in Progress
March 1999

USAID Bureau for Africa
Office of Sustainable Development
Division of Human Resource Development

USAID Global Bureau
Center for Population, Health, and Nutrition
HIV/AIDS Division



AIDS IN THE THIRD WORLD



A global disaster

PIETERMARITZBURG, HARARE, KAMPALA

The AIDS virus has infected 47m people, and shows no signs of slowing. It cannot be cured. Can it be curbed?

IN RICH countries AIDS is no longer a death sentence. Expensive drugs keep HIV-positive patients alive and healthy, perhaps indefinitely. Loud public-awareness campaigns keep the number of infected Americans, Japanese and West Europeans to relatively low levels. The sense of crisis is past.

In developing countries, by contrast, the disease is spreading like nerve gas in a gentle breeze. The poor cannot afford to spend \$10,000 a year on wonder-pills. Millions of Africans are dying. In the longer term, even greater numbers of Asians are at risk. For many poor countries, there is no greater or more immediate threat to public health and economic growth. Yet few political leaders treat it as a priority.

Since HIV was first identified in the 1970s, over 47m people have been infected, of whom 14m have died. Last year saw the biggest annual death toll yet: 2.5m. The disease now ranks fourth among the world's big killers, after respiratory infections,

diarrhoeal disorders and tuberculosis. It now claims many more lives each year than malaria, a growing menace, and is still nowhere near its peak. If India, China and other Asian countries do not take it seriously, the number of infections could reach "a new order of magnitude", says Peter Piot, head of the UN's AIDS programme.

The human immuno-deficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS), is thought to have crossed from chimpanzees to humans in the late 1940s or early 1950s in Congo. It took several years for the virus to break out of Congo's dense and sparsely populated jungles but, once it did, it marched with rebel armies through the continent's numerous war zones, rode with truckers from one rest-stop brothel to the next, and eventually flew, perhaps with an air steward, to America, where it was discovered in the early 1980s. As American homosexuals and drug injectors started to wake up to the dangers of bath-houses and needle-sharing,

AIDS was already devastating Africa.

So far, the worst-hit areas are east and southern Africa. In Botswana, Namibia, Swaziland and Zimbabwe, between a fifth and a quarter of people aged 15-49 are afflicted with HIV or AIDS. In Botswana, children born early in the next decade will have a life expectancy of 40; without AIDS, it would have been nearer 70. Of the 25 monitoring sites in Zimbabwe where pregnant women are tested for HIV, only two in 1997 showed prevalence below 10%. At the remaining 23 sites, 20-50% of women were infected. About a third of these women will pass the virus on to their babies.

The region's giant, South Africa, was largely protected by its isolation from the rest of the world during the apartheid years. Now it is host to one in ten of the world's new infections—more than any other country. In the country's most populous province, KwaZulu-Natal, perhaps a third of sexually active adults are HIV-positive.

Asia is the next disaster-in-waiting. Already, 7m Asians are infected. India's 930m people look increasingly vulnerable. The Indian countryside, which most people imagined relatively AIDS-free, turns out not to be. A recent study in Tamil Nadu found over 2% of rural people to be HIV-positive: 500,000 people in one of India's smallest states. Since 10% had other sexually transmitted diseases (STDs), the avenue for further infections is clearly open. A survey of female STD patients in Poona, in Maharashtra, found that over 90% had never had sex with anyone but their husband; and yet 13.6% had HIV. China is not far behind.

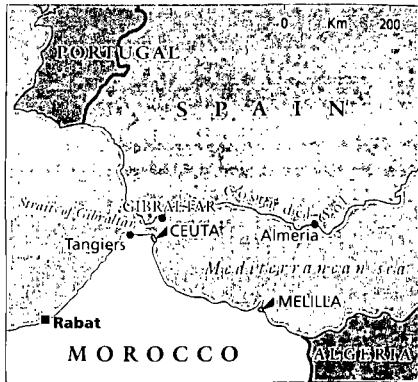
No one knows what AIDS will do to poor countries' economies, for nowhere has the epidemic run its course. An optimistic assessment, by Alan Whiteside of the University of Natal, suggests that the effect of AIDS on measurable GDP will be slight. Even at high prevalence, Mr Whiteside thinks it will slow growth by no more than 0.6% a year. This is because so many people in poor countries do not contribute much to the formal economy. To put it even more crudely, where there is a huge oversupply of unskilled labour, the dead can easily be replaced. Some people argue that those who survive the epidemic will benefit from a tighter job market. After the Black Death killed a third of the population of medieval Europe, labour scarcity forced landowners to pay their workers better.

Other researchers are more pessimistic. AIDS takes longer to kill than did the plague, so the cost of caring for the sick will be more crippling. Modern governments, unlike medieval ones, tax the healthy to

secticide. Unlike the countries of northern Europe, Spain does not penalise employers for using illegal workers: moreover, many illegals who find stable work end up with Spanish citizenship. Spain's problem is that it has to contend with a Brussels ban on work permits, whereas northern Europe was able to import its labour legally when it needed it in the 1970s.

Madrid's two North African enclaves, Ceuta and Melilla, probably offer the easiest way to break into the fortress. Earlier this year, the Spanish authorities, under orders from the EU, strung up a wire fence to keep out would-be migrants. But each night more arrive, cut through the barbed wire and demand political asylum. In Ceuta alone, the Red Cross is feeding 1,000 people. Almost all of them will eventually make it to Spain. Even if their applications are refused, Spain gives migrants a boat ride to the mainland and 15 days freedom to appeal—which is often time enough to disappear into the illegal morass.

The Red Cross camp in Ceuta is over-



flowing: refugees sleep 30 or more to a tent. Word of the backdoor to Europe has spread far: some have come from Kashmir and Iraq. Algerians are there in their scores, and West Africans—above all Nigerians—in their hundreds. They say they crossed the Sahara on foot, but many cruise the camp decked in gold chains, designer clothes and mobile phones. Spanish officials say that traffic in illegal migrants and substances goes hand-in-hand. Certainly, the sweet smell of Moroccan hashish wafts through the camps. And reports are now surfacing of a ring supplying southern Spain and Italy with child prostitutes from the deep south of Morocco.

Officials in Morocco say it is time to regulate the trans-Mediterranean traffic rather than leave the underground networks to do their worst. They suggest that the EU should replace the blanket ban on migrant workers with a quota, encouraging would-be migrants to seek a legal, safer passage to Europe. Morocco's proposal is plainly self-interested: migration is vital to the nation's economy. It acts as a safety-valve for a country that has an unemployment rate of 20%

and no welfare provision. Migration also provides Morocco with \$2 billion a year in remittances, its second-largest source of hard currency. If Europe were really to stem the flow, Morocco might implode.

Angola

Trapped in the middle

LUANDA

HELL and heaven are separated by a 20-minute drive along clogged streets. The centre of Angola's capital, Luanda, is a wasteland of piled-up rubbish, broken pavements and broken people; amputees from the war and its landmines beg at every corner. At the United Nations base on the outskirts of Luanda, freshly watered herbaceous borders run between rows of mobile homes. To keep the UN bureaucrats healthy and happy there are tennis courts and a swimming pool plus an all-American bar where beer can be bought only with dollars.

The government blames this haven of peace for the resurgence of the country's civil war in early December, venomously attacking the UN Observer Mission in Angola for incompetence. It claims that, if the UN had been doing its job properly, Jonas Savimbi, the UNITA rebel leader, would not have been able to stockpile weapons when, under the terms of the 1994 Lusaka protocol, he should have been handing them in.

They have a point. The UN's strategy was to make the most of the peace process in order to keep it going. UN officials regularly announced how many weapons had been handed in and how many soldiers and rebels were being demobilised at UN assembly points. No matter that many of the weapons were rusty and many of the UNITA "soldiers" at the centres were mere boys recruited a few weeks before.

But if the UN failed to spot Mr Savimbi's shopping habits in the world's arms markets, it also failed to draw attention to the government's crude lack of interest in a true peace. In territory abandoned by UNITA, where people were desperate for food and medicine, the government instead sent in thuggish policemen who, without supplies of their own, stole the last local food stocks.

On December 5th, the Angolan army attacked UNITA's strongholds at Andulo and Bailundo in the central highlands. At the same time, the ruling MPLA party, holding its annual congress in Luanda, replaced many veteran members with more military-minded men. The shuffle clearly signalled all-out war: the

party bosses were hoping to plant the government flag in the heart of the territory that Mr Savimbi once held.

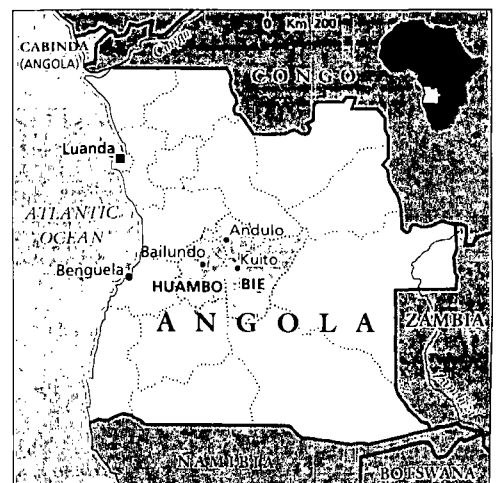
Most thought that would be easy. The rebels have no outside allies left. They are supposedly cut off by UN sanctions from both weapons suppliers and diamond buyers, and they have been weakened by attacks on their rear bases in Congo. But Mr Savimbi's forces proved stronger than expected and, by December 9th, UNITA was announcing that the government forces were in retreat "having been beaten at their own game". They were sent reeling as far as Kuito, which UNITA seemed on the point of seizing. Except that, at that point, the rebels ran out of petrol.

Angola makes \$2 billion-3 billion a year from oil, and UNITA usually has no difficulty finding supplies. This time, however, the rebels did not expect to find themselves advancing so fast. Like everyone else, they had overestimated government strength, and underestimated their own.

This gave the government a chance to regroup. The rebels set about shelling Kuito and fierce fighting is reported in Bie and Huambo provinces. On December 26th a UN-chartered flight with four crew and ten UN officials crashed near Huambo. Both sides accuse the other of shooting it down.

Four days after the crash, the UN's special representative, Issa Diallo, was still trying to get a local ceasefire to allow a search mission to look for survivors. The government said the aircraft had come down in UNITA-held territory and so it was not their business. The rebels denied having received any request from Mr Diallo until late on December 28th. UNITA also says that the government is carrying out air strikes on its headquarters, making communication impossible.

In short, neither side has shown the slightest interest in helping Mr Diallo look for the missing 14 people, let alone agreeing to a ceasefire or trying to work out a way of ending the war.



help look after the ailing, so the burden will fall on everyone. And AIDS, because it is sexually transmitted, tends to hit the most energetic and productive members of society. A recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GDP will be 14.5% smaller in 2005 than it would have been without AIDS, and that income per person will be 10% lower.

The cost of the disease

In general, the more advanced the economy, the worse it will be affected by a large number of AIDS deaths. South Africa, with its advanced industries, already suffers a shortage of skilled manpower, and cannot afford to lose more. In better-off developing countries, people have more savings to fall

ous, AIDS could break budgets and hobble the provision of services. In South Africa, an estimated 15% of civil servants are HIV-positive, but government departments have made little effort to plan for the coming surge in sickness. Education, too, will suffer. In Botswana, 2-5% of teachers die each year from AIDS. Many more take extended sick leave.

At a macro level, the impact of AIDS is felt gradually. But at a household level, the blow is sudden and catastrophic. When a breadwinner develops AIDS, his (or her) family is impoverished twice over: his income vanishes, and his relations must devote time and money to nursing him. Daughters are often forced to drop out of school to help. Worse, HIV tends not to strike just one member of a family. Husbands give it to wives, mothers to babies. This correspondent's driver in Kampala lost his mother, his father, two brothers and their wives to AIDS. His story is not rare.

Obstacles to prevention

The best hope for halting the epidemic is a cheap vaccine. Efforts are under way, but a vaccine for a virus that mutates as rapidly as HIV will be hugely difficult and expensive to invent. For poor countries, the only practical course is to concentrate on prevention. But this, too, will be hard, for a plethora of reasons.

- Sex is fun... Many feel that condoms make it less so. Zimbabweans ask: "Would you eat a sweet with its wrapper on?"

- ... and discussion of it often taboo. In Kenya, Christian and Islamic groups have publicly burned anti-AIDS leaflets and condoms, as a protest against what they see as the encouragement of promiscuity. A study in Thailand found that infected women were only a fifth as likely to have discussed sex openly with their partners as were uninfected women.

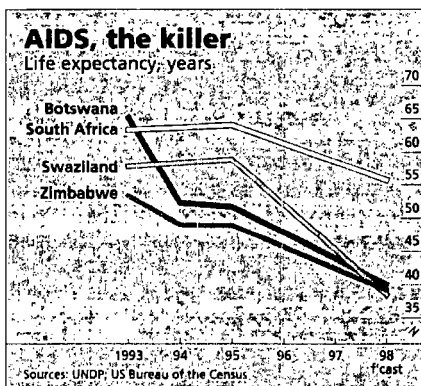
- Myths abound. Some young African women believe that without regular infusions of sperm, they will not grow up to be beautiful. Ugandan men use this myth to seduce schoolgirls. In much of southern Africa, HIV-infected men believe that they can rid themselves of the virus by passing it on to a virgin.

- Poverty. Those who cannot afford television find other ways of passing the evening. People cannot afford antibiotics, so the untreated sores from STDs provide easy openings for HIV.

- Migrant labour. Since wages are much higher in South Africa than in the surrounding region, outsiders flock in to find work. Migrant miners (including South Africans forced to live far from their homes) spend most of the year in single-sex dormitories surrounded by prostitutes. Living with a one-in-40 chance of being killed by a rockfall, they are inured to risk. When they go home, they often infect their wives.

- War. Refugees, whether from genocide in Rwanda or state persecution in Myanmar, spread HIV as they flee. Soldiers, with their regular pay and disdain for risk, are more likely than civilians to contract HIV from prostitutes. When they go to war, they infect others. In Africa the problem is dire. In Congo, where no fewer than seven armies are embroiled, the government has accused Ugandan troops (which are helping the Congolese rebels) of deliberately spreading AIDS. Unlikely, but with estimated HIV prevalence in the seven armies ranging from 50% for the Angolans to an incredible 80% for the Zimbabweans, the effect is much the same.

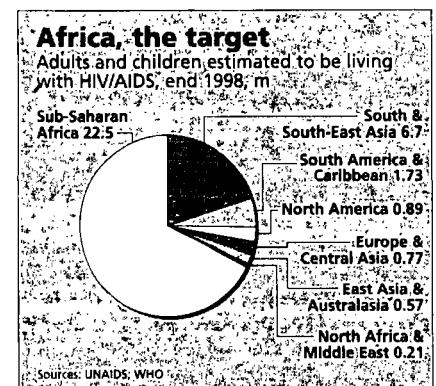
- Sexism. In most poor countries, it is hard for a woman to ask her partner to use a condom. Wives who insist risk being beaten



back on when they need to pay medical bills. Where people have health and life insurance, those industries will be hit by bigger claims. Insurers protect themselves by charging more or refusing policies to HIV-positive customers. In Zimbabwe, life-insurance premiums quadrupled in two years because of AIDS. Higher premiums force more people to seek treatment in public hospitals: in South Africa, HIV and AIDS could account for between 35% and 84% of public-health expenditure by 2005, according to one projection.

Little research has been done into the effects of AIDS on private business, but the anecdotal evidence is scary. In some countries, firms have had to limit the number of days employees may take off to attend funerals. Zambia is suffering power shortages because so many engineers have died. Farmers in Zimbabwe are finding it hard to irrigate their fields because the brass fittings on their water pipes are stolen for coffin handles. In South Africa, where employers above a certain size are obliged to offer generous benefits and paid sick leave, companies will find many of their staff, as they sicken, becoming more expensive and less productive. Yet few firms are trying to raise awareness of AIDS among their workers, or considering how they will cope.

In the public sector, where pensions and health benefits are often more gener-



up. Rape is common, especially where wars rage. Forced sex is a particularly effective means of HIV transmission, because of the extra blood.

- Drinking. Asia and Africa make many excellent beers. They are also home to a lot of people for whom alcohol is the quickest escape from the stresses of acute poverty. Drunken lovers are less likely to remember to use condoms.

How to fight the virus

Pessimists look at that list and despair. But three success stories show that the hurdles to prevention are not impossibly high.

First, **Thailand**. One secret of Thailand's success has been timely, accurate information-gathering. HIV was first detected in Thailand in the mid-1980s, among male homosexuals. The health ministry immediately began to monitor other high-risk groups, particularly the country's many heroin addicts and prostitutes. In the first half of 1988, HIV prevalence among drug injectors tested at one Bangkok hospital leapt from 1% to 30%. Shortly afterwards, infections soared among prostitutes.

The response was swift. A survey of Thai sexual behaviour was conducted. The results, which showed men indulging in a phenomenal amount of unprotected commercial sex, were publicised. Thais were warned that a major epidemic would strike

if their habits did not change. A "100% condom use" campaign persuaded prostitutes to insist on protection 90% of the time with non-regular customers.

By the mid-1990s, the government was spending \$80m a year on AIDS education and palliative care. In 1990-93, the proportion of adult men reporting non-marital sex was halved, from 28% to 15%; for women, it fell from 1.7% to 0.4%. Brothel visits slumped. Only 10% of men reported seeing a prostitute in 1993, down from 22% in 1990. Among army conscripts in northern Thailand, a group both highly sexed and well-monitored, the proportion admitting to paying for sex fell from 57% in 1991 to 24% in 1995. The proportion claiming to have used condoms at their last commercial entanglement rose from 61% in 1991 to 93% in 1995.

People lie about sex, so reported good behaviour does not necessarily mean actual good behaviour. But tumbling infections suggest that not everyone was fibbing. The number of sexually transmitted diseases reported from government clinics fell from over 400,000 in 1986 to under 50,000 in 1995. Among northern conscripts, HIV prevalence fell by half between 1993 and 1995, from over 7% to under 3.5%.

Most striking was the government's success in persuading people that they were at risk long before they started to see acquaintances die from AIDS. There was no attempt to play down the spread of HIV to avoid scaring off tourists, as happened in Kenya. Thais were repeatedly warned of the dangers, told how to avoid them, and left to make their own choices. Most decided that a long life was preferable to a fast one.

Second, **Uganda**. Thailand shows what is possible in a well-educated, fairly prosperous country. Uganda shows that there is hope even for countries that are poor and

barely literate. President Yoweri Museveni recognised the threat shortly after becoming president in 1986, and deluged the country with anti-AIDS warnings.

The key to Uganda's success is twofold. First, Mr Museveni made every government department take the problem seriously, and implement its own plan to fight the virus. Accurate surveys of sexual behaviour were done for only \$20,000-30,000 each. Second, he recognised that his government could do only a limited amount, so he gave free rein to scores of non-governmental organisations (NGOs), usually foreign-financed, to do whatever it took to educate people about risky sex.

The Straight Talk Foundation, for example, goes beyond simple warnings about AIDS and deals with the confusing complexities of sex. Its staff run role-playing exercises in Uganda's schools to teach adolescents how to deal with romantic situations. Its newsletter, distributed free, covers everything from nocturnal emissions to what to do if raped. Visiting AIDS workers from South Africa and Zimbabwe asked the foundation's director, Catharine Watson, how she won government permission to hand out such explicit material, and were astonished to hear that she had not felt the need to ask.

The climate of free debate has led Ugandans to delay their sexual activity, to have fewer partners, and to use more condoms. Between 1991 and 1996, HIV prevalence among women in urban ante-natal clinics fell by half, from roughly 30% to 15%.

Third, **Senegal**. If Uganda shows how a poor country can reverse the track of an epidemic, Senegal shows how to stop it from taking off in the first place. This West African country was fortunate to be several thousand miles from HIV's origin. In the mid-1980s, when other parts of Africa were already blighted, Senegal was still relatively AIDS-free. In concert with non-governmental organisations and the press and broadcasters, the government set up a national AIDS-control programme to keep it that way.

In Senegal's brothels, which had been regulated since the early 1970s, condom use was firmly encouraged. The country's blood supply was screened early and effectively. Vigorous education resulted in 95% of Senegalese adults knowing how to avoid the virus. Condom sales soared from 800,000 in 1988 to 7m in 1997. Senegalese levels of infection have remained stable and low for a decade—at around 1.2% among pregnant women.

Contrast these three with South Africa. On December 1st, World AIDS Day, President Nelson Mandela told the people of KwaZulu-Natal that HIV would devastate their communities if not checked. The speech was remarkable not for its quality—Mr Mandela is always able to move audiences—but for its rarity. Unlike Mr Museveni, South Africa's leader seldom uses his authority to encourage safer sex. It is a tragic omission. Whereas the potholed streets of Kampala are lined with signs promoting fidelity and condoms, this correspondent has, in eight months in South Africa, seen only two anti-AIDS posters, both in the UN's AIDS office in Pretoria.

How to dither and die

South Africa has resources and skills on a scale that Uganda can only marvel at. It even has an excellent AIDS prevention plan, accepted by the new cabinet in 1994. But the plan was never implemented. The government likes to consult every conceivable "stakeholder", so new plans are eternally drafted and redrafted. Local authorities cannot act without orders from the central government. NGOs, many of them dependent on the powers-that-be for their finance, waste months making sure that enough of their senior management posts are filled with blacks to satisfy the ruling African National Congress. And they have minimal freedom to experiment.

"There's an idea that if you disagree with the government, you are betraying the liberation struggle," says Mary Crewe, head of the Greater Johannesburg AIDS project. As a result, soldiers in the South African army are so ignorant that they snip the tips off their free condoms, and HIV has spread through South Africa as fast, according to Dr Neil McKerrow of Grey's Hospital in Pietermaritzburg, as if no preventive measures at all had been taken.

Such bungling is not unique to South Africa. Most governments have been slow to recognise the threat from AIDS. From Bulawayo to Beijing, apathy and embarrassment have hamstrung preventive efforts.

In anarchic countries, such as Congo and Angola, there have been almost no preventive efforts. Many people believe that the cause—a bid to restrain one of the most basic human instincts—is hopeless. As a Zimbabwean novelist, Chenjerai Hove, puts it with disturbing fatalism: "Since our women dress to kill, we are all going to die." But if the sexual drive is basic, so is the desire to live. If governments in poor countries wake up to the need to persuade their citizens that unprotected sex is Russian roulette, Mr Hove could be proved wrong.

This article is indebted to a number of UNAIDS reports, including AIDS epidemic update (December 1998), AIDS in Africa (November 1998), and "A measure of success in Uganda" (May 1998).

