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Global Future

Fourth Quarter, 2001

HIV/AIDS

The battle in the developing world

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Facing HIV/AIDS

THE BATTLE against HIV/AIDS received a welcome boost this year with the Declaration of Commitment signed by attendees at the United Nations General Assembly's Special Session on HIV/AIDS. And by the initiation of the Global Health and AIDS Fund, called for by UN Secretary-General Kofi Annan.

While such efforts must be applauded, more will be required in the months and years to come as the world community works to slow down and ultimately halt the spread of the virus. Because, while grand declarations such as these are fine, it will be hundreds of smaller steps in nations and neighbourhoods, clinics and communities, schools and social gatherings, that ultimately will turn the tide against HIV/AIDS.

We hear analogies meant to help us grasp the magnitude of the virus' toll. For instance, that the number of AIDS deaths is equal to a Titanic-size ship sinking weekly. Yet, such illustrations also can seem overwhelming. Given such odds, is there really any hope? There is, of course. Taking the analogy of a ship a step further, a vessel as small as a tugboat is all that's required to turn it around. Sure, it takes time and effort. But it can be done.

UNAIDS Executive Director Peter Piot, WHO Director-General Gro Harlem Brundtland and others on the front lines in the struggle against HIV/AIDS remind us in this edition of Global Future that, while the battles ahead may be daunting, we must press ahead and confront them.

While it may take years, even generations, to get this ship turned around, we have no choice but to take steps–globally and locally–to make every effort to do so. Our lives, and the future of our children, depend on it. ■

— Randy Miller

COVER PHOTO--UN/DPI: UNITED NATIONS SECRETARY-GENERAL KOFI ANNAN ADDRESSES THE UN GENERAL SESSION.
BACK COVER--PHOTO BY NIGEL MARSH: WOMEN IN TANZANIA GATHER FOR A TRAINING MEETING ABOUT HIV/AIDS.

The world's deadliest epidemic: 20 years & counting

Peter Piot

TWENTY YEARS AGO in June 1981, the first official report of the disease now known as AIDS was made in a nine-paragraph report of the U.S. Centres for Disease Control. Five people were affected.

No one reading those nine paragraphs could know that they were looking at what would become the most devastating epidemic in human history. It was inconceivable that HIV would spread so rapidly that within the first 20 years of the epidemic it would infect 58 million people, killing 22 million of them.

But from nearly the outset, the warning signs were there.

Major new epidemic

I will never forget the day in 1983 when I revisited Kinshasa's large Mama Yemo Hospital, a place I had come to know during the Ebola outbreak in 1976. When I saw the large numbers of emaciated young men and women, I instantly realised that the world would face a major new epidemic–one driven by sex.

Even so, none of us involved in those early days of AIDS could have imagined the scale of the epidemic that has unfolded.

For all the destruction the virus has already caused, we are still at the early stages of the epidemic.

It is a tale of globalisation: of the rapid global spread of a mainly sexually transmitted virus, of global inequities in health, and of the need for a truly global response and solution.

And it is a tale that is still in its opening chapters. HIV is characterised by a relatively long gap between infection and major illness. Its natural dynamic is to show up first among those at heightened risk, while at the same time gradually moving across the whole of the sexually active population. So one of the hardest lessons is that, for all the destruction the virus has already caused, we are still at the early stages of the epidemic.

But that does not mean that we have no choice but succumb to an inevitably growing toll of the disease. The opposite is true. The course the epidemic takes over the next 20 years will be a consequence of the choices the world makes now.

The brief history of AIDS is one of evolving understandings and shifting paradigms–from a medical curiosity to a complex health issue with major development, political and human security dimensions.

This year, the global response to AIDS is occurring in a radically new context. First, there is a convergence of scientific, economic and policy thought on the question of resources. Demanding billions of dollars for the response to AIDS in the developing world has moved from being a naive plea to a political imperative.

New paradigm

Second, access to a wider range of HIV care has moved from the realm of the impossible to the possible. For years, the price of drugs seemed to be an impossible barrier. But today, preferential prices for developing countries for AIDS drugs has been widely accepted within both the pharmaceutical industry and by policymakers.

In this new context, consensus is growing around a new paradigm.

First, investment now will prevent tens of millions of new infections and extend the lives of millions already living with HIV.

Second, whatever the stage of the epidemic, special recognition of the needs of young people maximises the effectiveness and impact of prevention.

Third, prevention, medical treatment and social support are all critical components of effective responses. Their effectiveness is immeasurably increased when they are used together.

UNDPI PHOTO

UNAIDS Executive Director Peter Piot, left, listens as UN Secretary-General Kofi Annan addresses the UN General Assembly Special Session on HIV/AIDS, held in June in New York.

Fourth, while the degree to which poor countries are able to extend access to antiretroviral therapy varies, in every case a beginning can be made. But these treatments have to be used carefully if they are to have lasting benefits, given that even under the best-resourced and most closely monitored conditions, the virus develops resistance to these drugs.

Prevention and treatment

And fifth, political commitment and planning exists in many countries around the world to build on existing programmes to greatly scale up prevention and treatment. What they lack are the resources.

The benchmark cost of providing a prevention and care response to the epidemic in low- and middle-income countries is US$7 to US$10 billion. There is a big gap between this figure and current AIDS spending from private, national and international sources in these countries of fewer than US$2 billion.

Filling this gap will undoubtedly need a greater level of commitment from national budgets. That is one reason why liberating funds through debt relief is a valuable part of HIV responses. As well, private sector involvement, in workplace and community responses to HIV, is another source of support.

But as well as building up these channels of support, meeting the resources gap will need a new global fund, attracting genuinely new money, from both wealthy country governments and from private donors.

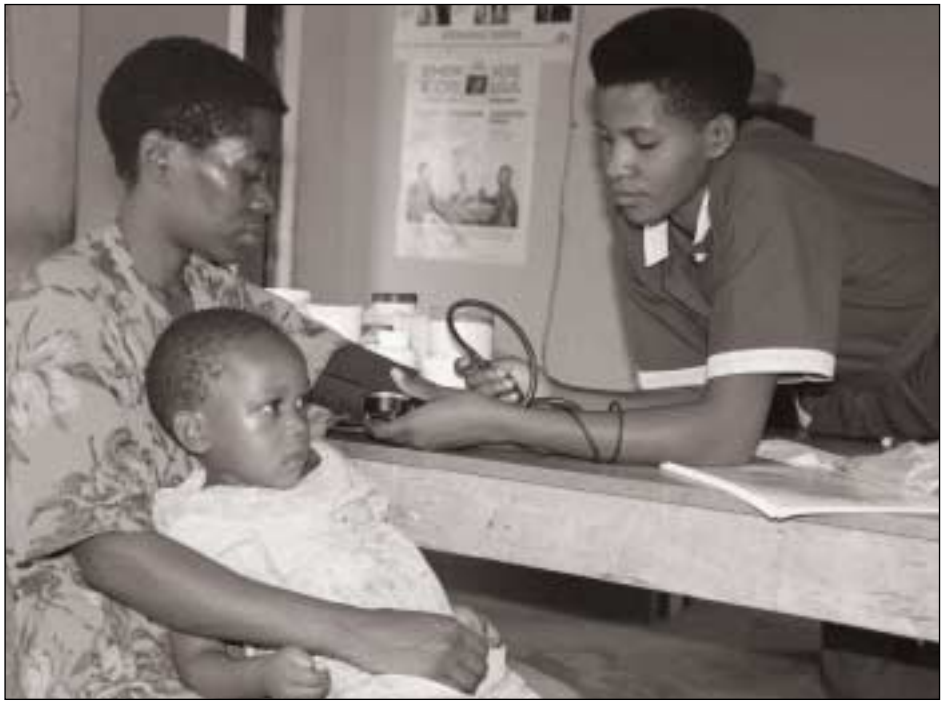
To this end, a Global AIDS and Health fund, as called for by UN Secretary-General Kofi Annan in April of this year, is rapidly taking shape. Already, more than US$1.5 billion has been pledged to the fund. These resources must provide for a wide spectrum of efforts, from supporting prevention programs, to increasing access to care and building the healthcare infrastructure that is sorely lacking in much of the world.

For the first time in the history of this epidemic we have the opportunity to turn the tide on a truly large scale–the scale that matches the extent of the epidemic.

We know what we need to do in order to slow new infections and provide care for those who are ill.

The stars are moving into the right configurations: we know what works, there is a strategy, there is political commitment, and resources are coming. There are still some stars missing–the ones with the vaccine and an effective microbicide that kills HIV on contact, as well as the one with the all-out effort to eradicate the stigma associated with AIDS.

UN/DPI PHOTO



Rose Namaganda, 28, an AIDS patient whose husband died in 1997, and her daughter Allen Nabusinde, 2, receive treatment at a clinic near their home in Uganda's Rakai District.

Special Session

In June, the United Nations General Assembly held its Special Session on HIV/AIDS. That Session, and the Declaration of Commitment it endorsed unanimously, showed that the nations of the world are prepared to demonstrate the resolve and the vision necessary to turn back the epidemic. Now is the time for these commitments to be made good, and for detailed programmes across nations and regions to the global targets set by the session. Pre-eminent among them are the commitments that by 2010, HIV among young people globally will be reduced by a quarter, and the number of infants infected with HIV will fall by half.

We know what we need to do in order to slow new infections and provide care for those who are ill. The only question is whether we have the will to do it. ■

Dr. Peter Piot is Executive Director of the Joint United Nations Programme on AIDS (UNAIDS).

A global crisis calls for global action

Gro Harlem Brundtland

HIV/AIDS REPRESENTS a threat to global development and regional and national security. The speed of the spread of this disease and the extent of the devastation caused by it is unprecedented.

The incidence and impact of HIV/AIDS demands commitment and action on regional, country and global levels.

At the end of June, the United Nations General Assembly held a Special Session on HIV/AIDS. The world's nations overcame differences to reach an agreement on the critical elements of a response. They made a profound political commitment to combat this scourge and agreed on a clear set of targets for action.

United Nations Secretary-General Kofi Annan called for a Global Health and AIDS Fund when he and I joined Organization of African Unity (OAU) heads of state in Abuja, the Nigerian capital, in late April. Since then governments, private entities, foundations, and individuals have committed more than US$1 billion to the Fund.

The World Health Organization is committed to reducing human suffering due to HIV/AIDS and its devastating global impact on human, social and economic development.

It is estimated that some 36 million people world-wide are currently living with HIV/AIDS, and that 22 million have died since this scourge began. Of the individuals living with HIV/AIDS, 95% live in developing countries.

As the epidemic grows, so does the caseload of HIV-related illnesses and the number of HIV/AIDS-related orphans, widows, widowers, and communities that have been stripped of teachers, doctors, nurses and others who have died from this disease. For the sake of our children and ourselves, we must do all that we can to provide care and support for the living victims of AIDS, both those who are infected and those whose lives have been affected.

HIV/AIDS is the leading cause of death in sub-Saharan Africa, where more than 24 million people are infected. Of that population, we know that more women are infected than men and that very young women between the ages of 15 and 19 years are particularly vulnerable, with infection rates up to four to five times higher than in boys of the same age in some countries.

More than 6 million people are infected in Asia. In fact, nowhere in the world is one safe from this highly communicable disease. Not in Africa, Asia, Europe, the Americas, or Oceania.

HIV/AIDS sufferers in developing countries become ill with treatable infections, such as tuberculosis, pneumonia and salmonella septicaemia, and die sooner than HIV-positive individuals in industrialized countries.

Dramatic reductions

Increasing numbers of people living with HIV/AIDS in industrialised countries are benefiting from recent developments in antiretroviral treatment. The vast majority of HIV-positive individuals in the developing world–individuals who cannot afford the cost of these drugs–are currently excluded. But thanks to the great effort of many partners we are beginning to see dramatic reductions in the prices of drugs necessary for treating people affected by HIV in developing countries.

This also must mean better access to drugs for preventing mother-to-child transmission of the virus in the least developed nations.

It upsets me greatly that this deadly disease continues to be transmitted from mother to child, especially in developing countries, even though a preventative treatment exists.

We will draw on the evidence we have to ensure that proven, gender-sensitive strategies for prevention, care and support are widely implemented and significantly impact on the epidemic.

These initiatives include differential drug pricing, specialised research, education, and prevention and treatment programs.

In every initiative, WHO will emphasise the fundamental principle of equitable access to prevention, care, support, and the most current knowledge derived from ongoing research.

We will strive to empower people, particularly those who are young, to take action to avoid HIV infection. Unnecessary sickness and death can be prevented by promoting safer sex, making condoms widely available, and convincing those who are infected and those who are not infected to use them.

We will continue our work to make the necessary drugs more accessible to developing nation health systems and patients, both by working to lower prices and to create viable distribution channels.

I sincerely believe the task is to focus on the everyday realities in people's homes, in their health systems and within governments and civil society. To confirm that our plans will work for real people in real life. This means collecting and analyzing the evidence, applying it, scaling up effective action and measuring results.

Together, we will rise to the challenge. We must apply the evidence and scale up our efforts so that, together, we can confront the greatest challenge faced by our global society. ■

Dr. Gro Harlem Brundtland is Director-General of the World Health Organisation.

A call for commitment

Poul Nielson

THE HIV/AIDS EPIDEMIC constitutes a global emergency, and is one of the most formidable challenges to human life and dignity. It is a cause of enormous suffering and a terrible barrier to the effective employment of human rights, which undermines social and economic development throughout the world, and affects all levels of society.

Never before has the gap between rich and poor been so great. The immorality of wealth and poverty side by side is clear. Never before has been such need for urgent action and collective effort. All of us are accountable for what we can do to take stronger national and international action against diseases affecting the poor. This is particularly true for AIDS, a virus that, in a span of less than 25 years, has become the world's deadliest infectious disease.

By the end of the year 2000, more than 36 million people world-wide were living with HIV/AIDS. Some 90% of these people were in developing countries, with 75% of these in sub-Saharan Africa, alone.

There is a common misconception that the AIDS epidemic is under control in the developed world.

There is a common misconception that the AIDS epidemic is under control in the developed world. While the mortality associated with HIV has been sharply reduced in developed countries, thanks to behavioural changes and anti-retroviral drugs, these are imperfect solutions. Drug therapies are expensive, often toxic, and they are not a cure. Still, we must make anti-retroviral drugs available where we can do so responsibly. Unfortunately, the great majority of people who are infected are not served by any basic health care system, and most suffer from poor nutrition. We need to do more to make drugs and services available. But, without greater commitment to building basic health care systems, most people who are infected will simply not be helped.

NIGEL MARSH

In parts of Africa, community groups including children and older adults perform skits and create posters designed to raise awareness about the dangers of spreading HIV/AIDS.

The European Commission has had long involvement in efforts to confront HIV/AIDS. Our priorities are to reinforce health and social services better cope with the demands of the epidemic; to reduce transmission of HIV and other sexually transmitted diseases; to assist governments and communities assess the impact of the epidemic and develop strategies to combat it; and to increase scientific understanding.

Accelerated response

The massive and rising impact of HIV/AIDS–as well as malaria and tuberculosis, the other two major communicable diseases related to poverty–has led us to revise EC policy and define a programme to deliver an accelerated response. This will involve increased action across the development, trade and research arenas.

We shall increase the impact of those presently underused interventions that we know can make a difference. With regard to HIV, these are well known. They include education programmes that influence behaviour change–particularly among the young; access to condoms; effective treatment of sexually transmitted infections; safe blood supplies; and scaling up early efforts to prevent mother-to-child transmission of the virus. We have to protect the vulnerable, in particular. If we are to make progress in tackling the epidemic, we must engage in direct, honest debate on ways to promote and protect the health of those at risk. While our first priority is to prevent the 5 million new infec-

tions each year, we shall also increase access to effective treatment and care.

We need to ensure that key pharmaceuticals are affordable for poor countries. The recent media focus has been on the cost of anti-retrovirals. Let us not forget that providing adequate quantities of effective drugs to treat TB and malaria may also be unaffordable if the annual health budget per capita is not sufficient. We are encouraging the pharmaceutical industry to establish tiered prices for key pharmaceuticals for the poorest countries.

Finally we want to increase and better co-ordinate investment in new generations of drugs, vaccines and diagnostics. We still have no HIV vaccine, no malaria vaccine and we rely on a less-than-optimal TB vaccine that is 50 years old. It is a tragic failure that so little past investment has targeted these diseases. Yet there are encouraging signs. The EC will commit Euro 130 million within the current research programme, and I hope that improved co-ordination will leverage additional investment from EU Members States and industry, specifically toward the testing of new vaccines.

Improved health care

The Commission is a major contributor to the health sector in developing countries. More than Euro 4.2 billion has been committed to health over the past decade, and the portfolio of active health projects and programmes currently totals more than Euro 1.4 billion. Further support is provided through co-financing NGOs and through thematic budget lines that aim to support the development of innovative approaches or new knowledge. Most resources are provided to support the strengthening of national health systems. Assistance targets systems development, human resources development, strengthening pharmaceutical policy, increasing access to reproductive health care, and programmes against HIV/AIDS.

WINNIE OGANA

Hon. Lillian Patel, Malawi's foreign minister, launches Africa's AIDS Cycle Relay, an awareness-raising event spanning six countries and 3,241 kilometres in Southern Africa in May.

The European Union offers a critical mass of development experience built up over many years in all parts of the world. European Community and European Union Member States' aid accounts for 55% of total development assistance and more than two-thirds of grant aid. The Commission and Member States are active in many of the worst-affected areas, but also in those areas where there remain windows of opportunity to prevent further escalation of the epidemic.

The European Union offers a critical mass of development experience built up over many years all over the world.

We recognise that the international community collectively needs to do much more. We must make a quantum leap in the provision of financial support to developing countries to improve health outcomes. This will require a mix of sustained and long-term efforts to build effective health systems and targeted support to deal with the major causes of mortality and ill health. Most of the new money will come from public budgets, but we are seeing increasing levels of support from the private sector and new forms of partnership. This is a welcome development that we intend to build upon.

With our partners, we share a sense of urgency to tackle HIV/AIDS. Our efforts should complement each other. We need to co-ordinate our responses and build on our comparative advantages. But the tragedy of millions of people dying of malaria and tuberculosis–which we can do something about–must also be confronted with the same urgency. ■

Poul Nielson is European Commissioner for Humanitarian Aid and Development.

AIDS: A global leadership and solidarity challenge

Mark Malloch Brown

IN THE WAKE of the United Nations General Assembly Special Session on HIV/AIDS, held in New York from 25 to 27 June this year, world leaders have a unique opportunity to translate into local action the commitment they made before a global audience to dedicate substantial and sustained resources to respond to the epidemic.

And nowhere is the crisis more urgent or widespread than in Africa.

More than 25 million people on the continent are currently living with HIV, including 4 million children. Another 10,000 are infected each day. Without international attention and collaboration, they will surely die from the disease. There are parts of Africa where going to funerals has become almost a full-time occupation.

It is more than just a public health catastrophe. AIDS is deepening poverty, reversing achievements in education (teachers are dying more quickly than they can be trained), and diverting meagre health budgets away from other urgent priorities. And it is undermining economic growth–on a course to reduce future GDP in Africa by one-third over the next 20 years.

HIV/AIDS has put huge additional demand on Africa's already weak public services, and set up a desperate conflict over inadequate resources. African governments now face the simultaneous challenges of preventing the further spread of the virus, coping with the staggering number of people who are dying, and managing potentially disastrous social and economic losses.

Anti-retroviral cocktails

The issue of drug prices in developing countries has dominated the headlines and spurred enormous public interest in responding to the HIV/AIDS epidemic. Lower prices mean that it is now realistic to consider international programs for providing anti-retroviral 'cocktails' to people in the world's poorest countries. But there must be an emphasis on prevention as well as treatment, and we must also focus on improving health care delivery systems.

As Brazil has shown, effective treatment programs can themselves also reduce infection rates. Offering treatment gives those infected a reason to be tested, and those who know they have the diseases are less likely to infect others. And treatment lowers viral counts, which also reduces the chance of spreading the disease. Facilitated by a South-South co-operation and other global alliances, we can share the benefits of these lessons.

There is an urgent need for strategic planning and budgeting, as well as for strengthening delivery systems.

This is not the whole answer. There is still a crying need for social mobilisation campaigns, basic development support and other initiatives to change behaviour and lower infection rates. The prevention successes in Uganda and Senegal, the result of local political, church and community leaders working closely with international partners, must be replicated elsewhere–hopefully in time to prevent hundreds of millions more from being infected. And in the world's low income countries, where the average person currently gets about US$20 worth of health care a year, there is an urgent need for strategic planning and budgeting, as well as for strengthening delivery systems.

Most importantly, we need to break the silence once and for all: to alter permanently the norms, values, and traditions that are fuelling the epidemic, especially those that perpetuate gender inequalities and discrimination against those living with HIV and AIDS.

Mining companies

UN Secretary-General Kofi Annan has set the initial target for global HIV/AIDS needs at US$7-10 billion. This might seem like a large amount until one considers that even with today's lower drug prices it will still cost at least US$1,100 per person for treatment. That means more than US$1 billion for each million people infected. And financing adequate prevention programs would cost at least US$3 billion a year.

Multi-national corporations might also consider an exceptional contribution to a global health epidemic that weakens their employees and their families. At the very least, they could follow the lead of several South African mining companies that are providing anti-retroviral drugs to their employees after concluding that it would be cheaper to keep them healthy than to find and train replacements.

Ordinary citizens could also voluntarily contribute. If half of all adults in the United States and the other rich countries each gave US$10 a year for five years, and the wealthiest 5% of adults in developing countries did the same, that would raise US$24 billion.

When President Bush announced the founding contribution to the global trust fund, he said simply 'We have the power to help.' He is right. And I am hopeful that his administration will expand its support and that other world leaders will quickly join him. ■

Mark Malloch Brown is Executive Director of the United Nations Development Programme (UNDP).

Uganda's ongoing struggle against the virus

Yoweri Museveni

THE AIDS EPIDEMIC, as we all know, is a world-wide problem that has taken a huge toll on the world population. The epidemic has been devastating through the huge death toll, but also through its huge social and economic impact. In Uganda, as soon as we understood that AIDS was prevalent in our country, we immediately took the bull by the horns and started working out various ways of combating the epidemic and reducing its spread. We have been trying to cope with the epidemic in the best way possible within our circumstances, and given the resources available to us.

For those who are not familiar with our society, I would like to inform you that this is not the first time our society has confronted an incurable disease. Syphilis was one such disease for which our people for a long time had no medicine. But they learned to avoid contracting it through education and discipline. Violation of the discipline code was traditionally very harshly punished. This, unfortunately, broke down with the advent of European norms and values which negated many of our own traditions.

Later on, this problem was compounded by the false security brought about by the discovery of penicillin in the 1930s. People started believing that any venereal disease could be treated so they could be sexually lax.

Inadequate infrastructure

When AIDS broke out in Uganda in the early 1980s, therefore, it found a society ripe for its spread due to the above mentioned factors. To compound this was the problem of an inadequate health infrastructure: poor health facilities, almost no regular check-ups, a very low doctor-to-patient ratio of one doctor per 23,000 people (although we have now reduced this to one doctor for every 18,000 people).

When our government came on the scene, as soon as we realized that we had a problem of such magnitude on our hands, we knew we must do something. Given the social realities of our society, we decided to resort to the loudest method of spreading an alarm to our people.

The first thing we did was to gather as much information as possible about the AIDS virus, especially how it manifests itself and how it is transmitted. We worked with doctors and other experts from other parts of the world to get a general picture of what we were dealing with both medically and scientifically.

We then put in place our own mechanism in the country to try and establish the magnitude of the problem in Uganda. Preliminary reports indicated that we had a national disaster on our hands. We decided that the best course of action was to educate our people, make them aware of the disease and how it spreads and, above all, to instill fear among the entire population. We realized that, in the absence of either a cure or a vaccine, it was our duty to protect those who were free of the disease by scaring them about the disease and its consequences. And we had to move fast because there was no time to lose.

Spreading the message

In order to have as wide an impact as possible on the population, we launched the campaign from the topmost level of the NRM leadership, that is the presidency. In a society where the majority of the population did not have access to television, we had to devise additional means to spread the anti-AIDS message if we were to reach the entire population. So we used very rudimentary methods, such as talking at political rallies. We started to spread the message at every political rally so that those who did not have access to radio and television could hear the message and spread it by word of mouth to others.

ROBBY MUHUMUZA

Training in bicycle repair has helped Ugandan AIDS orphan Gonzaga Wakulira, 17, gain a skill to support the family he has been forced to care for during the past five years.

At first, we met some resistance from the population. Many people felt that AIDS was an embarrassing issue to talk about since we had to explain that it was spread mostly through sexual contact. However, we persisted and went out of our way to explain that we would rather embarrass people by talking about this not very palatable subject than let our people die through ignorance.

One of the main targets of our campaign was of necessity the youth. Although a sizeable number of those above 30 years were already infected, we knew that the vast majority of our youths were free of the virus and could still be saved. Therefore, we targeted these in a special way through a multi-sectoral approach: public announcements and adverts in the media, billboards along the roads, posters in the waiting rooms of public places and in public transport vehicles, bombarding schools with messages and creating a culture where every school function would talk about AIDS through drama, song, dance, poetry, class lessons and every other medium imaginable. We worked around the clock to make AIDS a household word so that our entire population would be aware of the dangers of the disease.

In addition, we tried to communicate to the people using common imagery in their various languages. Some people found these embarrassing; but we persisted. We also met some resistance, at first, from religious circles who thought that AIDS was contracted through sin and, therefore, we should concentrate on teaching our people not to sin. We, of course, agreed that the religious people should continue to preach against sin. But time was of the essence and we were convinced that, in order to save our population, we needed to capture the population's sense of fear rather than their sentiments about what is morally good or bad. Fortunately, the religious people also eventually understood our position and they stopped being opposed to our methods of campaigning against the disease. In fact, many joined us in the campaign without abandoning their message about the moral side of the issue.

We also set up institutions to beef up and back the AIDS campaign and these have done tremendous work to publicize the campaign as well as in research and treatment of AIDS. The Joint Clinical Research Centre has been assisting in the treatment and management of AIDS patients. It has also carried out studies in the efficacy of some local drugs and vaccines and their results are quite encouraging. The Uganda AIDS Commission, also set up by our government, has worked to co-ordinate efforts to curb the spread of AIDS and continues to monitor and report on anti-ADS activities around the country.

A huge amount of personal, family and national resources are being spent on caring for people with AIDS.

We have repeatedly advised our people, and most especially our youth, on the crucial importance of behavioral change, abstinence from sex, use of condoms and fidelity in marriage.

As a result of these efforts, we have been able to bring down the rate of infection in Uganda from 30% in 1992 to 6.2% presently, the lowest in sub-Saharan Africa. We continue to work round the clock to ensure that we eventually bring it down to zero.

Continuing threat

This said, however, we remain very much conscious of the continuing threat of HIV to our people, to the people of Africa in general and to the whole world. We are determined to consolidate and expand the gains we have made in the fight against AIDS. Our policy is now to enhance vigilance and to continue sounding the alarm about this killer disease so that our population does not relax its guard. However, the current downward trend in the rate of infection is an encouraging step. It shows that we can win the war.

The social and economic costs of the AIDS epidemic have been very high indeed. The number of orphans has grown to over 1.7 million, a phenomenon that has overtaxed and overstretched the extended family members who, in the usual African tradition, take on the responsibility to care for these children. For the first time in our culture, we now have child-headed homes, sometimes with someone as young as 12 years taking care of younger family members. The long-term social consequences of this may not be felt until a decade or so later.

The AIDS epidemic has taken its toll on our labour sector, on our professional sector and on the agricultural sector. A huge amount of personal, family and national resources are being spent on caring for people with AIDS and on educating the public. Over the past 15 years, Uganda has had one of the fastest growing economies in the world at 6.5% per annum. This rate would be 7.5% if it were not for AIDS.

Our commitment to the fight against AIDS is total and irrevocable. We shall continue with our present campaign, which we shall consolidate, strengthen and expand so that all our people know about AIDS and ensure that they avoid it. We shall also continue to work with our development partners to obtain anti-retroviral drugs at a cheaper cost so that we alleviate the suffering of our people infected with AIDS.

We are convinced that the war against AIDS is winnable, given the will to do so. Therefore, we in Uganda are determined to win it. ■

His Excellency Yoweri Museveni is President of the Republic of Uganda.

A call for partnership

Omar Kabbaj

IT IS NO SECRET that HIV/AIDS has become a key factor in undermining Africa's economic growth. Along with the debt burden and various social crises, the pandemic is dealing a hefty blow to Africa's human capital development. Concerted effort at the national, regional and international levels is required in order to ensure that the pandemic does not overwhelm Africa's prospects for development.

According to UNAIDS estimates, out of the 36.1 million people living with HIV/AIDS worldwide, 25.3 million (70%) live in sub-Saharan Africa, a region that accounts for barely 10% of the world's population. Nearly 19 million people have died from AIDS; 3.8 million of them are children under the age of 15. Southern and Eastern Africa are the most affected regions, with prevalence rates among people aged between 15 to 49 years varying from 8% to 35%. In the central and western regions, with the exception of two countries, the prevalence rates vary from 6.4% to 1.3%. In North Africa, the prevalence rates range from .02% to 0.9%.

By striking people in the prime of their working and parenting lives, AIDS has become a serious threat to development and security. The social and economic impact of the pandemic in the countries that are most affected is devastating.

People in poverty

In terms of macro-economic impact, the annual per-capita growth in half of the countries of sub-Saharan Africa is falling by 0.5-1.2% as a direct result of AIDS. According to UNAIDS, per-capita GDP by 2010 in some of the hardest hit countries may drop by 8%, and per-capita consumption may fall even further. In some countries, estimates indicate that the number of people living in poverty has already increased by 5% as a result of the pandemic.

Due to the high prevalence rate of HIV/AIDS in some of the countries, life expectancy will decrease to almost 45 years between 2005 and 2010. In the absence of AIDS, life expectancy would have gone up to about 64 years. Age and sex structure of the population will also be affected as the most productive age group of the population, and increasingly more women and girls, are being infected.

Consider the impact of HIV/AIDS on the social sectors.

In the education sector, the increasing death of teachers and students and decreasing rate of enrolment reduce the quality and efficiency of educational systems, which further diminish the human capital in every other sector. The Millennium Summit goal of ensuring universal primary education by 2015 cannot be achieved in the worst affected countries of sub-Saharan Africa. As a medium for reaching young people, the education sector has a vital role to play in HIV/AIDS control, especially in disseminating information on prevention.

The social and economic impact of the pandemic in the most-affected countries is devastating.

WINNIE OGANA

AIDS-related deaths

The health care system is overstretched in many countries due to the advent of HIV/AIDS. Providing services to the growing number of AIDS patients with the existing inadequate health care infrastructure, equipment and declining number of health care personnel due to AIDS-related deaths has become an insurmountable challenge to the sector.

HIV/AIDS worsens gender inequality in many spheres of development. Women and girls are more vulnerable to HIV/AIDS and are disproportionately affected by the pandemic. Girls' education and future prospects are jeopardised as girls are forced to assume family responsibili-

NIGEL MARSH

ties, including caring for the sick.

The agricultural sector is vulnerable to HIV/AIDS, too. Due to reliance on a large number of migrant workers, the agriculture and some other sectors such as transport and mining have high HIV prevalence rates. It is estimated that HIV/AIDS is causing a loss of up to 50% of agricultural extension staff time in sub-Saharan Africa. AIDS also hinders knowledge and expertise in farming from being passed on to subsequent generations.

Production sectors also are affected when companies face higher costs in training, absenteeism and benefits. This will have an adverse effect on private-sector development, which is a core element in the development strategies of many nations.

Financing programmes

Aware of the devastating impact of HIV/AIDS on Africa's development, the African Development Bank Group started addressing the problem at the end of the 1980s. The first operation in this area dates back to1988. Since then, the Bank Group has been lending its support to Regional Member Countries (RMC) by financing projects and programmes that tackle HIV/AIDS directly or indirectly. In accordance with its Vision statement, endorsed by the Board of Governors in May 1999, and which identifies poverty reduction as its overarching development objective, the Bank Group gives priorities in its operations to human capital development, including interventions in education, health, HIV/AIDS and gender. With a view to enhancing the implementation of its Vision, the Bank mainly has been following the approach of mainstreaming of HIV/AIDS control activities in its sectoral operations in the social, agriculture and infrastructure sectors. To date, it has financed HIV/AIDS control interventions in selected countries with about US$200 million. These operations concern primarily: institution-building to enable countries to diagnose and study the disease (training of managers and the construction/equipment of laboratories); enhancing the safety of blood transfusion (construction and equipment of blood transfusion centres); improved access of the sick to therapy; and the sensitisation and education of the population through IEC (Information-Education-Communication) activities.

The Bank Group gives priorities to human capital development, including interventions in education and health.

Noting the importance of leadership and political commitment in the fight against HIV/AIDS, the Bank organised in May 1993 a symposium on 'HIV/AIDS and its implications in Africa.' The Bank took the opportunity to create awareness among the Regional Member Countries at the highest leadership level about the magnitude of the AIDS problem and its socio-economic impact. The symposium confirmed the need for political commitment at all levels, the availability of substantial human and financial resources, and the co-ordination of actions for effective AIDS control.

Strategic plan

In line with its Vision, the Bank is defining a strategic plan to support the RMCs in the fight against the pandemic, and simultaneously target actions against the immediate and long-term consequences of HIV/AIDS. The strategy takes into account the priorities defined by the RMC, and Bank Group's activities are designed to complement the efforts undertaken by organisations specialised in HIV/AIDS control.

In accordance with the consensus reached at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), held 25-27 June this year, leadership and financial resources are key to a successful global campaign against HIV/AIDS. The primary challenge in the fight against HIV/AIDS is to mobilise the resources to meet the scale and devastating impact of the pandemic. Greatly increased resources are needed to expand national capacities to cope with the situation, support essential infrastructure and training, mitigate the social and economic impact, expand successful prevention interventions, and implement a broad care and support agenda. Increased investment from donors, domestic budgets and private companies need to be combined with additional funds to

meet Africa's resource requirements. Additional resource needs to combat the pandemic are estimated at US$1-3 billion a year for Africa and US$7-10 billion per year globally. The UN-sponsored Global Fund initiative is a viable mechanism to address this urgent problem.

HIV/AIDS is a global crisis that requires global action. Partnership at the national, regional and international level is a key element to reverse the progression of the pandemic. The need for building strong partnerships in the fight against HIV/AIDS started gaining momentum at the ADF2000 Forum on 'HIV/AIDS: The Greatest Development Challenge', organised by the United Nations Economic Commission for Africa (UNECA), 3-8 December 2000 in Addis Ababa. The need for partnership was further emphasised during the African Summit on HIV/AIDS, Tuberculosis and other infectious diseases organised by the OAU, 25-27 April 2001 in Abuja. At this summit, African leaders pledged to devote 15% of their national budget to the health sector and to the struggle against HIV/AIDS. More recently, the UN General Assembly Special Session on HIV/AIDS made a landmark in affirming the crucial role of international partnership to fight this global problem, and in building on the momentum gained for a quantum leap forward in the responses to the pandemic as an international community.

Close co-operation

The Bank, with a view to intensifying its HIV/AIDS-control activities in Regional Member Countries and assist countries in implementing regional and international declarations on HIV/AIDS, will foster close co-operation and strategic partnership with regional and sub-regional organisations and institutions, such as the Organisation of African Unity (OAU), UNECA, Economic Community of West African States (ECOWAS), Union Èconomique et monetaire ouest-africaine (UEMOA), and the Southern African Development Community (SADC).

The Bank Group supports the strategic partnerships nurtured by UNAIDS under the International Partnership against AIDS in Africa (IPAA). The IPAA is a coalition that works under the leadership of African governments to harness the resources of the United Nations, donors, and the private and community sectors. A memorandum of understanding between the Bank and UNAIDS is being finalised for strategic partnership on HIV/AIDS. Similarly, co-operation on HIV/AIDS is one of the key objectives being pursued under the recent efforts of reinvigorating partnership with the United Nations Specialised Agencies, such as the UNDP, UNFPA, and others.

HIV/AIDS is both a development problem and a human problem, and affects every sector of the economy.

The strategic partnership with the World Bank, in respect of which a Memorandum of Understanding was signed in March 2000, also gives a prominent position to collaboration on HIV/AIDS-control activities in RMCs.

HIV/AIDS is both a development and human problem, and, as such, it affects every sector of the economy. The close relationship between the pandemic and most of the sectors makes it necessary to adopt multi-sectoral strategies and an integrated participatory approach. More than just a health problem, HIV/AIDS is now one of the main challenges to poverty reduction and sustainable development in Africa. Hence, the importance of the AIDS and Development issue, which underpins the Bank's strategic options. In light of its comparative advantage, the Bank will continue to intervene in selected priority areas to support RMCs in their efforts to control the HIV/AIDS pandemic. These activities are being undertaken within the framework of the programs and projects defined by the RMCs themselves and the specialised agencies. ■

Omar Kabbaj is President of the African Development Bank Group.

WINNIE OGANA

AIDS Cycle Relay participants rode 3,241 kilometres across Malawi, Zambia, Zimbabwe, South Africa, Swaziland and Mozambique in May to raise awareness about HIV/AIDS.

Malawi under the shadow of death

Sam Mpasu

MALAWI, a small, land-locked country in Southeastern Africa, is often referred to as the warm heart of Africa, or as Africa's best-kept secret. Its 10 million inhabitants crowd onto the two-thirds of the land not covered by lakes, which boast some 200 species of rare tropical fish. Plateaux in the north teem with wildlife. And the people, themselves, are known for their warmth and friendliness.

But silent death is stalking this idyllic setting. HIV/AIDS is decimating the population, with catastrophic results. Although Malawi is not heavily urbanised–and 8 million of its 10 million inhabitants still live in the countryside, where they scratch a living with hand-held hoes as subsistence farmers–the HIV/AIDS scourge has left no one unaffected. Nation-wide, 1 million people already are infected with the virus. Some 70,000 of them develop full-blown AIDS each year. The country's health system is creaking under the enormous weight brought on by the virus. Patients suffering from HIV/AIDS-related illnesses occupy about 70% of the nation's hospital beds. Opportunistic diseases, such as tuberculosis, that once were on the decline, have surged back with a vengeance. The early deaths of parents has saddled the country with an estimated 300,000 orphans, some of whom have no other family support system and are living on the streets. Their number grows by 70,000 every year.

The majority of those dying of this scourge are breadwinners, typically between the ages of 19 and 49.

As if this were not catastrophic enough for a developing country with a per-capita income of only US$300, seeds of a future economic decline are being sown. In urban areas, up to 30% of all pregnant women who go for antenatal services are found to be HIV-positive. The majority of those who are dying of this scourge are breadwinners, typically between the ages of 19 and 49. This raises the prospect of a large number of old people and young people without economic or social support. The average life-span has been drastically reduced to 48 years for women and 47 years for men. Among teenagers, the rate of infection is higher among girls than boys, probably because the girls go out with so-called sugar daddies, who shower them with money for sex. When these girls eventually get married to their own age-mates, the consequences are predictable.

HELEN SEIGNIOR

Lawyers, doctors, teachers

Some who already have succumbed to this scourge are the professionals who prop up the economy with their skills. Lawyers, doctors, teachers, civil servants and others cannot be replaced overnight. Political leaders are not spared either. Between 1994 and 1999, the Malawi Parliament lost 29 of its 177 legislators. Some of those deaths were due to AIDS-related illnesses.

For Malawi and Malawians, this scourge is not just a personal catastrophe for those affected and infected. It is not just a health problem either. It is a development issue because of the social and economic problems it creates.

The president, ministers and members of Parliament have led church leaders and non-governmental organisations in talking about this scourge. In public speeches, workshops, newspaper columns and radio broadcasts, messages on HIV/AIDS are being delivered, sometimes with uncharacteristic candour. It is now ascertained that up to 95% of the people in rural areas and 98% of people in urban areas are aware of the existence and dangers of HIV/AIDS. The real challenge now is not lack of awareness, but translating this awareness into behavioural change. Saving lives means saving a small nation that is under a shadow of death. ■

Sam Mpasu is Malawi's Speaker of Parliament.

Reaching the front lines

Ray Martin

MANY OF US from rich countries vowed at the United Nations General Assembly Special Session on HIV/AIDS in June this year to work hard for institutions and mechanisms that empower community leaders, pastors and priests who interact daily with the people infected and affected by HIV/AIDS.

One new opportunity is the Global AIDS and Health Fund now being established at the urging of UN Secretary-General Kofi Annan. The Fund will provide additional resources to address AIDS, malaria, and tuberculosis, three big killer diseases in developing countries. Initial grants may be made in early 2002. Commitments by rich governments and other donors have been disappointing, with only US$1.7 billion committed so far. This amount, plus bilateral and other multilateral resources, falls far short of the US$10 billion experts say is needed for the fight against HIV/AIDS only in developing countries.

As so often in the past, the rhetoric of the rich countries has been more pronounced than their financial resolve. By comparison, those same countries spend more on agricultural subsidies than on all development assistance, and even more still on their militaries.

Local community response

For the June UN Summit, a coalition of Christians facilitated by the World Council of Churches submitted a statement calling for the international community to form partnerships that build on the 'local community presence, influence, spirit of volunteerism and genuine compassion' of faith-based organisations. The groups involved, including World Vision, The World Council of Churches, Christian Connections for International Health and many others, continue to advocate for effective, community-level solutions, including those that mobilize the credibility and influence of faith-based organizations. With respect to the development of the Global Fund, their areas of concern can be summarised as follows:

1. The need to accept civil society as partner–The Fund should work with governments to devise mechanisms to ensure that Fund assistance and resources reach those best placed to make a people-level impact, such as effective government programmes, NGOs, community and faith-based organisations. Funding should be for activities that enhance efficiency and effectiveness and are consistent with nationally approved policies and strategies to address HIV/AIDS, malaria, and TB.

2. Accountability–Establish defined and transparent accountability and reporting mechanisms to ensure sound management of fund resources, both at the Fund management level and at the country level.

3. Transparency–Insist on transparency in negotiations to establish the Fund and in the execution phase in all interactions between the Fund management and recipients of fund resources, whether public, private or non-profit.

In addition to these three central principles, other points advocated by these Christian groups for the Fund include:

a) Consultation with civil society–The need to involve the poor themselves and civil society groups, including faith-based organisations, in the work of the Transitional Working Group and its Secretariat that are establishing the Fund. Consultation with civil society should include issues such as the design of the Fund, selection of criteria for grants, agreement on its objectives, priorities and implementing mechanisms, administrative and funding procedures, and other matters of governance.

Effective programmes

b) Allocation of resources– National campaigns and programmes are important to the fight against HIV/AIDS. In addition to national-level action, the behavioral change and other preventive measures needed to reduce transmission, and much of the treatment, care and support of infected and affected individuals can often be best administered and managed at the local level. The Fund should therefore also support effective government programmes and civil society groups that work at the local level.

c) Balance of strategies–Urge that the selection of programmes to be supported with Fund resources be balanced and include all appropriate and scientifically proven methods of prevention and treatment of HIV/AIDS, malaria and TB, including abstinence and fidelity as AIDS prevention strategies. Any sensitivities of religious and faith-based organisations on interventions should be respected.

d) Adequate coherent funding–Negotiate the Fund and its financing in the context of other approaches to augmenting resources such as debt relief, progress toward the target of 0.7% of GNP for Official Development Aid from rich countries, increased budgets from governments of both rich and poor countries, and increased allocations from corporations, foundations and various civil society institutions.

e) Equality of access–Ensure that equity in access to prevention services, treatment and care be a principal objective of the Fund, along with those relating to scientific soundness, efficacy and administrative efficiency. ■

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Prevention or care?

Kyi Minn

I HAVE A FRIEND in Cambodia who is HIV-positive. He shows no signs or symptoms, and is very healthy, even though he has carried the virus for three years. One day, he got a sharp abdominal pain, and called me on the phone. After checking him, I was sure that he had appendicitis. Subsequent blood tests and X-rays revealed this to be the case. It was also apparent that his appendix could burst at any moment.

We went together to one hospital, but the staff refused to operate on him because he was HIV-positive. He was deeply embarrassed over how he had been treated, and told me softly, 'Let me die, don't search for more hospitals. I can bear the pain and death, but I cannot bear the discrimination.' Nevertheless, we visited one hospital after another–I prayed that his appendix would not burst along the way–until we found one where a surgeon agreed to perform an emergency operation. The operation was successful, and he was discharged from the hospital after five days. My friend is now happily married to a woman who is also HIV-positive.

'Let me die, don't search for more hospitals. I can bear the pain and death, but I cannot bear the discrimination.'

Normal lives

Some of us might think that caring for and treating individuals with HIV would be expensive and unsustainable. But we need to realise that most people living with HIV can lead normal lives if we give them the same medical attention that any healthy person would receive. HIV may not be curable, but most medical conditions faced by those carrying the virus are.

The world community has made some headway in providing education and behavioural-change information to curb the spread of HIV/AIDS. It is time now to increase efforts toward providing the care and support components. The story above showed but one incident. Many others face discrimination and are denied basic needs and health care simply because of their HIV status. Health workers know that transmission of HIV is preventable if precautions are taken. Still, there is a big gap between knowledge and practice, even among the health care professionals. We must be more pro-active in our care and support of those who are in need. Care also should be extended to children and families affected by HIV/AIDS.

Non-governmental organisations and others involved in community development work are in a unique position to help strengthen and provide stability in communities, thereby reducing the social factors that could lead to the spread of HIV/AIDS. This is important in terms of prevention. But it is also important for communities, and society at large, to realise that it is also important to meet the needs of those who carry the virus today. The needs of people at both ends of the spectrum must be acknowledged and addressed equally. ■

There is a big gap between knowledge and practice, even among the health care professionals.

Kyi Minn is Senior Programme Manager and Health Advisor for World Vision Australia's Asia Pacific team based in Melbourne, Australia.

The time has come to act

Henry Hyde

THE TIME HAS COME for countries such as the United States to commit themselves to confronting one of the most compelling humanitarian and moral challenges of our time. I am referring to the HIV/AIDS pandemic that threatens the stability of both the developing and developed world–a crisis unparalleled in modern times.

The statistics are chilling. Throughout the world, more than 22 million people have died of AIDS. More than 3 million died last year alone. What is most alarming is that the number of infections and deaths is growing and the pandemic is quickly spreading from sub-Saharan Africa to India, China, and Russia. An incredible 36 million people are infected with HIV today–and 15,000 new infections occur each day. Tragically, most of the dramatic increase in infection rates is in poor countries where education, awareness, and access to healthcare are seriously lacking.

Without some expectation of hope or care, the poor have no reason to be tested for AIDS or to seek help.

40 million orphans

Children suffer inordinately from the AIDS pandemic. Millions are born HIV-infected, even though mother-to-child transmission can be easily avoided if adequate training and health care are provided. By the end of the decade, 40 million children will be orphaned as a consequence of AIDS. The impact on developing societies–socially, politically and economically–is incalculable, and threatens the stability of the globe.

For these reasons, the United States and other rich nations must be committed to combating and ultimately ridding the globe of this modern-day black plague. The problem is monumental, and our response needs to be both bilateral and multilateral.

As with any problem, financial resources are not the sole answer to a problem, and the generosity of the American people must be well managed. We must provide resources at a pace at which they can be absorbed and used wisely. We must continue to encourage and support faith-based organisations and churches that are doing good works to educate the poor about HIV and AIDS. We must also insist that other developed nations join us in this global effort.

Comprehensive programme

To support these efforts, I felt compelled to introduce legislation recently that would address both the bilateral and multilateral pillars of our response to the AIDS crisis. This legislation would authorise the United States Agency for International Development to carry out a comprehensive programme of HIV/AIDS prevention, education and treatment at a level of US$469 million in each of the next two fiscal years. This is US$100 million more than has been requested by the Administration for these purposes in Fiscal Year 2001. Moreover, my legislation authorises an additional US$50 million pilot program to provide treatment for those infected with HIV/AIDS by assisting the public and private sectors of developing countries in the procurement of HIV/AIDS pharmaceuticals and anti-viral therapies.

We also must work to extend the productive lives of those infected by the virus. Without some expectation of hope or care, the poor have no reason to be tested for AIDS or to seek help. I am fully cognisant of the challenge posed by treatment programs in developing countries. However, we have no other option if we are ever to stem the tide of the pandemic.

I think there is consensus in Congress that the AIDS virus is one of the great moral challenges of our era.

And we must emphasise the need for micro-enterprise development as a crucial component in the struggle against HIV/AIDS. Micro-enterprise gives the poor who must deal with HIV/AIDS the means to help themselves.

Consensus in Congress

I think there is consensus in Congress that the AIDS virus is one of the great moral challenges of our era. It is a scourge of unparalleled proportions in modern times. Every citizen has a stake in what tragically could be the black plague of the 21st century. Accordingly, we should do all we can to meet this test by reaching out now to those most in need–it is the right thing to do for our children, our country and our world. Let us not fail the challenge. ■

Henry J. Hyde is a member of the United States Congress. This article is adapted from a statement he made in his introduction of the 'Global Access to HIV/AIDS Prevention, Awareness, Education, and Treatment Act of 2001', 6 June 2001.

The culture of HIV/AIDS in Africa

Hector Jalipa

EFFORTS TO HALT the devastating AIDS epidemic in Africa must include serious examination of the beliefs, values and economic pressures that people at risk of infection face. These social and economic dynamics are proving more powerful than knowledge about HIV/AIDS, as millions of people aware of the risks continue to become infected each year.

A lasting response to the AIDS epidemic must rest on supporting cultural beliefs and conditions that encourage healthy sexuality, and fighting those that leave women vulnerable to sexual exploitation, and men trapped in potentially lethal definitions of masculinity.

Information about HIV/AIDS and how it is contracted is now spreading rapidly throughout Africa, fuelled by a powerful network of governments, local and international NGO's, and of course the terrible loss of nearly 20 million people.

But commercial sex workers in Zambia, well aware of the risks, do not refuse clients who pay 10,000 kwacha (US$3) for unprotected sex, as opposed to less than 3,000 kwacha for sex with a condom. At that moment, the hungry stomachs of their children, their lack of power to refuse, or even hopelessness about the future, represent a stronger reality than AIDS.

Driven by poverty

High percentages of truck drivers, also informed about HIV/AIDS, and unsure of their HIV status, discard precautionary measures after a relationship with a woman on their route becomes 'stable'.

These dynamics, driven by poverty and social expectations, must be examined closely if we are to understand why people continue to engage in behaviour that they know may cost them their lives, and the lives of their families.

If behaviour change is short-lived, as studies are revealing is the case following awareness-raising and distributions of condoms, then people have not been convinced enough to change their fundamental beliefs about sexuality.

Addressing poverty through sustainable development, disaster mitigation and relief, and advocacy is an essential aspect of fighting HIV/AIDS. Just as essential is developing and restoring beliefs and practices that are protective of children, women and men.

We must continue to raise awareness, and to promote abstinence, faithfulness in marriage, and the use of condoms.

Wife inheritance began as a protective and caring response to a woman suffering the loss of her husband. African women, who make up 60% of the continent's farmers, clearly demonstrate their ability to provide for themselves and their children if they have land and protection within a family.

However, the sexual aspect of this practice has taken over, and widows are now being abandoned following the 'inheritance' or 'cleansing' ceremony–fuelling the transmission of HIV and leaving the widow bereft.

While the protection and empowerment of vulnerable women and children must be promoted, the practice must be challenged where it exists to exploit and endanger those it was meant to protect.

Examining the prosperity, attitudes, practices and beliefs of a community, and discussing them publicly, is an important step forward.

In many African communities, the economic and social dependency of women makes it more likely that they will exchange sex for money or favours, be less likely to succeed in negotiating protection, and less likely to leave a relationship that they perceive to be risky. Halting the spread of AIDS without elevating the role of women is unlikely.

Young men at risk

In those same communities, prevailing notions of masculinity where men are expected to be knowledgeable about and experienced in sex put young men at particular risk as they experiment without being able to seek information or admit their lack of knowledge.

With all that we are doing now to halt the spread of AIDS, the risk for young men and women is only diluted to a small degree.

Extensive studies that focus on the social and economic dynamics within the sub-community of truck drivers and commercial sex workers are urgently needed. At the same time, we must continue to raise awareness, and to promote abstinence, faithfulness in marriage, and the use of condoms.

Sexual relationships between men, women, and the young–whether with pleasure or violence, responsibility or irresponsibility–are socially constructed. No intervention in the fight against AIDS is free of ideology, nor are the targets of those interventions living in an ideological vacuum.

However, where customs and practices are promoting a cycle of death and illness, it is imperative that communities encourage beliefs and practices that will not only protect their own families, but also allow future generations the freedom to live without this devastating disease. ■

Hector Jalipa is Africa Regional Health Advisor for World Vision International, and is based in Nairobi.

HIV/AIDS in the Mekong–river of hope, river of despair

Karl Dorning

THE MIGHTY MEKONG River is the lifeblood of millions of people who live on and around its meandering path. It also has been a silent witness to the sadness brought on by decades of war. Today, it is witnessing a new threat that has befallen the people of this region. It is not a threat brought by guns and mines, yet it is equally devastating. It is AIDS.

As world attention around the HIV epidemic focuses on the African subcontinent, it is important to acknowledge that despite some remarkable success stories in the region (such as Thailand), the threat posed by HIV/AIDS to many countries in the Mekong Region could result in equally catastrophic conditions. World Vision has been working in the Mekong Region countries (Vietnam, Cambodia, Laos, Yunan in China and Burma/Myanmar) for the past 10 years to combat the epidemic. It is a region diverse in culture, now challenged by an epidemic that has evoked mixed responses from its leaders, which vary from total denial, to the support of innovative and exciting prevention programs.

A mistake

In the past, programs that addressed education about the virus–how transmission takes place and how one can protect oneself from the virus–were felt to be sufficient. This was a mistake. HIV, perhaps more than any other epidemic in our history, has forced us to recognise that a disease of this sort and magnitude has far-reaching social, economic, political and spiritual dimensions that both fuel the epidemic and, if taken into consideration, have the capacity to bring it under control.

Firstly, it is important to recognise that, despite national boundaries in the region, cross-border movement of large numbers of people has played a major role in fuelling the epidemic. There are many causes for this. Economic circumstances in Burma (Myanmar), for example, have forced more than 1 million people across the border into Thailand in search of employment[1]. The involvement of young Burmese women and girls in Thailand's sex industry has been well documented. Yet this is the tip of a far greater problem. Many young Burmese men and women find themselves in harsh working conditions in the fishing industry, or working as labourers. Separated from their cultural values and their families, and with a steady, disposable income and no savings facilities, safe sex, let alone a relationship with a life-long partner, is something seldom considered. In addition, lack of access to health services by these predominantly illegal migrants further compounds the risk of transmission and the inability to provide care and support to those infected.

A second factor is the sharply increasing vulnerability of adolescents and young people across the region, particularly those who are out of school and who do not have access to education and health services. Limited resources in many countries of the region severely curtails the development of appropriate programs for the young (and indeed all those vulnerable to infection). For example, it is estimated[2] that last year a total of US$5 million (including United Nations and non-governmental organisation funding) was spent on combating the epidemic in Myanmar. By comparison, Thailand spent more than US$200 million. Even basic options, such as the use of condoms to prevent transmission, are not available to the vast majority of people in the region.

Restricted access to people engaged in high-risk behaviour, such as informal and formal sex workers, drug users (including injecting and non-injecting) and homosexual men, further compounds the complexity of response. This includes the continued difficulty of reaching people providing informal sex services and their clients. The associated epidemic of tuberculosis both complicates treatment and absorbs the meagre health resources of many countries in the region. Finally, many countries in the region are now being challenged by the need to care for those infected, and an increasing number of children orphaned by the epidemic.

Effective responses

There have been, and continue to be, innovative and effective responses to the epidemic, however. World Vision has worked across the Thai-Myanmar border for the past eight years, developing programs of education, care and support to migrants who move back and forth between the two countries. These programs seek to address some of the underlying causes of transmission. For example, in Ranong (Thailand), savings schemes have been established to enable illegal migrant Burmese fishermen to save their hard-earned money, rather than spend it for fear of being robbed. Evaluations of this program have shown a direct relationship to this and the reduction of HIV transmission amongst this group.

The challenges facing the Mekong Region are great, but, like the mighty river itself, given the necessary supportive environment, the great resilience of communities and individuals has the potential to turn the tide from despair to hope. ■

1. According to studies conducted by the Asian Research Centre for Migration.
2. According to UNICEF Myanmar data.

Karl Dorning is Special Programmes Manager for World Vision Myanmar.

Driving safely on Vietnam's Highway 1

Nguyen Viet My Ngoc and Mark Kelly

HIV/AIDS IN VIETNAM is no longer a distant threat. The first case of HIV in Vietnam was detected in Ho Chi Minh City in 1990. Today, HIV has been detected throughout the country, in all 61 provinces. Official estimates put the number of HIV infections in Vietnam at more than 30,000. However, cases tend to be underreported.[1] Most people with HIV/AIDS in Vietnam are between 15 and 49, but the proportion of infected adolescents out of the total number of detected cases is on the increase. In some northern and southern provinces, some 70-80% of infected persons are under 30. About 45% of Vietnam's population is under 19 years of age, which illustrates the potential impact of HIV in Vietnam. More importantly, HIV infection is spreading to remote rural areas where minority ethnic groups are living, and also along transport routes.

The only north-south road

In 1997, World Vision started working with truck drivers in four provinces in Central Vietnam. The National Highway Number 1 project focused on drivers who use the country's only north-south road to transport goods. With only one main transport route connecting the main cities of Hanoi and Ho Chi Minh, all trucks are funnelled through these four central provinces.

The project targeted truck drivers who are mobile, as well as young women who live along the transport route. While some of the lessons learnt in this project have also been experienced in other countries, the importance of gaining indigenous experience, while building upon the experiences of others, continues to be important in the fight against HIV. World Vision, other NGOs, and the Vietnamese government have incorporated some of these lessons into projects now being implemented.

—Participation of the target groups in design and implementation leads to successful models.

While Vietnam has general materials to raise awareness of HIV and address misconceptions, materials specifically targeting truck drivers did not exist. The integration of locally generated materials created greater ownership and reflected community values.

The proportion of infected adolescents out of the total number of detected cases is on the increase.

—Truck drivers were reached by trained community members who already had contact with them, such as restaurant workers and other service workers.

Truck drivers were reached through Frontline Social Networkers (FSNs). The FSNs were generally local people who worked in cafes, petrol stations, or vehicle checking stations where trucks regularly stopped. They talked with drivers, firstly to ask about their awareness of HIV, and then provide them with Behaviour Change Communication (BCC) materials and condoms. Over time, demand for more BCC materials increased.

—Activities for mobile population groups can have greater impact than expected.

Measuring the effectiveness of projects with mobile populations–particularly changing attitudes toward sex and protection–are notoriously difficult. An input measurement developed by the team involved a survey at a tollway on Highway Number 1. Over four days, 864 truck drivers were given the BCC materials and asked whether they had seen them before. If they had, they were asked where they had obtained the materials. A full 10% of the drivers had seen the materials. With drivers from all 61 provinces passing through this one point, the materials had spread throughout the entire country, instead of being confined to just the four central provinces, as planned.

—HIV-prevention programs should combine with care programs for people with the virus.

When people with the virus are provided with care and support, they remain healthy longer, and they are more likely to participate in community-based initiatives to prevent further transmission of HIV.

—HIV is not just a health problem, but also a social problem that calls for multisectoral collaboration to build HIV-resilient communities.

Building on experience

World Vision Vietnam is taking its experience with mobile populations, women and adolescents, and seeking to build this experience into its Area Development Programme (ADP) model. (ADPs are programmes designed to address a variety of needs in a given geographical region.) While most ADPs in Vietnam are in rural areas, and the number of HIV carriers is very low, the increase in mobility and migration as the country's economy grows can easily lead to an explosion. The ADP model thus allows for the integration of farmer training, peer educators networking, gender empowerment, and children's scholarships with HIV awareness-raising. ■

1. National AIDS Bureau, April 2001.

Mark Kelly is Director of Quality Support and Special Programmes for World Vision Vietnam. Nguyen Viet My Ngoc is a physician on staff with World Vision Vietnam, and manages several HIV projects in Central Vietnam.

Traditional ways of caring for AIDS orphans are inadequate

Wilfred Mlay

NOTHING IN AFRICA is creating orphans faster than the virus, that causes AIDS. In some countries now, one child in 10 is an orphan, compared with an average of one in 50 before the epidemic began.

These orphans are the most vulnerable people in the world when it comes to malnutrition, physical and sexual abuse, and sickness. Humanitarian agencies must come up with new and imaginative models for orphan care in Africa as a result of the HIV/AIDS pandemic.

Relinquishing the care of children to an institution is an alien concept in Africa–a continent where extended families and communities take the highest pride in being able to absorb and raise the children of departed members.

Extended families take the highest pride in being able to absorb and raise the children of departed members.

Yet the idea that the community can cope–if only given a little more help–is starting to look like blind optimism. We need new models, and we need them fast.

For a decade now, we have been hearing in one place after another that the extended family can no longer cope with the scale of the problem of the orphaned children among them. We visit rural people who tell us there are so many funerals, they do not know which one to attend on any given day.

Neighbours want to help

Once, it would have been a shame for any community to admit it could not care for the children of a deceased member. Now, it is not at all difficult to find children who have been left to look after themselves. Neighbours want to help, and often try, but in an increasing number of situations, they simply cannot.

As I travel around southern and eastern Africa, I am convinced that we have not yet grasped how wide and deep are the changes that HIV is going to cause in our societies. We are realising the economic damage that the loss of the working-age generation will cause, but I don't think we have yet imagined the devastation in the soul and psyche of Africa.

Millions of adults are dying, and many of our values and coping mechanisms are dying with them. We are left wondering how to deal with the effects of a disease unknown to our ancestors. The social structure and networks of relationships on which we have depended for generations are being torn apart before our eyes.

Traditions already assaulted by urbanisation are being swept away. To deal with the results of this plague, we must be realistic. I see no reason why, in the next 10 years, the statistics are not going to get worse, no matter how much money we put into the fight against the spread of HIV.

Our cultures tell us to shun institutional care, but our eyes show us that the traditional alternatives are geared toward circumstances that no longer exist, and simply are not going to cope, unaided.

We must not return to failed models of institutional care, but the search for viable new mechanisms has been slow. A new style of care must be found. An example might see widows from the community becoming mothers to groups of children with whom they would otherwise have had no relationship. Around such communities, farms and cottage gardens can be created, and schooling opportunities provided. The development agency becomes part of the community, reinvigorating it, creating new relationships when all the blood relations have died.

New approach

A short while ago I visited the Mchinji home in Malawi, which offers a new approach to the care of children by widows and the wider community. The whole thing looks like village life, with consensual relationships replacing the family ties that would have linked people once before. This points the way to a model of orphan care that is established in the child's home community, overseen by the village elders and local leaders, and into which development agencies can carefully channel resources that will reinforce children's hopes for the future and links with the past.

We have not yet grasped how wide and deep are the changes that HIV is going to cause in our societies.

As an African I would be the first to agree that any form of institutional care of our children represents the loss of an important cultural value. But the simple truth is that we are already losing that value to HIV/AIDS, and we must find a humane way in which to care for our children.

My hope is that we can find something that will meet the unprecedented needs with which Africa has been faced, while preserving as many of the good structures and traditions from our past as possible. ■

Wilfred Mlay is Vice President for World Vision's Africa region.

Many South Africans in denial about HIV/AIDS realities

Robert Michel

UNITED STATES Secretary of State Colin Powell told those gathered at the recent United Nations Special Summit on HIV/AIDS that the world is facing 'a time of plague' as it battles the virus. Of the world's continents, Africa is being hit hardest by the virus. In all of Africa, Southern Africa's statistics loom largest. And South Africa is among the handful of countries in Southern Africa whose statistics continue to rise. Today, some 20 percent of South Africans are infected with the virus. In spite of this, South Africa's President Thabo Mbeki was nowhere to be seen at the UN conference, for which he received a fair amount of criticism from the media at home.

Despite the fact that some 4.7 million of their population are HIV-positive, most South Africans seem to be in a state of denial over the virus. They may be aware of the statistics, and they may know how to prevent transmission of the virus. The trouble is, few people actually seem to do anything with this information. This at least is the consensus of most South African experts who observe no decrease in the rate of new HIV infections, believed to be around 1,700 a day. The truth is that the HIV epidemic in South Africa is showing no signs of slowing down.

Ecology of AIDS

There are factors–known in the scientific world as the ecology of AIDS–that tend to drive the epidemic and increase the incidence of transmission of the virus. These factors include high levels of illiteracy, the disempowerment of women, widespread poverty, and high rates of unemployment that result in more people working as prostitutes to ensure their daily survival. Added to this is the migrant labour system–labourers streaming from all over Central and Southern Africa to find work in South Africa–and its associated structures that act as fertile breeding grounds for the further spread of the virus in South Africa.

WINNIE OGANA

Hand in hand with the above go South Africa's high numbers of tuberculosis cases and the high prevalence of sexually transmitted diseases. As a result, South Africa has the perfect environment for HIV to flourish.

HIV/AIDS has not only hit many families, it also has affected the economy of the only industrialised nation on the African continent at large. HIV/AIDS is having far-reaching effects on the workplace through escalating medical and funeral costs, and increasing costs of employee benefits.

One can only hope that the country will wake up to the crisis soon, in order to prevent a true catastrophe.

The millions of South Africans who are either unemployed, self-employed or under-employed undoubtedly face the biggest hardship of all. With public health care crumbling, rural areas become dumping grounds for orphans and the dying, who are looked after by the elderly.

In order to mount an effective AIDS-prevention programme in South Africa, far more money needs to be spent on campaigns and orphan care. Sources that might be tapped for such additional resources include expansion and reallocation of public funds. Yet, the latter is problematic in a country where more than 7 million people are living in shacks, and the government has chosen to spend US$5 billion on new weaponry, when the biggest threats to South Africa's democracy come from within: poverty and HIV/AIDS.

The numbers continue to climb in South Africa. One can only hope that the country will wake up to the crisis soon, in order to prevent a true catastrophe. ■

Robert Michel is Communications Manager for World Vision's Southern Africa region.

Rwandan AIDS widows face additional burdens

Nigel Marsh

FRANCINE was widowed during the 1994 genocide in Rwanda. She witnessed her husband and many members of her family being killed around her. She was brutally raped by a gang of men, and although she did not know it at the time, was left with gonorrhoea that ate away at her internal organs for several years, leaving her in terrible pain.

'If it were not for the help of [others], who paid for me to be treated, I would now be dead,' she says frankly, speaking recently to a large group of youth in southern Rwanda, one of a series of similar presentations she is making. Taking advantage of her audience's stunned silence, she adds, 'I thank God that he spared me from death, and that I did not contract HIV and AIDS, which cannot be cured.'

Hearing a sparkling-eyed elderly lady using her horrific experience of a near-fatal sexually transmitted disease to warn about the dangers of the AIDS pandemic is disconcerting for African youngsters, but the ensuing discussion about sexual habits and the threat of HIV is a lively one.

The concept that Francine thinks herself in any way lucky is also troubling, but she has facts on her side. Rwanda's numerous widows are dying of AIDS at a dreadful rate.

After the genocide committed against the Tutsi and moderate Hutu, and the subsequent return from exile of around 2 million displaced Hutu villagers, 60% of Rwanda's 7 million population was female. Of those, 40% were widows.

Children leading families

Elderly women, widows and girl children now led many families. A great many of these had been raped during the genocide or in refugee camps, and many more were subsequently obliged by their poverty to entertain sexual advances from men who could lend support in difficult times.

The result was a tremendous surge in the number of people carrying the virus.

A Rwandese group composed of widows of the genocide, called AVEGA (Association of the Widows of the April 1994 Genocide), highlighted the problem this year when it pointed out to international media that two of its members were dying of AIDS each week.

The association's president, Danielle Mukandori, said many members recall being told by rapists that they were deliberately being infected with HIV to ensure they 'had a slow death'. Mrs Mukandori went on to tell the Rwanda News Agency that two out of every three widows of the genocide were HIV-positive. Seven years on, many of them have died or are dying.

Given such a firm foothold in the population, the pandemic has been able to spread far beyond this most vulnerable population. Government statistics suggest that in some urban areas, including the capital, Kigali, between one-in-three and one-in-four adults now have HIV.

After the genocide there were one-third of a million orphans left without adult help from relatives, friends or neighbours. Now the 'second genocide' of AIDS is killing parents, greatly increasing the number of orphans needing assistance.

No organisation interested in the development and well-being of the Rwandese people would ignore this new and complex peril, combining high death rates and a dramatic increase in the number of orphans in poverty. A number of NGOs are working with the Rwandan government, the United Nations and donors to support individuals and groups who are trying to combat the scourge, and to help those who are ill, and those left behind.

SIMON PETER ESAKU

The situation is dire, but all is not lost. Francine is one of many courageous Rwandese widows who have taken this opportunity to talk about their experiences in an education process designed to help a new generation avoid the misery of AIDS. ■

Nigel Marsh is Communications Manager for World Vision's East Africa region.

HIV/AIDS in sub-Saharan Africa–an appraisal

Kwazi Nimo

I FIRST VISITED Lusaka, Zambia, in 1988, and at that time there were only a few street kids on Cairo Road, the main commercial street. Today, there are some 300,000 orphans on the streets of Lusaka alone. The picture is the same in many other capital cities in Africa.

These street kids do not go to school. They sleep on the streets and do various odd jobs, such as washing and guarding parked cars, carrying luggage, picking the pockets of unsuspecting pedestrians, whisking away briefcases and handbags, and, in the night, even committing armed robbery. HIV/AIDS is turning a lot of these children into social misfits. Societies and governments in Africa need to institute remedial measures now. By the end of 1999, UNAIDS reported that there were 13.2 million orphans globally. Of these, 12.1 million lived in Sub-Sahara Africa.

Infection rates are extremely high amongst sex workers, long-distance truck drivers, itinerant businessmen, cross-border traders, border-post personnel and migrant work populations. These at-risk populations place other segments of society at risk also. A few highly mobile HIV-infected individuals with a large number of sexual partners, as is the case with many long-distance truck drivers, can spread the disease rapidly.

Separation from families

A number of factors contribute to the rapid spread of the infection in sub-Sahara Africa. These include separation from families over periods of time, as is the case with long-distance truck drivers, migrant miners and agricultural workers. Poverty forces some into commercial sex work. Lack of government support also has been a factor. Where governments have been fully involved, prevalence rates have either dropped (from 14% to 8% in Uganda) or stayed relatively low (1.7% in Senegal).

WINNIE OGANA

To help raise awareness about HIV/AIDS, Lydia Nyirenda, of Malawi, plans to wear this two-piece outfit as often as possible in her homeland.

Another factor is that in most African communities it is a taboo to talk about sex. This is even worse with religious organisations. In addition, cultural practices involving sexual cleansing, early sex for girls, lack of formal education for girls, and property-grabbing by relatives of a deceased husband. And the prevalence of other sexually transmitted diseases (STDs), and low use of condoms can lead to the formation of ulcers and sores in the genitalia, which facilitate the transfer of the virus in people who practice unprotected sex.

Lack of rights for women also figures into the equation. Women are looked upon as objects of sex, and their inability to say no to sex also endangers their health.

Wars take a toll

And, of course, the many wars in Africa also are exerting their toll, with some soldiers raping village women.

For Africa to reverse the devastating consequences of HIV/AIDS, some serious decisions must be undertaken immediately. There needs to be full support and active participation by governments. Communities and religious organisations need to become fully involved in providing care and support to orphans, people living with HIV/AIDS, and care givers such as grandparents. Non-governmental organisations, governments and religious organisations need to take advocacy issues seriously in order to change or modify harmful cultural practices. Orphans need to be placed in schools. Health care delivery systems, including voluntary counselling and testing, and prevention of mother-to-child transmissions, must be emphasised.

There must be access to anti-retroviral drugs for the infected persons, and anti-tuberculosis drugs for TB sufferers. And there should be adequate funding from both internal and external sources.

The HIV/AIDS epidemic has brought in its wake social upheaval throughout Africa, and especially sub-Saharan Africa. We need to plan and execute programmes that address the growing needs of the affected and infected. ■

Kwazi Nimo has been Health Coordinator for World Vision Africa for more than a decade.

A pastoral proposal for a world at risk

Bishop Jose G. Martin Rabago

THERE ARE MANY church documents that have dealt with the ethical and theological problems raised by the upsurge of AIDS. Among these there exists a practically unanimous rejection of considering AIDS as a punishment from God for the sins of mankind. Such a theological interpretation is explicitly rejected in multiple documents. The affirmation appears, with certain frequency, that AIDS is a consequence of the moral disorder of society (the reason also given for the environmental crisis) that above all, insists on permissiveness in the sexual arena. On the contrary, AIDS is described as a call to conversion and ethical rebirth. For Chris-tians it is a *kairos* moment, an opportune time to turn to solidarity, recognising Christ in those affected by HIV and giving them help and human warmth.

Compassion

Independently of the means of infection and the degree of personal responsibility of the affected, those who are ill, as much as those who are infected by the virus, deserve respect and must be cared for with compassion. Their lives continue to be valuable because they still reflect the image of God. For this reason, we reject all discrimination and marginalisation of those affected.

The ecclesiastical communities must create institutional assistance for supporting those affected. In the social ethic area, the stress is on the right of those affected to keep their jobs as long as possible, to not be discriminated against in the areas of work or housing, and to receive necessary help in the treatment of their illness.

RANDY MILLER

The topic of prevention provokes the most controversy in some ecclesiastical documents. All these stances agree on affirming that prevention cannot be limited to mere health information or advertising condoms[1] and their free distribution, as well as that of sterile syringes. They consider that prevention based exclusively on prophylactic measures carries with it the risk of increasing the transmission of the virus[2] and furthermore contributes to the moral degradation of society.

Lesser evil

Some ecclesiastical documents reject all information on and use of condoms, while others accept the instruction about these prophylactic measures and admit their use as a lesser evil in certain circumstances. The focus is on the layers that form the bases for spreading HIV, such as social injustice, the very serious problem of drug addiction, etc. But there is a much greater emphasis, even disproportionate, on the moral/sexual theme involved.

In light of these documents, the conclusion is imposed that one must consider AIDS as proof of a general law where human actions have consequences, and that disorder inevitably produces damage and, consequently, destruction. It is a symptom of something deeper. It is one of the consequences of promiscuous sexual behaviour. Promis-cuity is becoming suicidal.

There exists a general resistance to take this approach by public authorities. They talk a lot about 'safe sex', of prophylactic resources, but there seems to exist a general reserve in talking about a new way of understanding sexuality. If sexuality has been 'tabooed' in the past, today all that can be placed as obstacles in the sexual arena are also 'tabooed'. We live in societies that do not have qualms about putting large controls on important areas of the human life, but are absolute-

ly unwilling to place the minimum restraints in the emotional-sexual arena.

Even more, in many countries, including my own, public authorities are promoting a way of understanding sexuality that is predominantly biological and individualistic. The consequences are serious in several areas: the large spreading of sexually transmitted diseases, the large increase in teenage pregnancies, etc. A way of understanding sexuality is being promoted that is lacking in meaning, in which the human dimension, so rich in significance, is being converted into more an object of consumption. They ignore the multiple voices affirming that this form of superficial understanding of sexuality is making it impossible to live their lives according to deeper values. All of this is furthermore orchestrated by the large interests of the means of social communication, which are playing with this form of understanding sexuality in order to boost their financial success.

We have to consider a new conviction that is being created today that the human being must live a healthier life.

New conviction

We have to consider a new conviction that is being created today that the human being must live a healthier life. Clear repercussions of this tendency would be the themes of alcohol, tobacco, medicines, food, physical exercise, etc. Along the same line, we must talk of the need to understand sexuality in a healthier way. We talk too little and vaguely of the need to change attitudes in order to rein in the epidemic. Even in the short term, the greatest hope lies in a moral renewal of society. AIDS raises important challenges in the biomedical sciences. Perhaps it should also cause us to question our understanding of sexuality today. ■

1. A condom is a very deceptive prophylaxis due to the fact that the HIV virus is 10,000 times smaller than sperm, and we know of many cases of pregnancies resulting while using condoms.
2. A distinction must be made between those who are sick with AIDS and those who carry the agent that causes the disease. This deals with the people who are not currently sick but who are infected and can also be developing the disease.

Jose G. Martin Rabago is Catholic Bishop of Leon, Guanajuato, Mexico.

Will 50 years of progress be reversed?

by Ken Casey

WORLD VISION this year instituted a campaign called the HIV/AIDS Hope Initiative. Its purpose is to alleviate the global impact of AIDS by preventing the spread of HIV, caring for children affected by AIDS, and advocating for appropriate public policy and programs.

World Vision has been involved in assisting children and families for more than 50 years. Now, with more than 5 million children in World Vision projects at risk, we realise that much of the hard-won progress made during those 50 years of relief and development is in jeopardy because of AIDS. Reduced child mortality, improved health, rebuilt communities, reinforced food security and increased educational opportunities–all this progress could be reversed. The Christian and humanitarian imperative that undergirds everything World Vision does compels us to respond in the face of such pain and suffering.

We are enhancing and expanding our work with focused efforts to prevent the spread of HIV, particularly among children, high-risk groups, and pregnant women and mothers.

We are also committed to caring for vulnerable children infected or affected by HIV/AIDS, and we are giving special assistance to children orphaned by the virus. We also will campaign positively for national and international policies and action designed to achieve the same goals.

Through this campaign, we want to demonstrate a Christian response to HIV/AIDS, reflecting God's unconditional, compassionate love for all people, and the affirmation of each individual's dignity and worth. In the midst of so much misery, may such a response bring hope. ■

Ken Casey is director of World Vision's HOPE Campaign against HIV/AIDS.

Reversing apathy in fighting the AIDS pandemic

Rich Stearns

THE INTERNATIONAL AIDS crisis has been called the greatest health calamity since the Black Plague of the Middle Ages. In the southern African countries of Botswana and Zimbabwe, more than 25% of the adult population have HIV/AIDS, mostly through heterosexual transmission. Our world is reeling from an incurable disease.

And yet, a new survey by Barna Research shows that Americans have little understanding of the threats of AIDS, and more important, little desire to be a part of the solution. The survey also revealed something that should shock us: Christians are no more likely to support AIDS-related causes than non-Christians.

Reasons for withholding

The survey of 1,003 American adults revealed 8% of non-Christians were certain they would donate to help AIDS orphans, compared with 7% of Christians. The 92% majority gave a variety of reasons for withholding their support, the most popular being lack of money, and the second reason was the feeling Americans should be focused on solving America's problems first. A statistic that offers a sharp challenge to development workers to better communicate the realities of global interdependence and the unsustainable consequences of injustice.

But even amongst those who are ready to give toward work on AIDS there are issues to be addressed. A scant 3% of Christians said they would definitely give for AIDS education and prevention, compared with 8% of non-Christians.

Why the reluctance?

Perhaps part of the reason is that many people do not realise the magnitude of the problem. Some might be passing judgement on those who are victims of HIV/AIDS, quietly rationalising, 'It's their own fault.' This latter reason remains as misguided and disturbing today as it was at the start of the AIDS crisis 20 years ago. At a purely practical level, it is impossible to cast blame in a pandemic when two of the largest groups of sufferers are the faithful spouses of unfaithful partners and the children of those already infected. More importantly for Christians, judgementalism is an attempt to stand biblical teaching on its head. St. Paul tells us that the greatest fruit of the Christian life is love. The love he wrote of is an ability to feel for our fellow humans with the same passion felt by God, an absolute love that can never be deterred.

No one should harden their hearts toward the victims of AIDS. That is a message that World Vision is willing to take to any church or community. We have committed ourselves to education and raising awareness across the world on HIV/AIDS.

Why does World Vision take this perception problem among Christians so seriously? Because reaching out to people was Christ's calling card. And it should be ours. Jesus tended to shock religious people with his actions. If Jesus were walking through our world today, I am certain that he would be at the bedside of AIDS-stricken people, and providing for the children orphaned by the disease. He would be speaking out against the hypocrisy of a world whose distorted values have thwarted attempts to address effectively prevention, treatment and care.

Christians must act as Jesus would act. We must pray, give, keep abreast of the problem, and demand greater action from our governments whose leaders so far have offered more rhetoric than substance.

Whatever our level of involvement, this is our chance to show the kind of radical compassion that Christ holds for each of us. ■

Rich Stearns is President of World Vision United States.

WORLD VISION is a Christian relief and development partnership which serves more than 70 million people in nearly 100 countries. World Vision seeks to follow Christ's example by working with the poor and oppressed in the pursuit of justice and human transformation.

Children are often most vulnerable to the effects of poverty. World Vision works with each partner community to ensure that children are able to enjoy improved nutrition, health and education. Where children live in especially difficult circumstances, surviving on the streets, suffering in exploitative labour, or exposed to the abuse and trauma of conflict, World Vision works to restore hope and to bring justice.

World Vision recognises that poverty is not inevitable. Our Mission Statement calls us to challenge those unjust structures, which constrain the poor in a world of false priorities, gross inequalities and distorted values. World Vision desires that all people are able to reach their God-given potential, and thus works for a world which no longer tolerates poverty. ■

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