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Global Future

Second Quarter, 2004

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HIV/AIDS – where is hope?

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Late to the party

This edition of *Global Future* has been prepared to coincide with the XV International AIDS Conference.

It took far too many deaths for the world to begin taking HIV/AIDS seriously. To see that it is more than a "health" issue (as critical as that is) and also an economic, political, human rights, security and development issue.

How could this have happened? For the same reason that, still, there is politicking and economising of the issue – to the utter exasperation of those closer to the suffering.

Denying the problem and stigmatising people living with HIV/AIDS have not helped. Thankfully, there are now serious efforts to cease medieval-style "plague or punishment" attitudes and respond proactively, with level-headedness and compassion. Faith-based organisations, including churches, have been waking up to their own complicity in this stigma problem, and transforming themselves into vital, values-driven players in the solution.

Meanwhile, millions of children orphaned or otherwise made vulnerable by HIV/AIDS are on a frightening obstacle course – under siege on all sides. If they have made it through pregnancy and birth without becoming infected themselves, endured lives of AIDS-related poverty and then lost their mothers (often both parents), there's a risk they will end up ostracised, exploited or abused.

Anyone can foresee the dire situation not too far down the track. This is why it is critical not only to shake off any remaining slumber now, but to empower and equip younger generations to lead the way in reducing the epidemic in what is, ultimately, their own future.

Is there hope? There is. But whether we follow that path remains to be seen.

– Heather Elliott

COVER DESIGN BY : FRIEND CREATIVE (Melbourne, Australia) / Cover Image by Jon Warren/World Vision: A seven year-old girl in Malawi, with her caregiver grandmother. This girl watched her mother die of AIDS in 2001. Her elderly grandparents wonder if they can stay strong long enough to give their beloved granddaughter a chance in life.

The children's suffering is neglected

Ken Casey

PHOTO - JON WARREN / WORLD VISION

Some 130 children aged under five, up to 100 of them orphans, being fed donated maize by volunteers in a World Vision project in Chanjoka, Malawi

HELEN[1] IS 14 YEARS OLD AND wants to be a secretary for a humanitarian organisation like the one that has helped people in her village in Malawi.

She walks 15 kilometres to get to secondary school each morning, carrying books and wearing clothes provided by well-wishers. Each evening she makes the same walk home and then must help her elderly, infirm *Gogo* (grandmother) to cook for her and a seven year-old cousin, John.[1] She has little time left for homework or play.

Helen's parents died of AIDS in the late 1990s. Then the uncle and aunt who took her in passed away. Recently her only surviving aunt, John's widowed mum, also died painfully of AIDS. Her *Gogo* is the only adult left in the family, and she needs as much care as she gives.

Helen's grim determination to succeed, and a little bit of help from volunteers organised and trained by World Vision, may make her dream possible. For millions more children in Africa and increasingly around the world, the picture is much more troubling.

Before long, one in eight of Africa's children will be an orphan: the projection is 42 million orphans in Africa by 2010. At least half of these children will have lost a parent to AIDS-related opportunistic infections. And tens of millions more children's lives have been made extremely vulnerable by HIV/AIDS.

It's going to be a decade before we start to see the same scale of orphaning in the rest of the world, but as infection rates continue to rise in Asia, Latin America and Eastern Europe, it is inevitable that the misery will spread further among the world's children.

Tragic lesson

Our most important lesson in Africa is that we started far too late to tackle this overwhelming consequence of AIDS. If we aren't to make the same mistake again, what we begin now must have a global application.

Those orphans have to go somewhere to live and eat. Like Helen, they are often taken in by uncles and aunts, then by grandparents. As that generation dies, they find themselves in the care

of older children and strangers.

Children in families that take in orphans, and those where parents are sick but not yet dead, suffer the same kinds of stress and multiplied poverty as the orphans themselves, creating a category of "vulnerable children" that is probably more numerous than that of the orphans. The burden of care is falling on families who are already the poorest in the world. Only one family in 20 that is caring for these children receives help from any external source.

To avoid the same mistake, we must apply globally the lessons from Africa

Since World Vision launched its first specifically AIDS-related projects in 1990, the organisation has studied the impact of HIV in the countries where we work, seeking the best ways that we and others can take on this challenge. There's a long way to go, especially in scaling up the best practices that we've seen, but we're starting to produce and use some tools that seem to have an impact.

World Vision is primarily a child-focused organisation, so it was natural to begin there.

We see deepened poverty, deteriorating nutrition and health, curtailed education and emotional trauma for a quarter of Africa's children. The pattern is repeating itself wherever in the world HIV incidence increases. The social and economic ramifications of so many children growing up without adequate nurturing and support are severe.

Yet the impact of the pandemic on this vast and voiceless part of the human family is rarely talked about. Indeed, if you didn't travel to Africa, you might wonder if it really is an issue.

A line in the sand

It's not active ill will toward these children. It's simply that they are marginal, powerless, and easy to ignore. Care for orphans and vulnerable children is consistently at the bottom of the list of responses to HIV/AIDS, and often left off the list entirely.

We need to draw a line in the sand, and say that this neglect of one of the least-regarded segments of humanity is an offence against human dignity. It must stop.

It's not only wrong, but also extraordinarily short-sighted. Providing care and support for orphans and vulnerable children is an essential investment in the security and stability of their communities and countries, as well as their capacity to cope with HIV/AIDS in the coming years.

The plight of African children doesn't fit within the political messaging of many of the activist groups who are loudest when HIV is on the agenda. Drug companies can't make money from orphans. Under such pressure from powerful constituencies, donor governments have focused most of their resources on prevention and treatment.

It's right to invest in prevention, treatment **and** care for the sick. Often the lives saved or prolonged are those of parents – thereby delaying or preventing orphaning. It's possible that, by effectively using enough resources, Africa can be saved from the primary assault of HIV.

What are we saving Africa for? The next generation? We are starving that very generation of the resources it needs now to be able to take on its role in years to come. We must balance these worthy aims, not promote one or two and ignore others.

Perhaps we are just too daunted by the scale of the challenge, unsure how to face the reality of 42 million orphans in five years' time. The double-edged lesson from sub-Saharan Africa is that it will certainly not be easy, because of the pre-existing decay of many social and government institutions due to poverty; but nor will it be as intractable or as expensive as we might fear.

Unsung heroes

We don't have to start from zero, because an army of unsung voluntary heroes – actually, mostly heroines – is already providing an enormous amount of care to Africa's orphans and vulnerable children. Distant relatives, aged village elders, informal women's associations, faith-based groups, farmers' co-operatives; all are playing a part in rearing the children of the HIV generation.

These volunteer carers represent an enormous network of goodwill that, if provided with good organisation, training, and minimal resources, could quickly multiply the level of quality care available.

After 15 years of practical experience, listening and learning, World Vision has developed a broad strategy on HIV/AIDS, called the *Hope Initiative*. Foundational to that is the promotion of Community Care Coalitions.

This concords with our philosophy of development: we shouldn't try to do for communities what they can do for themselves. Even now, and perhaps especially now. Where local leadership and volunteers are willing to act on behalf of their weakest neighbours, it makes most sense to help them to do just that.

In areas with little organised help but a lot of motivation, volunteer caregivers are encouraged to form Community Care Coalitions. They are provided with training and some resources to help them improve the well-being of the orphans and other vulnerable children in their community.

Care for orphans and vulnerable children is at the bottom of the list

In areas where volunteers are already tending to the needs of these children, a local forum is set up in which all the parties engaged in combating HIV/AIDS and caring for orphans and vulnerable children can meet and focus their efforts. This can help avoid duplication of effort, ensure no part of the community is overlooked, give a seamless link to

government efforts and provide a common voice to the population in its appeals for more help.

Within this strategy, the faith community is often an important source of motivated and caring volunteers, and it is one that World Vision is making particular efforts to try to strengthen. Around the world, faith-based institutions already provide much of the health care and welfare support. I have met with many of these volunteers and have marvelled at the impact they are having in the lives of these children.

Uphold the carers

The potential of community volunteers is enormous. And yet, it's unfair for the rest of the world to simply regard them as a resource to be tapped. Although there is potential leadership and volunteerism aplenty, there are few seeds and tools, fewer books, and rarely any spare food or medicines that can be useful to the children.

To draw more from the human resources in Africa, for instance, more must be put in. From our experience across more than 20 African countries, I am convinced this will not be a wasted effort anywhere in the world. On the contrary, a little more training and thoughtful input into the community groups caring for orphans and vulnerable children will result in a greatly expanded and sustained care.

Using this strategy and with adequate commitment from the international community, millions more children left behind by AIDS can be ensured the protection, care, and support they deserve.

On the day Helen's aunt died, leaving her and her young cousin in their *Gogo*'s care, the 63-year-old woman remained stoic. "The children will come to live with me," she said. "There really is no-one else left in the family who can help."

"The volunteer visitors who come to help us have done commendable work," she added. "Two have been coming every day, and that means I can go and work on my gardens and

PHOTO - JON WARREN / WORLD VISION

Olipa Chimangeni of Malawi is living with HIV and is an active advocate and caregiver for orphaned children. Her own daughter, aged 2, has the virus.

bring some food for the children, or do a day's labour for someone else to earn half a *kwacha* (five US cents). That makes all the difference."

The motivation within local communities to provide for the needs of vulnerable children is astonishing, but when an issue of just a few cents is so important to a carer, the resources are clearly still woefully insufficient.

The commitment and investment of the international community are vital to take the best of local intentions and turn them into a response that will give hope to millions of children like Helen. ■

Ken Casey co-ordinates World Vision's HIV/AIDS Hope Initiative and is an adviser to the International President of World Vision on HIV/AIDS issues. See www.wvi.org/wvi/aids/global_aids.htm

[1] "Helen" and "John" are pseudonyms.

"If everyone does a little, much will be achieved"

Alexandre Grangeiro (interview)

PHOTO - BRAZIL MINISTRY OF HEALTH

GLOBAL FUTURE INTERVIEWS Alexandre Grangeiro, Director of Brazil's National STD/AIDS Programme.

Global Future: What is the impact of the HIV/AIDS pandemic on Brazil and its people?

Alexandre Grangeiro: The AIDS epidemic has been under control in Brazil since the introduction of antiretroviral therapy in 1996. However, we have not yet managed to move beyond stabilisation at 20,000 new AIDS cases per year. Our goal is to effectively reduce new infections, and to this end we have conducted, since the beginning of 2003, a permanent campaign for HIV testing among the sexually active population.

Around 150,000 people diagnosed as HIV-positive are in treatment. Antiretroviral therapy has reduced by 50% mortality from AIDS in Brazil; it has had an impact of only 1% on social security (for pensions and superannuation) while increasing six times the survival of patients. People living with HIV in Brazil have a normal life; they work, they study, and most importantly, they are very active. The majority are involved in a non-governmental organisation that works on an AIDS-related issue – such as integrating marginalised people into the health care system, or psychological support.

GF: How are children and young people affected?

AG: "Vertical" (mother-to-child) transmissions have fallen by around 80% through good attention to pregnant women. They undergo a pre-natal HIV test, or if this is not possible, are tested during birth. If they show positive, they are treated with AZT injection. The babies also receive AZT and a special milk up until the age of six months (since breastfeeding is suspended to avoid HIV transmission via breast milk). Around 60% of pregnant women are being reached with these processes, and vertical transmissions now account for only 2% of AIDS cases.

Children who have lost their parents and families – and they are not many – are cared for by institutions that have financial support from the National AIDS Programme. The Programme also supports more than 600 households that include people living with AIDS.

For adolescents, Brazil began this year (2004) a broad programme of sex education and distribution of condoms in schools, to contain an increase of cases among young people aged 13–19 years, primarily girls and young women. In this age group, there are now twice as many new AIDS cases among females than among males. This age group also has a high birth rate. While the number of cases is not actually increasing, the profile of this age group is changing.

GF: What do you consider to be Brazil's biggest challenges in terms of preventing HIV/AIDS and caring for those affected?

AG: The major challenge is reaching people who are far from the urban centres. The epidemic is moving outwards to the peripheries of the cities and to the countryside, where health services and civil society organisations are not yet well-established. Our task is to develop this structure as we have done in the large urban centres. At present, for example, we are meeting with neighbouring Latin American countries (Argentina, Paraguay, Uruguay, Bolivia and Chile) to draw up a common policy for responding to AIDS in the border areas.

In some municipalities, while the numbers are still small, we have seen a six-fold growth in AIDS cases over the past four years. This shows us clearly that the epidemic is not yet beaten – it only changes shape every four years; and that the fight needs to be constant if we are not to have a relapse in the advances obtained up till now.

GF: Brazil has taken considerable steps towards producing generic antiretroviral drugs. Could you tell us what led to this, and what have been the results of Brazil's actions?

AG: When Brazil began to manufacture generic AIDS drugs, in 1998, the Brazilian law of patents had not yet been passed. The seven medicines that Brazil made were not patented here and could be copied. In the process of manufacturing these generic drugs, Brazil acquired the know-how to manufacture any new one. Whenever a new medicine is released, the state laboratories begin to work on the formula and use this resource to negotiate a price reduction with the manufacturers of the other medicines Brazil imports.

When the law of patents was approved/passed, in 1999, one article guaranteed that – in case of public health risk or abuse of prices, or the formation of a cartel – our country can demand the compulsory licence

to a product, or in other words, breach patent. It is also based on this law that Brazil is in a position to manufacture generic forms of any drug, if we cannot manage to import them at just and fair prices. Up until now, we have not needed to do this. Brazil obtained a reduction in price of up to 80% on certain AIDS medications because it is quicker and cheaper to buy them than to produce them. But, if needed, we can produce them in a short period of time.

GF: How will Brazil ensure that poor Brazilian people who live with HIV/AIDS have access to low-cost antiretroviral drugs?

AG: Brazil's strategy is to negotiate low prices and learn to manufacture the drugs. This has enabled us to maintain the same budget for these medicines for three years (around 520 million *reais* or less than US$250 million per year) even with a rise in the number of people receiving treatment. Each year we have an average increase of 10,000 people in treatment, as well as including at least one new drug in the therapy.

And all of the 150,000 Brazilians living with AIDS are getting access to the medicines. Brazil's constitution, and a law specifically on AIDS, guarantee treatment, so Brazil will always need to allocate resources in its budget to ensure this therapy. This is why such efforts are made to ensure that the price increases do not compromise the budget.

GF: Can you tell us something of the support that Brazil is giving to other countries to combat HIV/AIDS?

AG: Brazil offers treatment to 100 people a year (a quota reviewed annually) for 14 countries in Latin America, the Caribbean and Africa. The African countries are mostly those with which we have co-operation agreements (9 in all). The aim is to demonstrate to the world that, if everyone does a little, much will be achieved in combating AIDS. Without solidarity between nations, it will not be possible to offer treatment to an extra three million people who are sick with AIDS by 2005, as the World Health Organisation seeks.

Apart from offering this treatment, with antiretrovirals manufactured in Brazil, the AIDS Programme offers technical training for health professionals in countries with which we have the accord, and technical co-operation only with other countries that are not receiving the medicines. In Mozambique, Brazil is offering technical assistance for the construction of three state laboratories for the manufacture of antiretrovirals, with technology from the Oswaldo Cruz Foundation, our largest public laboratory. ■

Alexandre Grangeiro is Director of the National STD/AIDS Programme for Brazil's Ministry of Health. This interview was translated from the Portuguese by Global Future.

PHOTO - JON WARREN / WORLD VISION

A nurse examines a newborn baby in Brazil's Amazon region. The national Ministry of Health is committed to preventing HIV/AIDS and ensuring access to antiretrovirals where needed, though it is a huge challenge to reach remote areas of Brazil with public health services.

The '3 by 5' Initiative – to save life and change history

Jim Yong Kim

HIV/AIDS IS DEVASTATING many parts of our world. Globally, an estimated 40 million people are infected with HIV/AIDS. Every single day AIDS kills 8,000 people and orphans thousands of children. Entire countries face social and economic collapse in a few generations if decisive steps are not taken.

Treatment in the form of antiretroviral therapy (ART) exists, and can transform HIV/AIDS from a death sentence to a manageable chronic disease. However, until now, treatment has been the most neglected area of HIV/AIDS programming. Six million people need ART and three million died in 2003 because they could not get the necessary drugs. Worldwide, only 440,000 people have access to treatment; in Africa, where some 70% of people with HIV live, ART is available to less than 4% of those in need.

Ambitious target

The failure to deliver life-prolonging drugs to millions of people in need has been declared a global health emergency. On World AIDS Day 2003, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) launched the *3 by 5 Initiative* – an ambitious global target to get three million people living with AIDS on antiretroviral treatment by the end of 2005. This target is a vital step towards the ultimate goal of providing universal access to AIDS treatment to all those who need it.

'*3 by 5*' builds on the ground-breaking work of human rights and treatment activists around the world as well as on the political and financial commitments made by the United States under President Bush's HIV/AIDS Initiative ($15 billion dollars for an enhanced AIDS response); Canada, France, the United Kingdom and many other donors who have contributed to the Global Fund to Fight AIDS, TB and Malaria; the World Bank; and the William J. Clinton Foundation. Never before has there been a more opportune moment for combined, collaborative and comprehensive action to combat HIV/AIDS.

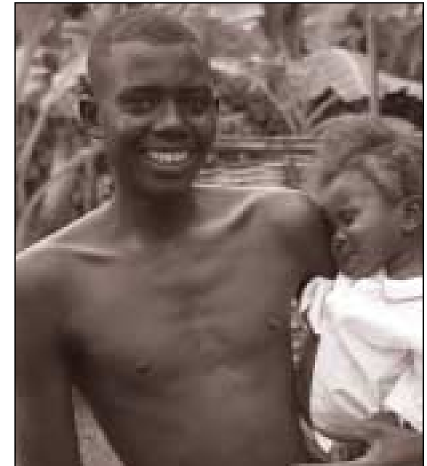


PHOTO - DAVID WALTON / PARTNERS IN HEALTH

Living proof that antiretroviral treatment works: this young man is shown in March 2003 and August 2003 – before and after receiving therapy for TB and AIDS at a clinic in Haiti.

We know that HIV/AIDS treatment can be scaled up – successful examples in Brazil and pilot projects in other countries have shown that it is both affordable and effective. We also know that focusing efforts on treating HIVAIDS can strengthen and lead to long-term recovery of health systems. In Brazil and other countries that have increased access to treatment, the costs of providing ART have been more than offset by savings due to reduced demand for inpatient services by people who are dying from AIDS, as well as by regained economic productivity.

The WHO and UNAIDS '*3 by 5*' strategy is focused on providing support to developing countries in the form of simplified norms and guidelines and other forms of direct technical assistance for scaling up antiretroviral therapy. Because procurement and supply chain management of pharmaceuticals and diagnostics is such a problem for most poor countries, WHO has established the AIDS Medicines and Diagnostics Service to help countries with all aspects of selecting, procuring and delivering both HIV medicines and diagnostic tools to the point of service delivery.

We have an unprecedented opportunity to alter HIV/AIDS' course

To ensure a comprehensive response to HIV/AIDS, treatment and prevention, programmes must enhance and accelerate each other. When people have hope that they can be treated and lead productive lives, their incentive to know their status and to protect themselves and their partners is much greater. Evidence and experience shows that rapidly

increasing the availability of ART increases community awareness about HIV/AIDS, promotes uptake of HIV testing and can lead to more openness about AIDS. Individuals on effective treatment are also likely to be less infectious and less able to spread the virus.

People who have hope of being treated have more incentive to know their status

Old and new partnerships

'*3 by 5*' is one of the most ambitious undertakings in the history of public health and it will be essential to learn by doing. Organisations like World Vision, faith-based and non-governmental organisations, groups of people living with HIV/AIDS, treatment activists, pharmaceutical companies, trade unions and the private sector all have an absolutely vital role to play and can provide valuable lessons about treatment scale-up in poor settings. We at WHO know that we must work with partners old and new, and we believe that if we do so with a common vision, it will be possible to eventually provide treatment for all who need it.

Involvement of communities and community workers is also essential to the success of '*3 by 5*'. There is significant evidence that with strong community support, people find it easier to adhere to their medical regimens. Motivating communities to know their HIV status in a context of access to ART is altering community responses to HIV/AIDS, encouraging greater openness, and helping to reduce the stigma and denial that has enabled the virus to spread so disastrously.

Since the launch of '*3 by 5*' in December 2003, 52 countries around the world have appealed to WHO for assistance with efforts to increase access to ART. WHO-led missions have already travelled to nearly 30 countries in all regions (the majority in Africa) to identify key needs within

PHOTO - KARL GROBL / WORLD VISION

At a Cambodian Red Cross health care centre, Ministry of Health staff who work part-time with World Vision conduct free, confidential, voluntary blood tests and counselling for people at risk of HIV/AIDS.

countries and to assist with writing national treatment scale-up plans and funding proposals. Currently, WHO is recruiting 40 country co-ordinators to provide full-time '*3 by 5*' assistance to WHO country offices.

Reaching the '*3 by 5*' target will mean making the most of the substantial existing resources in a co-ordinated way, and ensuring that patients get treatment for life. This will mean long-term financial commitments from all sources – poor countries themselves, donor governments and multilateral funding agencies. WHO estimates that the funding required by countries to scale up treatment is around US$5.5 billion over the next two years. WHO will need $218 million to provide the necessary technical assistance to help countries with scale-up of prevention and treatment. Thanks to generous contributions from donors, especially from Canada, Sweden and the United Kingdom, WHO is moving ever closer to reaching its funding target.

There has never been a more urgent call for action to save lives than now. This is a crucial moment in the history of HIV/AIDS and an unprecedented opportunity to alter its course. We have the moral imperative to respond to the global pandemic and to save lives. Every one of us has the chance to make a difference. The time to act is now. ■

Dr Jim Yong Kim (MD, PhD) is Director of the HIV/AIDS Department of the World Health Organization. For more information about the 3 by 5 Initiative, see www.who.int/3by5/en/

Towards a future and some hope

Lieve Fransen

THE HIV/AIDS PANDEMIC AND its ramifications for children are issues of international concern. By working in co-operation with governments, NGOs, international agencies, the private sector and people living with HIV/AIDS, the European Commission has been at the forefront of efforts to effectively address the plight of children infected, affected or left orphaned by HIV/AIDS.

Children born to HIV-infected mothers are at risk of infection during the pregnancy, birth or breastfeeding. Every year half a million babies, over 90% of them in Africa,[1] acquire HIV from their infected mothers. More than 90% of HIV infections in children are acquired through mother-to-child transmission; the remainder occur through blood transfusions or unhygienic conditions in hospitals.[2]

European Community initiatives

The European Commission has been a key player in addressing the issue of mother-to-child transmission. It has initiated and supported some of the first research into this issue in Africa, and continues to support projects that limit this mode of infection. The European Commission also developed the first comprehensive approach to blood safety in developing countries, and in some cases financially supported these projects for over 10 years.

The 30% of children born to HIV-infected mothers who are not themselves infected suffer an uncertain future, as one or both parents become ill and eventually die. AIDS has orphaned[3] at least 10.4 million children currently under the age of 15,[4] and every day more than 6,000 children are left orphaned by AIDS, a third of them under five years old.[5] These vulnerable children are forced into precarious circumstances where they are at high risk of exploitation, abuse, and becoming infected with HIV.[6] Girls are usually the first to be pulled out of school to care for sick relatives or look after younger siblings. In high HIV/AIDS-prevalence countries, girls' enrolment in school has decreased over the past decade, negatively affecting gains made towards the goal of universal primary education.[7]

Children of HIV-infected mothers face a precarious future

The European Commission therefore supports programmes that target children's rights and their access to education, in an effort to help children avoid the most dangerous situations and provide them with a future and some hope. The Commission also funds programmes that provide care and treatment for children, mothers and families.

HIV/AIDS and poverty

The link between poverty and HIV/AIDS is the cornerstone of European Commission policy, as HIV/AIDS affects the poorest and vulnerable populations the most – undermining global health and development. For example, mother-to-child transmission is many times more prevalent in developing countries. Currently, only 5% of pregnant women have access to programmes for the prevention of mother-to-child transmission (only 1% of the 27 million annual births in Africa are covered), and even fewer to treatment.

The *Programme for Action, Accelerated Action on HIV/AIDS, malaria and TB in the context of poverty reduction (2001–2006)*[8] is the European Community's response to the need for a broad, coherent and comprehensive approach to HIV/AIDS, TB and malaria, in line with the Millennium Development Goals. The Programme's primary goals are:

- to increase the impact of existing interventions
- to increase the affordability of key pharmaceuticals, and
- to encourage research in and development of public goods to tackle HIV/AIDS, TB and malaria at the national, regional and global levels.

It has a framework of comprehensive prevention, treatment and care strategies directed at the poorest and most vulnerable groups. In this context, it supports initiatives that aim to prevent mother-to-child transmission. Within the framework of the Programme for Action, the European Community also focuses on the rights of children, and in particular, orphans.

Increased funding

In addition to the regular country programme support, the Commission will spend EUR 1.1 billion in the period 2003–2006 to support the Programme for Action's strategies on HIV/AIDS, malaria and TB. This represents a fourfold increase in EC funding for these deadly illnesses.

The European Commission also works through the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Commission is a major donor to the Global Fund, having pledged EUR 460 million from 2001–2006 and having disbursed EUR 374 million to date. By 2008, Global Fund programmes will have supported over one million orphans through medical services, education and community care. ■

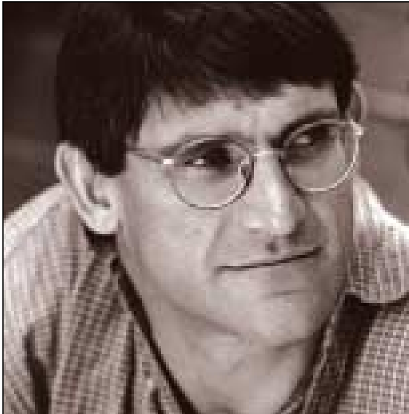
Dr Lieve Fransen is head of the Human and Social Development Unit in the European Commission's Directorate-General for Development, and Co-ordinator of the European Union's Programme for Action on HIV, Malaria and Tuberculosis. She also represents the EC as a voting member on the Board of the Global Fund.

[1] Tapper, A, *Mothers and children confronting HIV: Challenges, choices, lessons learnt*, 2000, page 11 [2] *Ibid.*, page 16 [3] That is, the epidemic has killed their mother or both parents [4] UNAIDS, via www.unaids.org [5] *Ibid.* [6] Almost three million children under age 15 are living with HIV today. [7] Millennium Development Goal Two is for all children everywhere to be able to complete a full course of primary education. [8] http://europa.eu.int/comm/development/body/theme/human_social/pol_health3_en.htm

A sleeping church awakes

Christo Greyling

PHOTO - BARD LUIPPOLD / WORLD VISION



Reverend Christo Greyling

"ONLY YOU KNOW HOW YOU are going to do it Lord, but let your kingdom come and your will be done…" was the prayer that flowed like a mantra from my lips as I drove from the hospital. The rain falling in sheets reflected the tears welling up within me. I had just heard that I was HIV-infected.

It was September 1987 in Cape Town. The next year, I would finish seven years of theological studies. I knew God had called me. And now this! What church would ever want a reverend with AIDS?

The years that followed have been no easy road. But what stands out is not the pain of judgmental attitudes and physical suffering. It is an expanding hope, nourished by the love of Christ that I received through the amazing support of others – especially Liesel, who married me knowing the risk she was taking.

"I did not want to wait until I was too ill to be of use"

Sadly, my experience of support and love has not been shared by millions of people in Africa living with HIV or AIDS. Working closely with faith leaders has shown me that many faith-based organisations had (and still have) a lack of scientifically accurate knowledge; inappropriate attitudes towards HIV-infected people; and cultural and religious taboos. These perpetuate stigma, discrimination, denial, silence and inaction by the organisations, and fear and self-stigma in people infected or affected by HIV or AIDS.

Breaking the silence

As the first opportunistic infections started to manifest, God's call on my life and the conviction to go public grew stronger: I did not want to wait until I was too ill to be of any use. I wanted, from first-hand experience, to show that people living with HIV are like anyone else, and to share my hope in the resurrected Christ.

Unfortunately, my own church was not ready for this in 1992. "AIDS is really not a problem within the Church; perhaps you should talk to some social workers," was the response to my request to start an AIDS ministry. I did not know that at the exact same time, others – such as Rev Gideon Byamugisha in Uganda – had the same vision and were facing similar struggles.

I learned that the largest insurance company in Africa had a slide series on AIDS, and shared my vision with their Namibia manager. His eyes flooded with tears as a new vision started in him. Six months later Liesel and I were appointed to develop their community AIDS programme, which targeted schools, community leaders… and faith communities.

Yet our vision grew that God wanted the Church and faith-based organisations (FBOs) to be instrumental in addressing AIDS. It became increasingly obvious to us that denial and stigma not only hurt those suffering the HIV/AIDS burden, but caused more people to become infected.

As the impact of HIV/AIDS in Africa became impossible to ignore, churches and FBOs began to move beyond judgmentalism, towards compassionate, effective programmes. At an inter-faith conference on HIV/AIDS in July 1999 in Johannesburg, faith leaders shared with each other the realities they were facing, and some recognised the need for a resource and training centre.

Someone encouraged us: "God will not call you, prepare you, then say: 'Sorry, I was joking!'" In 2001, an NGO representative was moved by our vision of a Christian AIDS bureau, and asked me for my CV. Eight months later, I was appointed to train World Vision staff in 25 African countries to mobilise and equip local churches and FBOs to respond to AIDS.

Transformed hearts

Faith leaders can be effective change agents, if they themselves undergo change: confront their own judgmental attitudes or lack of information, and grow in understanding of their role.

These days, at HIV/AIDS workshops, I see faith leaders on their knees, crying: "Lord, forgive me for judging others when I am a broken person myself!" I stand in awe as 38 Maasai church leaders openly repent for the way they treated HIV-infected people. I see people leave transformed, with a new vocabulary. They preach, pray and minister differently as they realise HIV is no longer "them" versus "us" – only "us".

My mind goes back to my prayer on the rainy day in 1987, and I see grace at work. ■

The Reverend Christo Greyling is World Vision's Africa Regional HIV/AIDS and Church Relations Adviser. He has been living with HIV for 17 years.

Is enough being done to give hope?

Milly Katana

HIV/AIDS IS NOT ONLY A health problem but also a threat to sustainable development. It is undermining the attainment of all of the Millennium Development Goals, including reducing poverty, child mortality and gender disparities. It is reducing social and economic capacity, with the deaths of people who have many years of training and expertise behind them. It is resulting in the loss of social values, traditions and practices that have held societies together through history. It is contributing to regional and global insecurity.

Children are losing parents to AIDS. Many of them are growing up destitute, without social values. Desperate adolescents with little or no value for life do not bode well for secure, healthy future communities. The ever-increasing numbers of deaths and new infections, particularly of women, does not inspire hope and motivation.

We can predict the future with a very small margin of error. We are losing the battle to AIDS. There is no indication that the world – developed or developing countries – is geared up for the huge volume of work that needs to be done. Instead, the world has been rendered helpless in the face of AIDS.

The needs-driven Global Fund is being forced to exclude countries

Even in some rich countries, we are seeing a fresh epidemic. We do not have women-controlled prevention technologies; there is no hope for a vaccine, and no cure in the pipeline. It seems we cannot even equitably use the technologies that we know work, including condoms and antiretrovirals. Some international efforts are making it very difficult for developing countries to access cheap generic drugs on a sustainable basis.

Need to gear up

What we need now is new inspiration and motivation to get back on course, to create a future that is desirable for us a global community. The past is gone; it can only serve as a lesson for what we commit to do now. Yet the big question is: what future do we want to create?

The current response to HIV/AIDS is too narrow and inadequately resourced. The world's major source of funding for the three major diseases, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), was able to attract US$5 billion in 2001–4. But the target was $10b per annum when the UN Secretary General announced the Fund in 2001. Today, the GFATM needs $5b for 2004–5 to be able to renew old programmes and finance new ones. Budget limitations have forced the GFATM – a fund that was conceived as need-driven – to develop exclusion criteria for countries. And we are living in the 21st century. Shame!

Yet despite this serious under-funding, the GFATM has managed to generate hope in the lives of many people across the world. In Uganda – the only "success story" against AIDS in the developing world so far – the GFATM has promised to provide ARVs in the public sector. This means free treatment. It is the first time such a bold step has been taken by the public sector in Uganda or indeed, in much of Africa.

Politicking AIDS

Subjecting HIV/AIDS to routine power and political struggles is not inspiring for those committed to delivering peoples of the world out of the bondage of AIDS. In South Africa, as AIDS became a political debate, more and more people got infected, sowing enough "seed" to give that country – which has better social services than almost all other African countries – the tragic distinction of having the biggest number of people living with HIV/AIDS in the world.

Meanwhile, statistics in some countries in Asia are produced in such a way that that annually the numbers do not go beyond certain thresholds. The purpose of epidemiological data is lost and appropriate action against the epidemic is not taken.

In some developing countries, as more resources are being made available, government officials are seizing the opportunity to flex muscles over who should control the resources – further marginalising frontline actors.

Where does responsibility lie? Squarely with both developing and developed countries. The developing countries need to step up their efforts in responding to the disease; developed nations need to take the bold (and, for most, extraordinary) step of supporting these efforts. Commitments made in the past have not been operationalised. Political commitments made in connection with HIV/AIDS are lagging far behind.

Inconsistencies

In April 2001, African heads of state made the *Abuja Declaration and Framework for Action for the fight against HIV/AIDS, tuberculosis and other related diseases*. One of the outstanding targets of their Declaration was to allocate at least 15% of their annual national budgets to improve the health sector to help address the HIV/AIDS epidemic. However, only two countries attained this target by 2003. Health care systems are now struggling, even crumbling, under the burden of AIDS. The good news is that with international help, a few countries are stepping up their investment in health care. Yet this investment is not enough to turn the tide of HIV/AIDS.

PHOTO - CLEVER MAPUTSENI / WORLD VISION

Three young boys - from (left to right) Zimbabwe, Democratic Republic of Congo, and Rwanda - hold posters with AIDS prevention messages during World AIDS Day celebrations at Tongogara Refugee Camp, eastern Zimbabwe

Globally, we have conflicting development policies. On the one hand, countries commit to increase spending on health care; on the other, they put recruitment ceilings in the public sector as well as budget ceilings to attain macro-economic stability. All this has resulted in a vicious cycle where health care systems are not able to deliver services to the people. Decades ago, the Organisation of Economic Co-operation and Development (OECD) countries committed to providing development assistance of at least 0.7% of their gross domestic product. By 2000, only five countries had attained this target. This has major implications for the level of financing for the global health crisis.[1]

Countries pledge to increase health funds, but restrict the public sector

Some countries have come close to making a remarkable dent in the epidemic of HIV/AIDS, but not other diseases. In Uganda, new HIV infections have been reduced from as high as 30% of pregnant women in the late 1980s and early 1990s, to as low as 5% now. This is a breakthrough. However, the country is struggling to care for those living with HIV/AIDS. And meanwhile, malaria is getting out of hand – killing the young, old and middle-aged, and further exacerbating the impact of HIV/AIDS. South Africa has done very well in managing malaria, but it is struggling with the heaviest burden of AIDS in the world. It is difficult for countries to register success over disease.

Continued denial of the risk factors, including intravenous drug use and homosexual sex practices, means that many countries are sitting on a time bomb. Practices that fuel the epidemic are on the increase in many developing countries, but political leadership is sweeping these factors under the carpet in the name of "morality", with the result that HIV/AIDS prevention programmes are not user-friendly for people who engage in these practices.

Hear the people

Many failures, in health and development policy formulation alike, stem from a failure to hear the voice of "the people", and to value human capital. In principle and in practice, we must increase people's voice in health and development policy formulation, and support integrated development planning that takes into account all the MDGs.

On the positive side, the Highly Indebted Poor Countries (HIPC) initiative is coming through to support responses to HIV/AIDS and other health goals. In Mozambique, savings made from debt servicing have been used to increase vaccination of children. In Cameroon, the savings have supported the National AIDS Control Programme. In Nigeria, President Obasanjo is openly campaigning for debt relief for AIDS and health care such that Nigeria can attain the Abuja Declaration target of spending at least 15% on health care. However, the HIPC initiative has an exclusion clause that has left six of the seven countries with the highest HIV/AIDS prevalence out of the initiative.

For there to be hope in a future free from AIDS and other diseases, all of these issues must be addressed. Hope lies in whether we are able to, now, mount an extraordinary response that gets results – that reverses the trend of the global health and development crisis caused by HIV/AIDS. The good news is that with the right intentions, policies and actions, the trend of the epidemic **is** reversible. ■

Milly Katana is Director of the Health Rights Action Group, a Ugandan NGO that advocates against HIV/AIDS stigma and discrimination and mobilises communities to prevent mother-to-child transmission. She is also a Commissioner of the UN Commission on HIV/AIDS and Governance in Africa. See: www.uneca.org/chgal

[1] United Nations Development Programme, *Human Development Report 2002*, page 202

Adolescents, gender and HIV

Nafsiah Mboi

PHOTO - KARL GROBL / WORLD VISION

Young people, such as these Cambodian students, hold the key to reducing future HIV infections. These students are part of an innovative World Vision programme that trains at-risk groups to share HIV/AIDS prevention messages with their peers.

TODAY'S ADOLESCENTS, THE children 10–19 years of age, stand directly in the path of the HIV/AIDS epidemic. They can either feed the fire or help bring it under control.

These young people, an estimated one billion in the developing countries, live in an era of often-unpredictable change, brought on by rapid urbanisation, economic globalisation, a revolution in global communications, and vastly increased mobility. These phenomena present young people with choices about lifestyles, social relations and employment – and expose them to risks and temptations – that earlier generations never had to deal with.

Indications are that it is not always easy to make safe choices. Last year, 67% of new HIV infections in developing countries were among adolescents and young adults, aged 15–24. If we are to stop the destruction by HIV we must do a better job of working with our adolescents, both for their own sake and the sake of the whole human family.

Boys and girls – different risks

In most societies it is during adolescence that gender distinctions – the social definition of what is "masculine" and what is "feminine" – begin to solidify. These distinctions will influence the course of life in profound ways thereafter. In many societies, a boy's options tend to broaden at this point: he is encouraged to take risks (including sexual risks) and learn about a wider world outside his home and family. A girl's world at this time often becomes smaller: in many cases, even the ways she moves, dresses and expresses herself are more strictly regulated. A girl is encouraged to "preserve her innocence", rather than to learn about reproductive health, sexuality and even her own body. Both boys and girls learn that in sexual matters, it is the male's prerogative to initiate, to dominate.

Many girls pay a high price for their innocence in sexual matters

Girls pay a high price for their innocence and lack of sexual autonomy. They fall prey to exploitative employers, boyfriends, even husbands. Indeed, today it is

estimated that 64% of the people aged 15–24 who are living with HIV or AIDS in developing countries are women and girls!

It is true that the push towards risk taking can place an adolescent boy at increased risk of HIV infection from unsafe sex, experimentation with drugs, or excessive use of alcohol which may lead to other risk taking. However, the situation of girls is worse. Among adolescents aged 15–19, HIV infection rates often run two to six times higher among girls than among boys of the same age. Examining the situation in country after country one finds that gender-based differences – in education, access to information, socialisation, and thus, experience and expectations in life – are primary factors influencing the vulnerability of these young people to HIV infection.

The theme of the World AIDS Campaign 2004 is *Women, Girls, HIV and AIDS*. The impact of gender inequities radiates throughout all facets of life – social relations, issues of public participation, access to public services, legal status, and so on. It is not solely an issue of power relations in sexual transactions between men and women. In fact, we know that the nature of sexual relations does not improve substantially without changes also occurring in other aspects of gender dynamics.

This is confirmed by data about girls across Asia showing that **knowledge** about HIV and how to protect themselves from infection often does not lead to effective **action**. Even when they know what to do and why, many adolescent girls feel unable to resist the sexual advances of a demanding male, either in or out of marriage. Unless they also have an enhanced sense of their right to protect themselves and the confidence to believe that they might succeed, most girls will accept sex as and when demanded by their male partner.

Useful approaches

Is there a specific "plus factor" which can help overcome the inequities of traditional gender relations? Different settings, different obstacles and different opportunities have produced different kinds of activities, but there is no silver bullet. Nonetheless, most of the successful activities are ones that have contributed one way or another to girls' information, skills, self-confidence, self-respect, self-reliance, or a sense that they were not alone, that they had a support network to consult or fall back on. For example:

- Extended schooling has had positive results for both girls and boys, contributing to delay of entry into sexual activity, practice of safer sex, and delayed marriage.

- Theatre, music, athletics and other group activities have helped girls gain confidence in their right and ability to interact with a larger world. They give girls the "protection" of group membership as they consider new behaviour and, maybe, try out leadership in a group of friends. HIV information introduced in this sort of setting can be well received and is more likely to be acted upon. Indeed, surveys in a number of places have found that membership in well-run community youth groups reduces a young woman's chance of being HIV-positive.

- Activities can also be directly related to a girl's more conventional progress towards marriage, but may open the door to the possibility of more equitable gender relations within the family. For example, in one Indian state, in order to encourage girls to delay marriage, a sum of money was made available to every girl who waited until age 18 before marrying. The result: when she married, a girl came to her husband with some money of her own, giving her more confidence and the possibility of more independence than if she entered her husband's home merely as the result of family negotiations, a "gift" of her family to her husband's family.

Girls on the margins

These are innovative activities reaching "mainstream" adolescent girls, urban and rural. However, significant numbers of girls are at extra risk and extra efforts are needed to reach them. These are the girls who because of extreme poverty, childhood abuse, adolescent rebellion, employment, armed conflict and other factors are out of sight – adolescent girls in prostitution, trafficked internationally or within their home country for sex work or exploitative child labour, girls in domestic service, street dwellers, girls in regions of conflict, refugee camps or found among the world's internally displaced people (IDPs). All these girls are difficult to reach, are basically unprotected, and are particularly vulnerable to gender pressures, sexual violence, drug use, and ultimately, HIV infection.

Adolescents deserve special support in constructing safer ways to live

"AIDS has a woman's face," said Carol Bellamy, Executive Director of UNICEF in 2002. Sadly, every year that is more accurate than the year before. If we do not learn to do better by our adolescent girls, the numbers will continue to increase each year. Girls and women are vulnerable because our societies make them so. Their access to information and their right to act on it are limited because they are female. Without addressing the all-important issue of gender, any increased knowledge of personal hygiene, safe sex or reproductive health will not be put to use and little progress will be made against HIV/AIDS.

Adolescents, with their lives in front of them and on the verge of becoming sexually active, deserve special opportunity, encouragement, and support in addressing this challenge and constructing new safer ways to live. ■

Dr Nafsiah Mboi is Senior Adviser to the Indonesian National AIDS Commission, and a Member of the Board of World Vision Indonesia. She was formerly Director of the Department of Women's Health for the World Health Organization.

Voices from the village

Nigel Marsh

An orphan, a grandfather caring for orphans, and a child with AIDS shed light on life in Africa in the grip of HIV.

PHOTO - JON WARREN / WORLD VISION

(Left to right) Maggie's cousin Bright, Maggie, Eleanor

Orphan: Maggie

Maggie lives near Kitwe in Zambia with her paternal grandmother, Eleanor, who is around 70 years old. Maggie was 13 when she told us her story.

"When my mum died in 1998, everything changed. I don't really remember Daddy – I'm told he died in 1995. They both died of AIDS.

My older sisters had married and left home. After Mum passed away I was taken away with my little sister Josephine, who was born just after Daddy died, to the home of my mum's sister. She lived in a distant village, in Northern Zambia. It was such a poor place to live. We had nothing.

My aunt was a widow and had her own children. Then she fell sick, and we all had to look after her, until she died. Her children, Josephine and I were left with her aged mother, my maternal grandmother. That was even more terrible. There was never enough to eat, even though we worked long days in the gardens instead of going to school. We had no blanket, just a place to sleep on the mud floor in the house. Our clothes were tattered.

Worst of all, I was the only one in the world to look after Josephine, who was suffering fevers, diarrhoea and body pains. I recognised the sicknesses as AIDS. I despaired; I thought we were both going to die.

But I had not been forgotten. My late father's mother, Eleanor, heard we were in trouble. She sold her furniture to buy a bus ticket so she could come looking for us. She was shocked at the way we were living, and agreed to take my two cousins and I home with her.

Things are so much better here. But Josephine was too sick to travel, and she died soon after we left. I am still sad that my little sister died in that village and never got to come here.

Now, I am doing well in school again. I have clothes to wear, and there's enough to eat.

I'm so happy that my gran came to find me and bring me back from that village. And I'm grateful for the other support that has enabled me to stay in school.

I hope people will continue to provide help for others like me. There are so many children who need these things as much as I do, whose lives have become so bad, and who can't do anything about it."

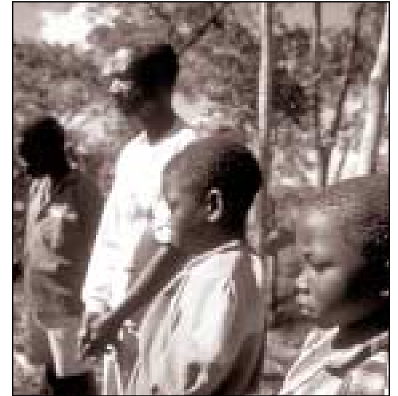


PHOTO - JON WARREN / WORLD VISION

Kenneth and three grandchildren visiting Martha's grave

Grandfather caregiver: Kenneth

Kenneth Kavwenge is a sprightly 75 year-old widower in Kandani, Malawi. His tendency towards cheerful optimism was battered when Martha, the last of his ten children, died, leaving him with three orphaned grandchildren. He spoke to us two weeks after the funeral.

"Martha had been sick with AIDS for five months, and her husband died the same way in 1997. It was not until she was tested and found to be HIV-positive, only a month before she died, that I realised how much AIDS had hurt our family. She told me she knew her days were up, and asked me to take care of the children.

I felt so sad that this was the only choice for the children, because I am very old. I couldn't answer her, because I didn't know how I would

Abridged from interviews conducted by Nigel Marsh, a journalist who is based in Africa and travels for World Vision investigating the impact of HIV/AIDS. All interviewees consented to World Vision using their stories and photos to raise awareness about HIV/AIDS.

take care of the children. Now there's no-one but me here for them, to try to make sure they have clothes, soap and food. I'm still strong and healthy, but of course I wonder how long I can keep it up.

My older grandson is dependable and works hard around the house and in the gardens. That helps, though it's a lot of work for a boy of 14. He is growing up to be a good man and he's doing well at school.

I spend a lot of my time now going around the village, talking to people about AIDS, helping to care for the sick. I'm doing what I can to get my fellow church-goers to be more active about HIV.

Even in the past it was hard when there was nobody to take care of the children, and grandparents would take responsibility. This would happen, for instance, when a mother died in childbirth, and the father died later of some disease. But back then that was very rare. People weren't dying as they are nowadays.

AIDS has really spoiled lives in our community, creating too many orphans. You don't see many people of my age any more as you go about, but when you find them, you find them with orphans.

It would be easy to give up, but it's better if I'm here for the children now that all their aunties and uncles have gone. There would be so many more problems for these children if I wasn't still here."

PHOTO - JON WARREN / WORLD VISION

Kelvin Mkuntha

Young person with HIV/AIDS: *Kelvin*

Kelvin Mkuntha was 14 years old when he spoke about his life with AIDS, sitting on a mat in front of his widowed grandmother Fulare's home in Matalala, Central Malawi. He has since died.

"They looked after me well in hospital, but it's better to be home and I'm glad to be here.

My blood was tested, and I was told I had HIV. They said that maybe I got HIV from my caring for my mother when she was very ill, here at my gran's house. I think I was doing a good job helping her, keeping the place clean and preparing her for bathing. She died of AIDS in the district hospital, while my stepsister and I were looking after her.

She was suffering in my hands while my stepfather was with other women. He sent my mother and me away as soon as he realised Mother was getting sick. He hasn't helped Grandmother or me at all. He took my stepsister away, and that troubles me, because I loved her and I am lonely now. But I do get visitors, and that means a lot to me.

My best friend, John, comes often and cheers me up. On Saturdays he spends the whole day here; other days he only drops in for a short time because he has been at school.

I was doing well in school. I'm sorry that I haven't been well enough to go for six months now. The sores in my mouth and pain in the throat are worst, but I'm also coughing a lot and I've got bad diarrhoea.

I wanted to study to become a medical doctor. They are good people. We had a medical assistant in the local clinic who was kind and looked after me very well. Now he has gone to work with an NGO that deals with leprosy, and there is no-one there to replace him.

I used to like going to church, too; it was very encouraging. But I'm too sick now. It's nice when friends come here to pray with me. I believe people don't die forever – there is life after death, and my mother is still alive in heaven. Heaven is up there, a joyful place, where there is God, and Jesus, and life forever. I'd like to see that. If I want to get there, I have to die first, don't I?"

Disrupted lives

Mark Connolly

A 16-YEAR-OLD BOY IN ZAMBIA is left without parents – and three younger siblings to look after. A 12-year-old girl in Namibia must drop out of school to care for her mother, who is slowly dying. After their mother dies, 10 year-old sisters in Lesotho move in with their aunt, who is already raising three other orphaned relatives.

Nothing is disrupting the lives of masses of children as radically as the HIV/AIDS epidemic. More than 14 million children under the age of 15 have lost one or both parents to AIDS. By 2010, this number is expected to exceed 25 million. With global infection rates still rising, HIV/AIDS will continue to cause unprecedented suffering among children for at least the next two decades. Because of the lag time of roughly 10 years between HIV infection and death from AIDS, the numbers of orphans will continue to increase even in countries where HIV infection rates now appear to be declining.

Although HIV/AIDS has reached almost every part of the world, no other region has been harder hit than sub-Saharan Africa, where an estimated 11 million children have been orphaned by AIDS (and 12% of all children are orphans). In Latin America and Asia, where the overall orphan population is much greater than in Africa, the proportion of children who have lost their parents to AIDS is much smaller.

Children orphaned by AIDS often suffer the added pain of being ostracised

Wherever they live, HIV/AIDS creates hardship for children well before they are orphaned. A parent or caregiver who becomes ill with AIDS often is unable to work. The economic impact is felt by the entire family. Children often have to drop out of school to go to work, care for their parents, look after their siblings and put food on the table. Families are strained when they assume the care of nieces, nephews and other children who have lost parents to HIV/AIDS.

Losing a parent is emotionally devastating, but children orphaned by AIDS often suffer the added pain of being stigmatised or ostracised by their communities. They are often more at risk of becoming victims of violence, exploitative child labour and discrimination. Girls left on their own are at higher risk of being sexually abused and becoming HIV-positive.

Substitute families

When HIV/AIDS overturns the lives of children already struggling with extreme poverty, armed conflict or exploitation, it can put them on the brink of disaster. Pulling them back requires a concerted and widespread effort to assist the families and other people caring for children affected by HIV/AIDS.

In sub-Saharan Africa, 90% of the children affected by HIV/AIDS are living with a surviving parent, sibling or other relative. But these families, who are not receiving any external help, are stressed to the breaking point. They are in dire need of support.

Whether the head of the household is a widowed parent, an elderly grandparent or a young person, family capacity represents the single most important factor in building a protective environment for children who have lost their parent(s). Children deprived of such an environment are at increased risk of exploitation, abuse, violence and discrimination.

There is an urgent need to develop and scale up family-based and community-based care for boys and girls who are living outside of family care. Placement in residential institutions is best viewed as a last resort, when better care options have not yet been developed, or as a temporary measure pending placement in a family.

Strategies for action

The United Nations and many partner organisations, including World Vision, have endorsed a framework of action to provide guidance to donor nations and the governments of affected countries to respond to the urgent needs of children impacted by HIV/AIDS. The key strategies are:

- strengthen the capacity of families to protect and care for children by prolonging lives of parents and providing economic, psycho-social and other support;
- mobilise and support community-based responses to provide both immediate and long-term support to vulnerable households;
- ensure access of orphans and other vulnerable children to essential services, including education, health care and birth registration;
- ensure that governments protect the most vulnerable children through improved policy and legislation and by channelling resources to communities; and
- raise awareness at all levels through advocacy and social mobilisation to create a supportive environment of all children affected by HIV/AIDS.

Until these strategies are realised on a massive scale, HIV/AIDS will continue to rob generations of children of the future they deserve. ■

Mark Connolly is Child Protection Adviser for UNICEF. See www.unicef.org/aids/

Boys and men – key to reducing girls' HIV vulnerability

Sara Austin

GIRLS ARE HIGHLY VULNERABLE to HIV/AIDS. They are particularly susceptible to HIV infection, and carry a significant burden of responsibility to care for family members who have HIV/AIDS. Girls' vulnerability to AIDS is tied to social/cultural, economic, biological and political factors, and is intrinsically linked with gender inequality. In some of the countries worst affected by HIV/AIDS, girls are infected at a rate five to six times higher than boys.[1]

Addressing the unique issues that girls face in relation to HIV/AIDS requires an approach that overcomes a current gap – between awareness of HIV/AIDS and changing behaviours to prevent the spread of the virus.

Even if women and girls are aware of the factors that put them at risk of contracting HIV, they may have little or no agency to reduce their vulnerability. It is thus critical that boys and men be actively engaged in interventions to change behavioural practices that currently promote or perpetuate gender inequality and consequently the vulnerability of girls to HIV/AIDS.

An empowering approach

World Vision developed an action-oriented research project to enable boys, girls, men and women to identify the key factors that make girls vulnerable to HIV/AIDS, and participate in developing interventions to address these problems. The research was piloted in two countries: Tanzania, where the prevalence rate for girls aged 15–19 is 4.8% compared with 1.5% of boys,[2] and Zambia, where the rate for girls aged 15–19 is 6.6% compared with 1.9% of boys.[3] Research participants included boys and girls aged 8–17, youth aged 18–25, parents/guardians, teachers, religious and traditional/cultural leaders, and key local and national government leaders. A critical research strategy was its emphasis on the resilience and strength of boys and girls, and on the need to build their capacity as agents for change. The research sought to build on children's existing coping strategies by facilitating a process that promotes children's right to participate in all matters that affect their lives. Thus, boys and girls in the target communities participated in focus groups to give input to the research proposal; in designing the research methods; and in the implementation, analysis and dissemination. They supported the (adult) research team in an advisory capacity throughout the research process.

HIV/AIDS prevention fails girls and women unless it addresses gender inequalities

Research findings

The research in Tanzania and Zambia highlighted that sexual exploitation of girls is a significant factor in girls' vulnerability to HIV/AIDS. Girls in the target communities were subject to a wide spectrum of gender-based violence, including: sexual abuse in the home; sexual abuse by teachers; rape; early sexual activity; commercial sexual exploitation; sexual harassment in homes, schools, and the community; harmful traditional practices including early marriage and female genital mutilation (in Tanzania) and initiation ceremonies (in Zambia).

Conversely, the research also indicated that HIV/AIDS is increasingly a causal factor for specific forms of sexual exploitation of girls. For example, girls who are orphaned or who are caring for parents living with AIDS have significant responsibilities to provide for their families' economic needs, and in many cases girls engage in "survival sex" in order to gain income or other necessities such as food or educational materials. Another example is the rape of girls by HIV-positive men as a fallacious "cure" for AIDS.

The research highlights World Vision's recognition that the "ABC" (**a**bstinence, **b**e faithful and use **c**ondoms) message must be part of a strategy that addresses the underlying gender inequalities, or it will largely fail girls and women. In cultural contexts where women and girls are largely monogamous, but men and boys are not, and where girls and women have little to no sexual agency, sole reliance on condoms as a prevention measure is not sufficient for reducing girls' and women's vulnerability.

It is therefore recommended that HIV/AIDS prevention strategies be directed towards expanding the substantive freedoms of girls and women, increasing their power to negotiate their relationships and environment, and towards engaging boys and men in this strategy so that they are also engaged in the change process.

HIV/AIDS prevention interventions should go beyond the conventional "ABC" approach, and address the structural roots of vulnerability to HIV/AIDS that are bound up in gender inequality, by engaging girls, boys, women and men in critically analysing their own context and in proposing local solutions. ■

Sara Austin is a Policy Analyst with World Vision Canada. This research was assisted by Corey Wright, Research Intern with World Vision Tanzania/Canada, and Gertrude Chanda, Gender, Child Rights and Advocacy Manager with World Vision Zambia.

[1] *What is vulnerability to HIV?* UNAIDS Fact Sheet, June 2001 [2] *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections – 2002 Update: United Republic of Tanzania,* UNAIDS, WHO and UNICEF, 2002 [3] "HIV prevalence rate among young people, by age and gender: Zambia 2001–2002", *HIV/AIDS Epidemiological Surveillance Update for the WHO African Region 2002 Country Profiles,* WHO/AFRO, 2002

Mobilising the community

Claudina Valdez and Ramón J Soto

POVERTY AFFECTS MORE THAN 50% of the population of the Dominican Republic[1] – most dramatically in the rural and border areas of the country, where 44 of every 1,000 children born die before they reach one year old.[2]

The first case of AIDS in the Dominican Republic was officially registered in 1983, and within a short time there was a sustained, rapid increase in the number of cases. At the end of 2001 an estimated 130,000 people were living with HIV/AIDS; around 5,000 of these were children under 15. At that time, an estimated 33,000 children under 15 were orphaned because of AIDS. The general prevalence of HIV infection was 2.5%.[3]

Reports indicate that prevention efforts carried out in recent years seem to be stabilising HIV prevalence in the 15–24 year-old age group,[4] and the national average of infection with the virus seems to have been lowered to 1%.[5] However, in Haitian–Dominican (*bateyes*) communities in the midst of poverty, denial, stigma and discrimination, HIV prevalence is 5.6%.[6]

While there have been gains in the fight against HIV/AIDS in the Dominican Republic, it is critically important to redouble advocacy efforts – both **for** access to antiretroviral medications, and **against** stigma and discrimination. To this end, World Vision Dominican Republic has had some success in raising awareness among, empowering and mobilising communities and their leaders.

Using participative and reflective methodologies, in a spirit of respect and solidarity, these interventions have focused on educating couples, "multiplying" knowledge of preventive measures, and building skills to advocate and to combat stigma and discrimination. The community involved has been empowered through the training of its traditional leaders (including teachers, parents, civil authorities, health providers and religious leaders).

Nurturing young leaders

The project also has led to a burgeoning of new leaders, particularly among the young. One of the most successful initiatives is the *Time of Hope Project*, for adolescents and young people. Its acronym PROJETA (*Proyecto Tiempo de Esperanza para los Jóvenes y Adolescentes*) means "Protect" in Spanish. It is helping young participants to develop responsibility for preventing HIV/AIDS, as the following story (see box) speaks eloquently:

PHOTO - WORLD VISION DOMINICAN REPUBLIC

Members of the PROTEJA youth network

Hi Josefina!

I'm writing you this letter to tell you how well I feel, and how different I am, since we stopped seeing each other a few years ago. Remember how I was a sad, boring person, with very low self-esteem, and very shy in relating to others? Well, I tell you if you saw me now you wouldn't recognise me.

I've joined a project called PROTEJA here in Villa Altagracia, which has trained me in prevention of sexually transmitted diseases and HIV/AIDS, and in sexual and reproductive health. This has helped me so much; my self-esteem has grown and I've even become a youth leader in my community, promoting healthy and responsible living.

PROTEJA has given me the opportunity to train other young people in my area. I've learnt to work with others and many of us have become "multipliers". Now that I'm a real community leader, I co-ordinate a theatre group which has helped me achieve amazing goals, for myself and for my community.

We've formed a network that important leaders (like teachers, municipal authorities, neighbourhood council members, health and church leaders) have joined. Young people are actively participating in this network's HIV/AIDS prevention campaigns for the health of the community.

Many people in the barrio have changed their way of looking at things. They now talk about HIV/AIDS without feeling shame, and show solidarity and support for those who are sick (this just didn't happen before). It's so interesting to see teachers working with other teachers, doctors with other doctors, housewives with their neighbours, and even pastors and religious leaders now acting as "information multipliers" – in the church services they talk to the people about HIV and the importance of learning about prevention.

This may seem incredible to you, if you remember that in our church nobody ever talked about this kind of thing! But thanks to these networks, a new social conscience has been created, and some of the taboos that there used to be among Christians have been broken. They've even created day clinics where people sick from HIV can go and receive attention, care and good support.

Good news, hey? Well, that's all for now. Take care,

Joel Vargas Figueroa

PHOTO - WORLD VISION DOMINICAN REPUBLIC

Religious leaders meeting to discuss HIV/AIDS

Faith-based networks against HIV/AIDS

The *Communities of Faith Network for Life* initiative has supported church leadership in articulating an effective response to HIV/AIDS. The leaders have learned that church members are vulnerable to HIV too. More than 15 networks in some 500 churches have allowed 5,000 people to be reached with messages about HIV/AIDS. Once a church becomes aware, it is better equipped to generate an effective response, as part of its mission and calling. This initiative has tackled the challenges of overcoming taboos and prejudice associated with HIV/AIDS, through relationships of respect and understanding.

Lessons learned, future vision

The experience to date has brought valuable lessons, including:

- Actively involving communities throughout the process has been a major success factor.
- Mobilising key actors, including people living with HIV/AIDS, has been fundamental.
- Work with young people has involved the adults in their circles, which has created a more favourable environment for the adoption of healthy practices by young people.
- A "life and hope" focus on the AIDS epidemic has allowed a quicker approach to youth and religious leaders.
- Improving our organisation's capacity to network and negotiate, along with credibility for our programme work, have enabled World Vision to more substantially participate in various networks in the Dominican Republic.

Continuing with our holistic, integrated development strategy that is centred in the value and dignity of the human being, the vision is for a broad community mobilisation to strengthen the promotion of healthy lifestyles, to reduce the number of people being infected by HIV and lessen the socio-economic and emotional impacts of the epidemic. ■

Claudina Valdez is HIV-AIDS Programme Manager for World Vision Dominican Republic, and Dr Ramón J Soto is Regional HIV/AIDS Adviser for World Vision Latin America and the Caribbean. Joel Vargas Figueroa, aged 15, is a participant in World Vision's youth journalism initiative.

[1] ONAPLAN, 1997 [2] *World Development Report 2000–2001*, World Bank [3] UNAIDS/WHO Dominican Republic, *Epidemiological Fact Sheets on HIV/AIDS, 2002 Update* (www.who.int/emc-hiv/fact_sheets/pdfs/Dominicanrepublic_EN.pdf) [4] UNAIDS/WHO, *Situación de la epidemia de SIDA*, December 2003 [5] ENDESA, *Encuesta Demográfica y de Salud* 2002 [6] ***Ibid.***

Helping tumbleweeds grow roots

Stuart Flavell

WHAT IS STIGMA? STIGMA can be defined as a judgment on the part of society (or the general public) about a type or group of persons that devalues or rejects the humanity of members of that group.

More than 20 years into the HIV pandemic, people living with HIV/AIDS (PLWHA) continue to experience social stigma because of their serostatus. The well-documented effects of this stigma range from PLWHA being denied the use of common toilet facilities or shunned by fellow community members, through to beatings or attacks on them and their loved ones.

As to the sources of HIV/AIDS-related stigma, the United Nations Joint Programme on HIV/AIDS (UNAIDS) cites ignorance, fear, stereotyping and negative judgments about possible sources of HIV transmission. HIV transmission is popularly associated with behaviours judged as "immoral" – the judgment about these **behaviours** being extended to the **people** thought to engage in them. Indeed, popular opinion goes so far as to blame HIV-positive (HIV+) persons for contracting HIV, assuming they deserved infection because of "what they must have done to get it".[1]

Some PLWA face discrimination even in AIDS organisations and in the clinical care setting

Multiple stigma

Many PLWHA describe the experience of being stigmatised as like bearing a taint or stain on the skin. Indeed, PLWHA belonging to other marginalised or socially vulnerable groups usually suffer multiple instances of stigma. In some cases, such people have even been the object of officially-sanctioned violence and killings.

The fight against HIV/AIDS-related stigma has thus become a cornerstone of PLWHA activism. We, the activists, believe we will not succeed in rolling back or even containing the HIV/AIDS pandemic unless we form a strong and united front against discrimination. Yet some HIV+ drug users tell us that AIDS organisations and PLWHA groups do not fully support their involvement in HIV/AIDS work, and even discriminate against them.

HIV+ people who experience multiple forms of stigma fare worse in the clinical care setting than their fellow PLWHA. For example, HIV+ drug users often have poorer access to adequate medical treatment; they are less likely to be offered antiretroviral treatment, or when treatment is offered, it is late or inadequate. This can be because medical practitioners evaluate them – without medical grounds – as less likely to adhere to therapy, or as undeserving of treatment.

The stigma against HIV+ drug users is such that often they will not disclose their drug use to their HIV treatment providers. This is dangerous, as it can lead to misdiagnosis and harmful interactions between HIV treatment drugs and "street drugs".[2]

Members of the Global Network of People Living with HIV/AIDS (GNP+), the only global voice of people living with HIV/AIDS, are now calling for PLWHA groups to acknowledge and respond to the additional stigma-related problems that HIV+ drug users face.

A vicious cycle

AIDS-related stigma makes us socially vulnerable: disempowered, oppressed and marginalised at several levels. Such inequity weakens people's capacity to express themselves and to control their lives. It reduces them to "tumbleweeds" blown here and there by the winds of their circumstances. A vicious cycle then brings more stigma on them, precisely because they are socially vulnerable.

PHOTO - SANJAY SOJWAL / WORLD VISION

People living with HIV/AIDS who also belong to marginalised groups such as "drug users" face additional stigma and discrimination

Although HIV/AIDS-related stigma remains a great problem, the level of stigma is lower today in many places than it was just 10 years ago. This is partly due to the advent of highly active antiretroviral therapy (HAART), which makes it possible for people to manage their HIV as a chronic disease – cracking the "HIV/AIDS = death" equation. But it has much to do with the time, effort and risks activists have taken in fighting stigma.

Since the launch of the PLWHA movement over 20 years ago, people living with HIV/AIDS and their allies have advocated for visibility, changes in social attitudes, and a greater and

more meaningful involvement in the design, implementation and evaluation of AIDS policies and programmes. They remind the world that PLWHA have the same rights as all human beings, and that HIV/AIDS-related discrimination is ultimately a human rights issue.

As a result of AIDS activists' hard and courageous work, a structured response to stigma is increasingly part of more comprehensive responses to HIV/AIDS. The focus of UNAIDS' 2002–2003 World AIDS Campaign, *Live and Let Live*, was stigma and discrimination. The International Federation of the Red Cross and Red Crescent (IFRC) leads a campaign against stigma, called *The Truth about AIDS. Pass it on....*

GNP+ is a partner with both UNAIDS and the IFRC in the fight against discrimination. At last, key partners understand how crucial it is to work as equals alongside people living with HIV/AIDS.

There is still considerable work to be done. Some Ministers of Health succeeded in eliminating references to specific vulnerable groups in the critical *Declaration of Commitment* that came out of the United Nations Special Session on HIV/AIDS in July 2001. Implementation of the Declaration in relation to drug users, for example, remains disturbingly low. Of 80,000 injecting drug users in Belarus and Romania, only 4% can access HIV-related health services – this despite the fact that HIV is spreading at alarming rates in Eastern Europe, and mostly via the sharing of syringes among injecting drug users.[3]

Ongoing vigilance needed

We must remain vigilant. Stigma and discrimination breed each other, and are not yet defeated. The Canadian magazine *+ve* reports that HIV tests are to become a fixture in the application process for the priest-hood. In the Netherlands, the Supreme Court recently ruled that a patient can be ordered to submit to HIV testing if a doctor has been exposed to that patient's bodily fluids.[4] In Switzerland, the Federal Health Office is considering implementing HIV testing for all asylum seekers, with the option for them to "opt-out".[5]

In order for PLWHA to take responsibility for the fight against stigma, we must refuse to be tumbleweeds. We must grow roots and stand fast, building our skills, talents and capacity.

How do we address the fact that some AIDS organisations and PLWHA groups discriminate against certain HIV+ people, such as HIV+ drug users? David Burrows, an expert in harm reduction and injecting drug use, confirms this discrimination within groups established to tackle HIV/AIDS and support PLWHA.[6] Activists at the International HIV Treatment Preparedness Summit in March 2003 reinforced the claim, arguing there is discrimination within AIDS advocacy communities around injecting drug users and other marginalised groups such as sex workers.[7]

Groups such as HIV+ drug users must be included in responses to the pandemic

Among the many approaches crucial to fighting the stigma that affects HIV+ drug users, which include guaranteeing equal access to medical treatment and care, is a greater involvement of marginalised groups such as HIV+ drug users in the response to the pandemic. Bridges need to be built or reinforced between such groups and the greater community of people living with HIV/AIDS.

The recent 11th International Conference for People Living with HIV/AIDS in Kampala, Uganda, hosted closed (and therefore safer and more confidential) sessions for HIV+ drug users to discuss issues of specific concern to them. Attendees declared that there is little involvement of drug users in the overall response to the pandemic, and that drug use issues are not a government priority in many countries. They called for solidarity from all communities to address the issues that surround drug use and for a follow-up global consultation in 2004.[8]

As a further example of our commitment to addressing stigma and discrimination against HIV+ drug users, GNP+ will, as a co-sponsor of the XV International AIDS Conference in Bangkok, provide a satellite meeting on "Health and Human Rights of HIV-Positive Drug Users".

All of us must help to create and facilitate access – especially for PLWHA – to the tools and safe spaces necessary for being involved in the response to the pandemic. No-one should be left to be a tumbleweed. ■

Stuart A Flavell is International Co-ordinator of Global Network of People Living with HIV/AIDS (GNP+). See www.gnpplus.net

[1] Aggleton, P & Parker, R, "A conceptual framework and basis for action: HIV/AIDS stigma and discrimination", UNAIDS, 2002 [2] Burrows, D, "Stigmatisation of HIV-positive injecting drug users", STIGMA-AIDS, online discussion forum of Health and Development Networks, 21July 2003 [3] UNAIDS, "Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS: Progress report on the global response to the HIV/AIDS epidemic, 2003" [4] Sheldon, T, "Patients can be made to have HIV test to protect doctor", *British Medical Journal* , 2004 (328): 304 [5] *Neue Zürcher Zeitung*, 18 January 2004 [6] Burrows, D, "Care and support needs of HIV positive drug users in Australia", paper presented at the International Conference on AIDS in Asia and the Pacific, Chang Mai, Thailand, 1995 [7] *Final Report of the International HIV Treatment Preparedness Summit*, 13–16 March 2003, Cape Town, South Africa, posted to www.fcaaids.org.
[8] See their declaration on www.gnpplus.net

Women and AIDS in Mumbai – a programme evolves

Reena Samuel

GITA IS A YOUNG WOMAN from the slums of Mumbai who is HIV-positive. She does not fall into one of the high-risk categories for HIV infection; she had an arranged marriage at a young age and remained faithful to her husband. Unfortunately, her husband was not faithful, and brought HIV into the home. After he died, Gita and her two year-old son were banished by her in-laws – sent to live in the street. Five months later, she discovered that her husband had died of AIDS, and had passed the disease on to her and to their son.

Gita is not alone in her predicament. The virus, first reported in India in 1986, has touched every level of society, and given the socio-economic ethos prevalent in India, women and children are most vulnerable to it.

Initial research

To address the vulnerability of adolescent girls to AIDS, World Vision India initiated a research project in late 1991. It studied the sexual behaviour patterns of adolescent girls in six slum communities in north-west Mumbai, to develop an effective model for sex education and AIDS prevention. But talking about sex and sexuality was taboo; the initial challenge was to break the silence.

PHOTO - REENA SAMUEL / WORLD VISION

Girls participating in education designed to empower them to protect themselves

Only after approaching the mothers, to build their confidence and convince them of the issues, could the focus move to adolescent girls.

The research found that ignorance was a major factor in girls' HIV-vulnerability; others were unsafe sex practices, gender discrimination, poor access to health services and poor nutrition. Sexual abuse, including incest and rape, were also factors that could not be ignored.

Education models

The education model developed for adolescent girls covered topics such as: being a woman, growing up, dealing with sexual harassment, reproductive health, general health, STDs and HIV/AIDS. It used interactive teaching methods, films, skits, puppet shows, group discussions, quizzes and role play. Since our interaction with mothers revealed that they too were at risk, in 1994 World Vision initiated the *Women and AIDS Project*, which grew to focus on both adolescent girls and married women in 25 slum communities.

The education model for adult women helped them to articulate their concerns about sex, sexuality and health in general. The work faced resistance from elders and community members, and this required cultural sensitivity.

The education process identified that women were aware of safe sexual practices, but were powerless to make the decisions. This led to the evolution of a complementary educational model targeted at men and adolescent boys – to create awareness and influence their behaviour as husbands and partners. By 1995, models were implemented for all four target groups – men, women, adolescent girls and boys. Over the next four years, the project covered 30 slum communities with approximately 55,000 people. As World Vision worked with these communities, we became convinced that HIV/AIDS could not be addressed alone; it was linked to other social, economic and political issues. We offered adult education programmes, health camps and vocational training for women and adolescent girls. Adolescents were motivated to form a street theatre to reach communities with HIV/AIDS messages.

Meanwhile, across India the number of reported HIV/AIDS cases was rapidly increasing, mostly among "high-risk" groups including commercial sex workers and drug users. It was not known at this stage that the deadly virus had already entered the lives of scores of innocent women and children who hitherto were considered "low-risk".

World Vision's community base meant it was looked to for support

In 1996 the first case of an HIV+ family in these communities was reported. Clearly, there was a stigma associated with the virus, and both infected and affected people needed support. World Vision, with its strong community base, was looked to for support. A Drop-in Centre with a trained counsellor was opened outside the community area, where infected and affected people could go for care and advice. Support groups enabled people to share common problems and issues.

An area-wide approach

As HIV infections continued to emerge, a more holistic approach was needed. The *Mumbai Area Development Programme* (ADP) was launched in 1997 to support communities in developing their responses to the now rapidly-growing AIDS threat. One response was the Andheri HIV/AIDS Prevention and Care Programme, to focus on prevention through awareness, caring for infected and affected people, and advocacy for

their rights.

Meanwhile, the ADP focused on general health, education, economics and leadership. Slum Development Committees were formed to prioritise community needs and pursue solutions; SDCs were trained to be vocal and to care for people living with HIV/AIDS in their communities. These groups have helped challenge stigma and discrimination.

In 2000, the Andheri Programme extended to 52 slum communities in Mumbai, with a population of 200,000. The Drop-in Centre extended its services – counselling, children's school fees, medical support (including a weekly clinic with female doctor), food rations, legal referrals, and a women's income-generating Self-Help Group – to reach more infected and affected people.

PHOTO - UNKNOWN

An Indian wedding. Sadly, unfaithful husbands have put many Indian women at risk of HIV/AIDS.

Three or four new cases come to the Drop-in Centre every month. Of the female clients, 98% have been infected by husbands who have had multiple partners. Having migrated from rural areas to marry, then been abandoned by their deceased husband's families, many have no social safety net and see World Vision as their only hope. Indeed, women who are HIV+ volunteer as Care Givers themselves.

To address women's basic rights from a broader platform, we have established links with like-minded organisations. World Vision is active in the *Forum of Those Concerned with HIV/AIDS in Mumbai, Navi Mumbai and Pune,* which comprises 75 NGOs, government agencies, academic, research and media groups, and addresses issues including access to ARV therapy, rights of infected women and children, and mandatory HIV/AIDS testing.

Programmes need flexibility to evolve with new understandings and changing contexts

World Vision's long association with the HIV/AIDS issue in these communities, from the early days of creating awareness to a fully-fledged community development effort, has taught us the importance of programmes being flexible to evolve with new understandings and changing contexts. We consider the Mumbai HIV/AIDS programme a "centre of learning", lessons from which can be replicated in India and beyond. ■

Reena Samuel is Communications Officer, External Relations, for World Vision in Mumbai, India. She was formerly manager of the Mumbai ADP.

REBUILDING BROKEN LIVES

Heather Ferreira *has been linked with World Vision's HIV/AIDS initiative in Mumbai since its inception, wearing many "hats".*

During the early research period, as an educator she helped develop the education model for adolescent girls living in slum communities. After a brief stint with a UNICEF HIV/AIDS prevention project, she returned to World Vision and as a social worker, led mass awareness campaigns among 30 slum communities. Then her growing concern for widows living with HIV/AIDS led to her helping initiate the Drop-In Centre where women could go for support. Heather says:

"Reflecting on the stories young widows have told, I realise how easily HIV/AIDS can make the life of a young woman crumble around her. It is so rewarding to see the resolve emerge within her to go on, even with little emotional support from people around her."

Heather developed a proposal for the AusAID-funded Prevention and Care Programme for over 50 slum communities. In 2002 she became

PHOTO - REENA SAMUEL / WORLD VISION

Heather Ferreira

World Vision's HIV/AIDS point person in Western India – training and building capacity to ensure all 16 ADPs in the region were responding effectively to the challenge. She is trained in Economics and Political Sciences, and Reproductive and Adolescent Health Monitoring.

Heather now provides technical support for World Vision India on women, youth and HIV/AIDS issues. Her passionate concern for these issues means she is often invited to speak to other groups. She says:

"Working with HIV/AIDS and especially women has changed me personally. I see how a little emotional support for these women can go a long way to rebuild broken lives."

— Reena Samuel

How Chilean children see HIV/AIDS

Patricio Cuevas

IN CHILE, IT'S OFTEN ASSUMED that children from rural areas, and particularly ethnic minority communities, have less knowledge than urban children of topics such as sexuality or sexually transmitted diseases like HIV/AIDS. A study by World Vision Chile[1] measuring children's perception of AIDS indicated that this is not so.

Responses by the *Mapuche* children of Puerto Saavedra, a small rural town in the south of Chile, are a case in point. Of these children, 77% said that HIV is an easily transmitted disease and 65% think it is a problem that affects the whole of society. In urban areas, on the other hand, only 55% of children surveyed answered that HIV is an easily transmitted disease, and 47% think that it affects all of society.

The research used closed questions with multiple choices and involved 333 boys and girls between the ages of 11 and 17. The children are sponsored by World Vision through nine development projects, four in rural areas and five in urban areas.

On the risk of HIV infection

The research indicates that:

● 64% of the children believe that young people are at major risk of being infected with the virus; and

● 57.5% believe there is a greater chance of being infected by the virus in cities than in the countryside.

On transmission of the virus

● A high percentage of children believe that the disease cannot be transmitted by ordinary contact such as shaking hands and sharing knives, spoons or forks.

● 61.9% of urban children believe that sexual relationships are the principal method of becoming infected – almost twice the number of those in rural areas who believe the same (33%).

● 65.8% believe that condoms are the most effective protection against AIDS.

● Yet the research showed that the children do not have a clear idea of how alcohol or drug consumption affects the transmission of AIDS. Of the children studied, 53% either have no knowledge of this topic or think that consumption of these substances has no impact on transmission.

● One of the established myths regarding the spread of HIV is that if a mosquito bites an HIV-infected person, it can transmit the virus to another person. This belief is more common in urban areas (60.9%) compared to rural areas (38.1%).

On discriminatory attitudes

● Some 59% of children gave the discriminatory (and incorrect) response that AIDS affects the homosexual population more. This view is more frequently expressed by boys in urban areas.

● On the other hand, 61.7% think that people with AIDS do not have to be isolated or segregated but need to be taken care of. This non-discriminatory response is seen more often among rural children than urban ones.

HIV/AIDS in Chile

In Chile, the first case of AIDS was reported in 1984. Since December 2001 (the date of the last official study) there have been 4,646 cases of AIDS, 5,228 HIV-positive cases, and 3,012 deaths reported. The annual trend has been an increase, reaching 4.51 cases per 100,000 people in 1999. Studies carried out by the National Committee on AIDS indicate a clear pattern of HIV/AIDS transmission in Chile:

● an increasing rate of the disease among women, with the gap in the infection rate between men and women getting smaller;

● an increased transmission rate in heterosexual relationships compared to homosexual relationships;

● a major increase of infection among people with a lower level of education; and

● that the disease has moved to the rural areas, and is no longer exclusive to cities.

These findings clearly show that HIV/AIDS is a problem that affects the whole of society, as the majority of children surveyed by World Vision perceived.

PHOTO - PATRICIO CUEVAS / WORLD VISION

World Vision sponsored children participating in the survey about their perceptions of HIV/AIDS

Chile should not wait to experience terrible numbers before having a public policy and a level of citizen awareness that stops the spread of this disease. That way we will not have to say in 2020: "Why didn't we do something in 2000, when we had time?" Let's assure Chile's children of access to a complete and proper education and to the necessary resources for protection, so that they can have healthy and long lives with the full exercise of their rights. ■

Patricio Cuevas is Communications and Advocacy Co-ordinator for World Vision Chile.

[1] The research took place in the context of a strategic relationship between World Vision Chile and the National Committee on AIDS (CONASIDA), a government entity responsible for preventing and reducing the impact of HIV/AIDS in Chile.

ONE in the Spirit – against global poverty and AIDS

Jenny Eaton

PHOTO - C. TAYLOR CROTHERS

Bono launching the ONE Campaign at Philadelphia's Independence Hall in May 2004

THE APOSTLE PAUL WROTE to the Corinthians, "Now there are varieties of gifts, but the same Spirit… varieties of activities, but it is the same God who activates all of them in everyone".[1] Paul was teaching this early church community that while each person is called to a unique role, there is unity through the Spirit. Now, more than ever, we are all called with our particular gifts, services and activities to join together as ONE against global poverty and the AIDS pandemic.

The emergency is unprecedented. This is the worst plague to hit humanity in 500 years. Before long, more will have died from AIDS than in all the wars of the 20th century combined.[2] HIV/AIDS kills children, parents, teachers, doctors, nurses, farmers, business people, bureaucrats – devastating entire communities that are already crippled by poverty and unfair international trade or debt policies. If we do nothing, there will be an estimated 25 million orphans in Africa by the end of the decade.

Seized by the vision of ONE voice and ONE goal – to eradicate poverty and HIV/AIDS in Africa – DATA's co-founder Bono, gospel musicians Michael W. Smith and Jars of Clay, World Vision US and Bread for the World, jointly launched The ONE Campaign in a rally in Philadelphia. Bono called upon all North Americans to commit to actualising justice, equality, and liberty – pointing out that in the stark light of history, we will be judged by our children and by our God for our response to this great pandemic.

Following the rally, a worship service was held in the Philadelphia Cathedral. As the song "We are one in the Spirit" echoed through the Cathedral, the doors were flung open, symbolically welcoming all to join – voices for awareness and hands for action – across national, racial, religious and political lines.

With our varied gifts, roles and callings, in ONE spirit, we can conquer this pandemic. ■

Jenny Eaton is Faith Outreach Co-ordinator for DATA (Debt AIDS Trade Africa), an international non-profit organisation co-founded by Bono of U2 – see: www.data.org, or to join The ONE campaign, go to: www.theonecampaign.org

[1] I Cor. 12:4–5, New Revised Standard Version
[2] UNAIDS, at Security Council Session on the AIDS Crisis (based on a count of 33 million people dying in war in the 20th century; 22 million cumulative AIDS deaths at the start of this century; and a projected three million deaths per year)

WORLD VISION is a Christian relief and development partnership that serves more than 85 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 that constrain the poor in a world of false priorities, gross inequalities and distorted values. World Vision desires that all people be able to reach their God-given potential, and thus works for a world that no longer tolerates poverty. ■

BACK COVER : HIV/AIDS prevention programme in action, in Vietnam. Long-distance bus and truck drivers have been identified as a "high-risk" group. PHOTO - SANJAY SOJWAL / WORLD VISION

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