AIDS and poverty: the links

In the heated debate about whether HIV causes AIDS, and the role poverty plays in driving the epidemic in South Africa, it is all too easy to ignore the fact that there are many links. Poverty has contributed to the speed and scale of the epidemic and in turn AIDS increases poverty. However, the relationship is complex. In this article we will explore how the epidemic is driven by poverty.

People who are poor are more likely to become HIV positive if they are exposed to the virus. Malnutrition and compromised immune systems due to exposure to other diseases may make people more susceptible to HIV infection. This is an area of research that has not been fully explored, but it seems intuitively correct, and there is work being done.

A better-documented link is between poverty and the chance of being exposed. Poor people are more likely to engage in sexual practices that expose them to the risk of infection. This is not to say that the poor have more sex with more partners – there is no evidence either way – rather that the environment in which they have sex is riskier. Compare a middle class person who is generally faithful to his/her partner but decides to have an affair. They are likely to do this with someone in their own social milieu, in an environment where they can use protection. A person living in a squatter camp is more likely to have a partner from outside the area and the affair will probably not involve protection.

There is a world of difference from being able to switch on a light and locate a condom in one’s own private bedroom to living in a shack. Where in poor settings do you keep the condoms? How do you find them in the dark in a room you probably share with other people including your children, and how do you then dispose of them?

Poverty may also influence knowledge. The poor do not necessarily have the same access to information about HIV/AIDS and how to protect themselves. Even if they do have the information they may not have the resources. Condoms may cost money! The choice to information about HIV/AIDS and how to protect themselves. Even if they do have the information they may not have the resources. Condoms may cost money! The choice between buying condoms or bread may be a stark one.

Poverty also affects perspective on life. A middle class person who buys a house or puts money into an endowment policy is making the assumption that he/she will be about to enjoy the endowment and pay off the house. A poor person does not have that perspective and it may well spill over into sexual behaviour and attitudes to risk.

The poor are more likely to be victims of crime and this includes sexual crime. Thus, poor women are at greater risk of infection through rape.

However, the relationship between poverty and HIV infection is not a simple one. If it were, then South Africa would not have the epidemic it has. By African standards South Africa is rich. It has one of the highest GNPs on the continent (see Table 1). Botswana is also rich yet this country has the highest levels of infection in the world. Clearly poverty alone is not the determinant of the epidemic.
Editorial

This issue includes an article comparing data from the latest surveys in Botswana, Namibia, South Africa and Swaziland. The rates are highest in Botswana and lowest in Namibia but in all countries they are devastatingly high. It is rumoured that a well-run survey has been completed in Zimbabwe with the support of the US Centres for Disease Control. The results have not been released yet. Rumour also has it that they are depressingly high and are being suppressed by the government.

In mid-July the United Nations Development Programme released its annual Human Development Report. This too tells the story of the AIDS epidemic. It includes estimates of life expectancy, which now seem to consider the impact of AIDS in all countries. According to the report 1999 life expectancy was 53.9 in South Africa, 44.9 in Namibia, 41.9 in Botswana, 47 in Swaziland and 42.9 in Zimbabwe. In the absence of AIDS we would expect these rates to be in the 60’s and in Botswana probably approaching 70.

The life expectancy data tell of the epidemic we are experiencing, the HIV data warn of the epidemic to come. It is clear that there will be more death, more impoverishment and more orphaning in the years ahead. The irony is that our good quality HIV surveillance allows us to know what will happen with regard to numbers. It is possible to predict the number of infections, the number of deaths and orphans. We can estimate the impact these deaths will cause. The question is: what will we do with this information?

The Government of Botswana has announced that it will provide anti-retroviral drugs to the population. There are problems with these drugs: they are expensive to buy and it also costs money to administer them properly; some patients will not tolerate them; resistance will develop; and they are not a cure – at best they may buy six or seven years of life, although the hope is always that new and better drugs will become available. However the government is taking this step and it may provide a model for other countries as prices drop and global funds become available.

Even Botswana will see a rise in illness and deaths although this may happen later than in other Southern African countries. What can we do? The one way forward may be through welfare transfers. These should be made available to all impoverished families. Many lives may be extended through proper diets, minimum standards of food, shelter and clothing. Certainly we must provide for those impoverished by the epidemic, and this must include both the young and the old. We need to recognise that grandparents will in many instances be the only ones left to care for their grandchildren. They need help, and there can be no questions of loans that will be repaid – they need grants.

The advantage of the data we have is that it gives us time to plan. Let us hope we use that time wisely.

From tragedy towards hope: men, women and the AIDS epidemic


Madhu Bala Nath, with an MA in History and Agrarian Economy, has built her career as a freelance researcher for grassroots organisations involved in women’s issues. She entered the realms of HIV/AIDS as a regional adviser for India and South East Asia as part of the UN Development Programme. Since 1997 she has been responsible for undertaking programme implementation and advocacy in varied capacities to incorporate gender concern in global HIV programmes. The rest is history! Her first-hand experience with men and women in HIV-vulnerable communities has left her a powerful messenger.

Her 108-paged book is a REAL account of the toll which HIV has taken. Nath focuses inwardly by way of personal accounts delivered by people living with the virus. The subject matter is eye-opening, poignant and refreshingly hopeful in the face of a subject which has instilled doom and gloom for the last, relatively apathetic decade.

The main focus is that which is least tackled because of its complexity: sexuality and gender inequality. It brings home the fact that this pandemic is not a mere medical onslaught, but also a human affliction which touches the very core of our humanity and challenges the way we think and live as societies today.

Nath elucidates the initiative taken by UNAIDS and the UN Development Fund for Women to minimise the negative effects on both men and women and to create a credible space for women within decision-making processes at a national level. Gender empowerment is emphasised as she records the voices of reality on paper. So too, does she weigh up the fortitudes and failures of existing policy and programme constitutions set up in reaction to the pandemic. Nath furthermore explores the ensuing multicultural intricacies involved and asks some pertinent questions:

We try to put up all our defences, snap out of our apathy, but the query is relentless. ‘Are you human?’ ‘What verdict will your descendants pass on you if you stand by silently while a generation of children is reduced to a biological underclass by this sexual holocaust?’

Despite the urgency of the situation being firmly ensconced, Nath’s optimism is absolute:

"Life with HIV/AIDS can be beautiful."

Nath’s experience as an ‘up close and personal’ observer has certainly polished her wisdom and her vision is constructive:

"The only options are acknowledging that HIV/AIDS is a crime against society; acknowledging that the orphans of the new generation have a boundless horizon before them; acknowledging that the way ahead needs to be built on expanded partnerships compatible with national priorities, sensitive to local contexts, driven by innovation and above all ethically unassailable."

This visual and compelling read is recommended to both men and women, novices and experts, HIV positive and negative. It breathes life into the facts and figures, and as the title suggests, hope into tragedy. Beautifully written and embossed with philosophy, no one with even a minute sense of duty can deny the urge to turn all the talk into action after reading it. We may not have a choice.
UN General Assembly Special Session on HIV/AIDS
by Samantha Willan

25-27 June 2001 saw about 500 NGO’s and 189 government delegations gather at the United Nations in New York for a General Assembly Special Session on HIV/AIDS (UNGASS). It was the first time such a session focussed on health, and in particular on HIV/AIDS. The outcome was a Declaration of Commitment on HIV/AIDS, which 189 countries endorsed!

What will this declaration of commitment mean for the global fight against HIV/AIDS? Is it going to lead to treatment access for people living with HIV/AIDS? Is it going to mean that people living with HIV/AIDS can expect to be treated with dignity and respect? Does it mean that employees can expect to continue working, receive medical benefits and not be stigmatised? Does it mean that education systems around the world will NOT be eroded by the pandemic? Does it mean that women, and especially young girls will no longer face the daily threat of contracting the disease?

The declaration certainly sees some exciting advances in what governments globally are prepared to endorse in a declaration of commitment, in terms of the crisis and its impact. Nonetheless it is simply a political tool, not a technical document. It will not bring automatic changes mentioned above nor progress, simply by its adoption at the UN meeting.

However, it is a very powerful political tool, one we have not had. All countries at the UNGASS committed themselves to this document, to making the fight against HIV/AIDS a priority. Governments undertook to conduct national periodic reviews. The UN undertook to devote at least one full day of the annual General Assembly session to review and debate the process. Now that we have government’s commitment to this declaration it is up to citizens, pressure groups, NGO’s and research organisations to ensure that each and every government lives up to this.

Some of the exciting and important outcomes from this declaration are:

• The recognition throughout the declaration that this is a gender-biased pandemic. Girls and women are most vulnerable and addressing gender imbalances is key to stemming the pandemic. Kofi Annan, Secretary General of the UN stated at UNGASS that “Girl Power is Africa’s vaccine against AIDS”.
• There is recognition “…that poverty, underdevelopment and illiteracy are among the principal contributing factors in the spread of HIV/AIDS… (and) is compounding poverty and is now reversing or impeding development in many countries…” (para 11).
• The issue of Human Rights caused much heated debate. However, the final document recognises that “… human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS”. (para 58.)

There was a strong feeling among many of the presenters and NGO delegates at the parallel events that this document stands out from most other declarations, codes, and statements of commitment, which have been adopted on HIV/AIDS. This difference stems from both content victories such as those outlined above and also the process. The parallel NGO process, means that a large number of NGO’s globally are keenly aware of its contents and have already begun engaging in debates about both its content and implementation. Some countries even involved NGO delegates in their national delegations.

Despite these gains there are still massive challenges ahead for organisations working in the HIV/AIDS arena, and for all governments.
• The main challenge lies in ensuring that this declaration does not simply become yet another document to which governments pay lip service, and do not implement. The document needs to be widely circulated so that civil society is made aware of it and can use it as a political tool.
• A further weakness is that many of the timelines for achieving changes and progress are for 2003 or 2005. While one can understand that this is not a ‘quick-fix’ crisis, the timelines are unnerving. This epidemic is moving through populations with terrifying speed, and these dates seem to be at discord with the reality of the speed of the spread.
• In addition African civil society was not comprehensively involved in the UNGASS process. This is evidenced by the fact that few of the African national delegations to UNGASS included civil society representatives. Secondly, reportedly a number of duly accredited civil society partners from Africa were denied visas. Such exclusion of African civil society will mean that the content of the declaration has less input from one of the most important sectors in the struggle against HIV/AIDS. It will also further hamper the distribution of this new tool.

From the civil society perspective the most beneficial part of the UNGASS process were the parallel events, which were hosted by NGO’s, donor groups, and UN agencies during the UNGASS deliberations. There were panel discussions, symposiums and receptions. These were invaluable opportunities for people to share experiences, knowledge and ‘best practices’, not to mention business cards! Topics discussed ranged from Gender & HIV/AIDS; Community-based orphan care in Uganda; Implications for poverty reduction; the impact of HIV/AIDS; Socio-economic impact of HIV/AIDS; through to Women and prevention: dual protection and the female condom.

These events were also opportunities for delegates to hear more about new developments. One of the most crucial recent developments was the International Labour Organizations “Code of Practice on HIV/AIDS and the World of Work”. This code is exciting as a guide for both employers and employees, but it goes far beyond that. Just some of its important contributions are: the fact that it makes reference to managing the crisis in sectors often neglected in such codes such as the agricultural sector, it refers to the integration of human rights into labour policies, prevention policies etc.

It is also an important tool because of what the ILO can offer to assist with its implementation. The ILO is a respected international organisation which can offer technical assistance with regard to implementation, development of manuals etc. This is not International Law, merely guidelines. But they are practical, implementable, and have been widely consulted in their drawing up, thereby rendering them powerful and realistic guidelines. Many people in the field have probably seen similar codes, but this is concise, well-written and supported by a respected international movement.

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Conference Report

World Economic Forum: broadening access to health care services

For Africa to broaden access to healthcare services, especially for people with AIDS, there must be a vast improvement in political leadership, better co-ordination between all role-players and a dramatic increase in international and domestic resources to fight the disease. This was the message from the World Economic Forum’s (WEF) plenary session on healthcare held in Durban at the beginning of June.

The big question put to delegates was how to achieve affordable access to AIDS treatment? Radio and TV broadcaster Tim Modise presented a summary of the recommendations of seven working groups. He listed the chief priorities as: effective, unambiguous political leadership; an integrated approach involving partnerships across departments, groups and borders and especially between the public and private sectors; promoting voluntary counselling and treatment; expanding healthcare infrastructure and training; and gaining access to global financial resources.

There was consensus that partnerships must be expanded, pilot programmes scaled up, protocols on best treatment practices drafted, and business encouraged to do more to combat AIDS in the workplace, including the extension of treatment to uninsured workers.

Botswana’s decisive move to start providing antiretroviral drugs to people with AIDS in partnership with the private sector was hailed as a model for the rest of Africa. Botswana President Festus Mogae was repeatedly held up as an example of the political leadership required if African governments hope to get to grips with AIDS. Mogae’s willingness to take bold steps in tackling the epidemic is one of the reasons why Botswana has scooped a $100m five-year partnership deal with the Merck and Bill and Melinda Gates foundations, the most comprehensive HIV/AIDS private-public sector partnership in Africa to date. It encompasses mass prevention programmes, the training of health workers, building new laboratories, counselling and treatment, including the provision of free antiretrovirals.

Uganda is also making strides in partnership with the private sector. Soon after the WEF, the Pfizer Foundation announced that it is to fund the first large HIV/AIDS clinic in Africa in Kampala. It will be operated by the Academic Alliance for AIDS Care & Prevention and is expected to make First World care, including antiretrovirals, available to up to 50000 patients a year.

The WEF session ascribed distinct roles to government, business and civil society in the fight against AIDS. Of paramount importance is that governments show their political commitment by devoting greater resources to healthcare and leveraging international and private funding. This commitment must translate into action on all fronts. "AIDS is a low-technology, low-cost issue but a high human commitment issue", said Dr Jeanne Stephens, head of Business Against AIDS in Mozambique. Without the commitment from heads of State things won’t work.

Business should promote drug literacy, expand medical scheme coverage to uninsured workers and share best practices on combating AIDS. Civil society’s role is to mobilise and educate communities and lobby for policy change while the international community must provide debt relief and funds to help build the capacity of healthcare systems in developing countries.

The director of Harvard University’s Centre for International Development, Amir Attaran, castigated the international community for ‘their deafening silence’ on AIDS. He said the total global aid for AIDS in 1999 was a mere $100. Harvard estimates that it will cost $1200/person/year to provide carefully monitored treatment, including antiretrovirals, in Africa.

This should be compared to per capita health spending of $2 - $8 in the poorest African countries, he said. The $7bn - $10bn that UN Secretary-General Kofi Annan is asking for to make up a Global Fund equates to 0.04% of the GDP of the wealthy nations.

"For a tax of 4c in every $100 we can save thousands of lives," he said. "If not, history will be a very severe judge on us because it will be known that we had the technology to do something about it."

After the WEF it emerged that Annan’s war chest is likely to receive only around $1bn this year, according to the Financial Times. Britain recently pledged around $100m, following an earlier $200m contribution by Washington. A UN conference in Geneva in early June concluded that the fund should concentrate on AIDS prevention rather than the mass purchase of antiretroviral drugs. (World Health Organisation spokesman David Nabarro estimated that 70% - 80% of the fund will be used to combat AIDS and the remainder for the prevention and treatment of malaria and tuberculosis.) Many speakers at the WEF argued that while antiretrovirals are not the sole solution to AIDS in Africa, and in fact raise a whole host of new problems, they are the one thing that could make the biggest impact on how the epidemic unfolds.

The UNAIDS position is that treatment and prevention are inextricably linked because until countries make treatment available for people with AIDS, the stigma and denial which encourage ignorance and risk-taking behaviour will persist. Once treatment is available, people have to come forward for HIV testing to access it. Taking an HIV test forces each person to confront the epidemic and this is key in getting them to change risky sexual behaviour. So providing treatment reinforces HIV prevention efforts.

"Looking back over the last 15 years, well basically we’ve failed to stop the advance of this epidemic," said Anglo American vice president (medical) Brian Brink. "We have got to find something that’s going to work for the next 15. I believe that effective treatment is going to be the most important short-term strategic measure that is going to make the biggest difference to how the epidemic unfolds."

South African Health Minister Manto Tshabalala-Msimang stressed the need to broaden access to healthcare in general and called on the UN to name its war chest the Global Fund for Communicable Diseases. She stressed the relationship between poverty and the spread of disease and said that despite recent price cuts by the pharmaceutical industry, South Africa could still not afford to dispense antiretroviral drugs. For good measure, she added that they do not cure AIDS. Speaking earlier, the SA Ministry of Health Director General Dr Ayanda Ntsaluba told WEF delegates that the ability to improve AIDS patients’ quality of life by treating opportunistic infections was the best response to HIV/AIDS, and not the provision of antiretrovirals. However, he did not rule out any role for the latter.
Many speakers emphasised that there could not be effective action against AIDS without openness. Leaders should be prepared to lead by example and should all step forward to be tested for AIDS, suggested Unilever UK co-chairman, Niall Fitzgerald.

Although the WEF produced all the right messages about how to tackle the AIDS crisis, it was little more than a re-enactment of the Durban International AIDS Conference without the passion. At the AIDS conference in July 2000, South African researchers delivered the positive trial results on nevirapine but, almost a year later, the government has yet to produce a clear policy to provide universal access to the drug to prevent mother-to-child transmission. And despite it having won a dazzling court victory against the pharmaceutical industry over access to cheaper drugs, the average person with AIDS is no closer to receiving treatment than before. In this environment it is easy for those in the trenches to become despondent. UNAIDS executive director Peter Piot rightly emphasised the need for hope.

"We must believe success is possible," he said, "and hope the message from Africa will soon be that it is fighting back."

Perhaps a more important issue is inequality. This would suggest that where there are rich and poor people then the epidemic spreads more rapidly. Table 1 gives the Gini coefficients for the countries. This shows that there is a link between inequality and HIV prevalence for these countries.

Again the reasoning is simple. A mixture of poverty and inequality is driving the epidemic. For example in the South African context a truck driver is not well-paid compared to the executives who run the company. However, as he drives through rural areas he is rich in comparison to the people living there. For a commercial sex worker working a truck stop, a person who has R50 is wealthy compared to her. And this may buy unprotected sex because, although she knows the risks, her need for money to feed her children is overriding.

This adds the third element to the equation of poverty and inequality: the gender dimension. The worst of all possible worlds for the spread of HIV might be poor and powerless women serving ‘relatively’ rich and powerful men.

This has important implications for prevention messages. If the factors driving the epidemic relate to ‘relative’ poverty and wealth then they need to be addressed to stop the epidemic. But these are long-term goals and the HIV epidemic needs to be tackled now. However, short-term efforts at behaviour change and condom promotion have to be seen in this context. Perhaps the answer lies in a mix of actions. Development will address the epidemic, and development – social and economic upliftment and reduction of inequality – is a national goal anyway. It can’t be sped up, but it may be possible to do this in a more ‘AIDS sensitive’ manner.

HIV/AIDS-aware development would mean looking at the effect of projects on mobility and social status. For example, a new road may be built by a road gang who are housed in a camp, are all male and relatively rich. How can this be done differently? It might mean looking at increasing welfare payments, recognising that some people are destitute and have no prospects if earning an income. It is in the interests of all that they get support.

Development that addresses HIV/AIDS might aim particularly at income inequality and gender imbalances. If there was affirmative action aimed at employing women then this may go some way towards addressing the epidemic.

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HIV/AIDS policy implementation in Kenya: a source of conflict

Kenya's National AIDS Control Council (NACC) was formed by an Act of Parliament in November 2000 after HIV/AIDS was declared a national disaster in 1999 by the President. NACC was formed to co-ordinate all activities and organisations that deal with HIV/AIDS. It had to establish a structure that could oversee AIDS activities in both the private and public arenas from national to grassroots levels. The need to have the politicians’ support and involvement at all levels was especially true for those involved directly at community level.

The Constituency AIDS Control Committees (CACC) were established to focus the efforts of the essential service organisations aimed at prevention and control of HIV. Local members of parliament were asked to act as chairpersons and patrons of the control effort. The membership of THE CACC was proposed to be drawn from provincial administration, and to include a public health officer, a respected elder, a member of the church, a youth leader, a women’s leader, a representative of People living with AIDS, (PLWA) and any other person the committee deemed appropriate.

Unfortunately, NACC, having made this decision, failed to specify what criteria could be used to identify which respected leader in the locality was most suitable, which church the leadership would come from, who could best represent women’s organisations and who would be an appropriate spokesperson for the young. I feel this has created two big problems: It has opened the way for the politician to choose people in the community he or she counts as allies. Secondly, it has created a rift between the government (read Provincial Administration) and HIV/AIDS control, despite government’s involvement in policy implementation in the country since independence.

So, firstly, local people within the community regard the committee as a non-starter because they did not participate in electing who should actually be their representative in HIV/AIDS issues. Furthermore, those that don’t support the elected MP are not ready to work with the committee for fear of being seen as working with the ‘opposition’ or the ‘ruling party’ (KANU as the case may be). Secondly, perhaps more crucial, is knowing who controls the whole process of policy implementation. Is it the political arm of the government or is it the executive?

These issues are already damaging the operations. A recent seminar in Kisumu hosting all the District Commissioners in Nyanza Province questioned the efficacy and legitimacy of political appointments within the organisation.

The key issues causing conflict in discussions are:

- Why is there difference in policy implementation? The District Commissioners and District Officers’ role in the committee has been subordinated - they are just members and NOT chairpersons, yet they chair virtually all committees in the Districts and Divisions.
- Who is in charge? Is it the politician or is it the Executive? While donors do not want the government in overall control of the process, this alternative is obviously questionable.
- The issue of ‘large’ sums of money to be allocated to the constituencies invites corruption. Who will control the funds and who will decide on financial allocations? Who is ultimately accountable for money which, in other programmes, is the responsibility of an Accounting Officer.
- Critics have yet to be convinced that HIV/AIDS has been taken seriously in the formation of NACC and its structures. Many feel individuals within NACC and especially CACC consider HIV/AIDS as an opportunity to make money rather than a critical cause urgently requiring their support.

- In the case of the Member of Parliament’s demise, failure to be re-elected or resignation, the CACCs could well fail. Those who make up the committee other than the District Officer and the Public Health Officer, are likely to be relatives and supporters of the absent MP. A replacement MP will not want to work with them. A valid fear is that the CACCs will not live beyond the current parliament that ends this year in December. This will require a new appointment strategy. Furthermore, continuity of tenure for the membership is lacking as the MP has the power to replace committee members at will. The continuity of the committee and its activities is a crucial element in policy implementation and accountability.

While there are politicians who support the CACCs, others see it primarily as a requirement of the NACC (which is the government). Others see an opportunity to get ‘free’ money to channel to their supporters through various ‘women groups’ or ‘youth groups’ as spelled out by NACC. That is why the MPs’ supporters on the committee pass many proposals from groups allied to him.

- It was assumed that the CACCs would recognise and incorporate existing HIV/AIDS programmes, yet the majority of the CACCs have failed to recognise existing HIV/AIDS organisations and therefore have not included them.

Where the Executive and the politician are not in accordance, the programmes associated with them are doomed to failure. No discussions can take place or proposals agreed upon due to mutual animosity. Whenever a politician has influence rather than scruples, political expediency rather than effective co-ordination of grassroots enter prises will guide the CACC.

In conclusion, it is evident the success of any programme depends on social cohesion and, as outlined above, the CACCs will offer a fertile ground for intrigue and corruption. Whatever mechanisms already function in HIV/AIDS matters for the public good, are likely to suffer. Such confusion of motives, responsibilities and power structures are likely to damage the existing HIV/AIDS initiatives irreparably.

Most CACCs have no grasp of what needs to be done in the field of HIV/AIDS because Kenyans created the CACC’s solely in response to donor conditions. It was donor recognition of the potential of grassroot responses that prompted them to make the CACC’s a condition of cash injections. They were designed to include and involve popular participation so that the CACC’s supported the programmes already ‘owned’ by the locals. Instead human misery will be the pawn of the CACC’s committees run by the local elite.

HIV/AIDS has not been prioritised by the majority of the politicians. This has depended on the work of international and local NGOs, and civil society with the support of the media. This explains why it took 15 years (from 1984 when the first case was reported to 1999 when it was declared a disaster) for the government of Kenya to realise that HIV/AIDS was a crisis that needed their immediate attention and action. Their sense of urgency is still suspect. However, it is vital to maintain the struggle to lower the epidemic prevalence from 16%, to drop the figure of 200 000 infections in a population of 28 million. The goal must remain to decrease AIDS-related deaths from 700 people per day to less than 20. This can only be achieved when Kenyans are prepared to unilaterally stop politicising HIV/AIDS programmes. The onus will continue to be on civil society to wrest control from those who consistently undermine them.
Planning at district level in Malawi: disseminating the strategic framework document to the masses

Malawi has developed a National HIV/AIDS Strategic Framework (SF) to guide all HIV/AIDS interventions from 2000 to 2004. At the launch of this document on 29 October 1999, the State President, Dr Bakili Muluzi, said, “I want every Malawian to know the content of this document, I do not want it to gather dust on empty shelves.”

Armed with the statement, the National AIDS Secretariat, (NAS), started an intense exercise of disseminating the document to all the 27 districts in Malawi. They developed comprehensive and multi-sectoral district HIV/AIDS implementation plans. Each of these, guided by the SF, addressed issues prevailing in different districts. There were four recommended activities:

1. A district capacity assessment exercise that took place in 8 of the 27 districts of the country. The exercise aimed at assessing capacity of the districts to plan, co-ordinate, implement, monitor and evaluate HIV/AIDS activities. This found:

   • There is generally a shortage of planning capacity for HIV/AIDS in most districts. This is not surprising as it will be the first time that districts will be allowed to develop their own interventions for HIV/AIDS.
   • Although there have been initiatives to put in place, co-ordination structures, and co-ordination of HIV/AIDS activities at the district level have not been effective.
   • There are structures, institutions and organisations e.g. local and international NGOs, District Development Committees, religious organisations etc., that can be mobilised and used for implementation of HIV/AIDS activities.

2. The training of facilitators to manage the district planning exercises. This took the form of a workshop to build capacity of the participants to utilise the Strategic Framework in the facilitation and development of HIV/AIDS plans at district level. The outputs of this workshop were:

   • Training of 20 facilitators for district planning and development processes.
   • Facilitation materials and facilitation presentation schemes for district planning workshops.
   • Workshop schedules and objectives for district planning workshops.

3. Briefing sessions for key stakeholders from the districts. These key stakeholders included District Commissioners, District Development Officers, District Health Officers and District AIDS Co-ordinators. They were briefed in order to gain their support and commitment to the process and also so they could take a leading role in managing the process at district level.

4. Development of district HIV/AIDS plans through workshops. The aim of overall district planning workshops was to use the SF document to develop multi-sectoral and comprehensive district workplans. A team of six people facilitated the workshops, guiding the districts in developing their plans. They ensured that at the end of the session, a draft copy of the plan was produced and left with district officials to finalise in a set period. Once finalised, a copy would be sent to the National AIDS Secretariat (NAS) for record purposes.

The planning workshops process

The district planning workshops always began with a meeting of all key representatives of relevant organisations in the district. Up to 30 people were invited to attend the initial day. The proceedings for the day emphasised the need for participants to familiarise themselves with the rationale and the key characteristics of the Strategic Framework document. The participants were informed about the HIV/AIDS situation in Malawi, with a particular focus on the situation in the district under review. A core team of about 15 people was identified in advance of the general meeting to prepare the district plan. This was made up of:

   • Active professionals within the district already engaged in HIV/AIDS activities through NGOs, public or private organisations, religious bodies or community-based organisations.
   • Professionals with planning skills and experience in the area of HIV/AIDS or general planning skills which would facilitate the process of planning HIV/AIDS interventions.

The planning process was open, and participatory. Members of the Core Team were required to obtain data and information about the district to guide planning decisions. In addition they were required to collect existing plan documents or draw from their own experience of district activities to inform the process. Plans were directed towards critical areas identified in discussion of district priorities and gaps. The whole district planning process took about 10 months to cover the 27 districts.

Major lessons learnt

The briefing workshop of key district officials on the district planning exercise helped build commitment to the planning process. The resulting workshops went smoothly with high and full participation. The first day of the planning workshops had broader participation that included traditional, political and religious leaders. This was important for advocacy and mobilisation. It was further noted that traditional leaders raise and validate issues with cultural implications. Their involvement helped to encourage the community to own the programme.

The capacity at the district level, in terms of planning skills and availability of data and information, is generally weak. Consequently, the planning exercise took longer than expected. This means that for plans to be successfully implemented, the district capacity has to be improved.

Most of the participants in the workshops requested copies of the SF document in their local language to disseminate to friends and relatives. This meant that the Strategic Framework document was translated into all local languages to reach every Malawian. Documents that are for the perusal of nationals should therefore always be available in local languages to optimise access.

Participation of special groups, i.e. women, PLWAs and youths in the core planning teams had to be checked for by NAS, otherwise they would be forgotten.

The greatest challenge

The greatest challenge is now to move funds to districts for implementation of the plans knowing that, if anything goes wrong in terms of financial management by the districts, NAS will be held accountable. This is to avoid the donors’ tendency to withdraw aid when they are not happy.

(continues on page 9)
Culture: a barrier to fighting HIV/AIDS in Caprivi
by Sylvester Kabuku Mbangu

This article considers how the different cultural beliefs and social behaviour of the Silozi-speaking people of the Caprivi, North East Namibia affect HIV/AIDS. Can such a culture accommodate contemporary strategies designed to combat HIV/AIDS? Does this community admit the presence of HIV/AIDS? To what extent is HIV/AIDS being confused with other multi-faceted diseases long familiar in the community?

The Ministry of Health and Social Services in Namibia has conducted a Sentinel Sero Survey of HIV/AIDS among pregnant women bi-annually since 1992. The latest survey was concluded in 2000. Of the sites selected, the Katima Mulilo Hospital is the only centre in the Caprivi region. The past four surveys of pregnant women revealed the Caprivi site as having one of the three highest HIV positive results nationally. In 2000, HIV prevalence was 33 per cent in adult pregnant women.

In May, 2001 the Ministry of Health and Social Services’ press release of the 2000 Sentinel Sero Survey results warned that the results do not fully represent the prevalence rate in the population.

In my view some of the reasons the Ministry holds this opinion are:
1. The sample is very small, limited to just one centre, Katima Mulilo.
2. Such poor rural women may opt to deliver with the traditional assistance of experienced women in the village or a nurse from the nearest clinic. Such deliveries may well not be recorded.
3. Women from Impalila very often use Botswana’s maternity services at Kasani while those from Schumansburg and neighbouring places use the Zambian services at Mwandi.
4. Likewise, many Zambian women use the Katima Mulilo centre. Many are visiting relatives who do not come with passports and stay for long periods. They will not be recorded as Zambians. Still other foreigners may come in pursuit of better quality nursing and are counted as Namibians. These anomalies add to the HIV incidence recorded in Katima Mulilo and should be allowed for interpretation.

The Caprivi borders primarily on Zambia and Botswana, both countries that have high prevalence rates. In the 1980s, the region, Katima Mulilo in particular, became an attractive centre for Zambian women who in turn, entertained young men who, compared to their Zambian counterparts, were well-off. The Caprivi region is also the gateway to Zambia, Zimbabwe and Botswana and connects these countries to the Walvis Bay harbour. Katima Mulilo is a layover place for most truck drivers, who, refreshed with local beer, find it does not cost a fortune to get a Caprivian girl in the pubs around Katima Mulilo. Prostitution is not culturally acceptable so there is a degree of denial prevalent in such transactions. This deliberate denial rebuts prostitution and the gay culture also.

There are, therefore, no prostitutes in Caprivi, yet such terminology is recognised. (However, a prostitute is defined as women who sleeps with more than one man, not necessarily being an acknowledged sex worker.) Lacking candour, young women may well visit pubs with the intention of accepting a proposition for remuneration, but feel unable to exact payment if one is not freely given. After all, such a gift should only represent appreciation, not settlement in a crude financial contract.

Because of this subjective attitude, women may fail to demand the use of a condom. A man has to approach the girl as if he loves her, rather than in pursuit of a one-off fling, otherwise he may face rejection. The reason behind the charade is that a woman does not want to give a man an impression that she is a prostitute. The man does not want to give a woman an impression that that he thinks she is a prostitute. Such coyness is conducive for the spread of HIV/AIDS. A woman asking for a condom may imply a woman sleeps around. Likewise, a man using a condom may imply that he assumes the woman is sleeping around.

Popular culture in Caprivi accepts polygamy, admires inhibition and believes in the mystic powers of the ancestors, of witchcraft and “spirits”. The Lozi accept polygamy, and this is commonly practised by the well-to-do: chiefs, Indunas or businessman and “those who can plough”. However, even the word ‘sex’ is very “heavy” and not voiced lightly. Instead, a euphemism can avoid insult and still retain meaning. Those who can will employ English in such delicate conversations.

It is difficult for teenagers to acknowledge their sexual relationships to parents before a firm marriage commitment is made. Young men and women are therefore forced into secrecy. This is, of course, highly conducive to both sexes, especially males to enjoying the opportunity to engage with more than one partner.

In the Caprivi region there is a strong belief in witchcraft, surprisingly even more so among the educated and well-to-do people. The first stop when one is sick is to consult a witch doctor, whose diagnosis of the problem will be based on intelligent and psychological guesswork. Knowing what the client would like to hear and believe, the conclusion will be: “You are bewitched by your grandfather, your uncle down the village or your boss. Or maybe even your subordinate.” Compounding the problem, these witch doctors or traditional healers are ‘Jacks-of-all-trades and Masters of none’.

Related to witchcraft is the belief in the continued influence of ancestors and powerful spiritual beings, the “Mwendanjangula” and others. Mwendanjangula is believed to bring luck as well as a variety of diseases. There are some members of society who can perform the “spiritual acts” to drive out such diseases and evil spirits. Despite over 95 per cent of the population claiming to be Christians, these beliefs still exist.

It should be noted that before HIV/AIDS was brought to the attention of society, people who were sick for a number of many years had their health restored by spiritual consultants. It is therefore very confusing to be told that people with similar symptoms are almost bound to die from this ‘new’ virus.

There other diseases such as “Kahomo” which still exist and are recognised as what is known to Europeans as AIDS. These kinds of diseases are not usually cured. It is thought that there were people who could cure such cases but that these people are all dead.

Do these beliefs help spread of HIV/AIDS?
In theory, polygamy may increase HIV infection in Caprivi. However, economic realities together with other less obvious factors, (e.g. tradition: firstly to practice polygamy, a non-Christian habit, and secondly, to marry rather than just have alliances and arrangements) make polygamy the preserve of the over-50-year-olds. HIV prevalence among these age
People in the Caprivi are inhibited by inculcated cultural values which clash with changing lifestyles. Consequently, embarrassing, controversial and confrontational issues tend to fester unchallenged as people ignore matters which are awkward and which threaten the even tenor of their ways. It is not a society used to public or even family debate. For this reason, the sexual behaviour of growing children often flourishes in a conspiracy of silence. Young people assume cautions against premarital sex are just a means of control.

Why a fear? Because a relationship will mean sex and sex is preserved only for married persons. Also any mistake a girl or a boy will commit in the house the reference will be made that it is because she/he has a boy or girl friend. There is no room for discussion about HIV and sex. The way around this problem is through teachers who are able to talk easily about sex with their students.

Do people in Caprivi believe there is HIV/AIDS disease? The answer is uncertain. If you go around Katima Mulilo and into the villages you will hear such remarks as "butuku bo bu tuna bu ta lufeza", which means "The big disease will wipe us out". Colloquialisms are used which indicate that people are aware of this deadly disease. In the pubs around Katima Mulilo, you may be told: "Be careful of that one and if you do get involved, please use a condom."

This raises another concern: is there confidentiality in HIV diagnosis in Caprivi? However this gossip means there is awareness and, more importantly, condoms are easily and mostly freely available in Namibia and neighbouring regions. However, having a condom and using it are two different things. It is easy to use a condom for quick couplings but not for night-long activities. Even quick liaisons are unlikely to involve condoms because of the delicacy of the negotiation in Caprivi where this could convey the message of prostitution.

Surprisingly, and despite HIV awareness teaching, a family member who becomes sick with symptoms of AIDS or who has received a positive HIV test result, will tend to first consult a witch doctor. The witch doctor’s diagnosis will either be that the person is bewitched or the person will be referred to spiritual healers who can deal with evil spirits and other diseases believed to be caused by such spirits.

When a person dies and the death is formally stated by a Western doctor to be as a result of AIDS, families will consult a witch doctor to be advised otherwise. There is a lethal confusion of old and new cultures and beliefs in Caprivi with regard to HIV/AIDS. It is to be hoped that changes can be initiated with tact and efficiency, which will support the community in these difficult times.

Sylvester Kabuku Mbangu works in Namibia.
Country Focus

Openness and corporate strategy: the challenge of HIV/AIDS in Nigeria

by Reginald Chima

Introduction

In Nigeria, industries and businesses requiring migrant and highly skilled labour, and those that are labour-intensive will be worst affected by HIV/AIDS. Firms operating in the downstream and upstream areas of the oil industry; manufacturing, transport and communication, building and construction, banking and financial services, and the solid mineral sector such as tin, coal, iron ore and aluminium are dependent on these types of labour.

There are about 15 foreign firms and over 100 indigenous firms operating in Nigeria's oil sector. Similarly, there are about 10 foreign firms and over 25 indigenous firms operating in Nigeria's solid mineral sector, especially tin mining. Uniquely, these firms depend on advanced technology and a mix of expatriate and local professionals, semi-skilled and unskilled labour.

There are four industrial clusters in Nigeria with large-scale industrial investments located in cosmopolitan cities. These cities are Aba (southeastern Nigeria), Otta near Lagos (south-western Nigeria), Kaduna (north-western Nigeria), and the export-processing zone in Calabar (southern Nigeria). Most manufacturing firms are found within three clusters, Aba, Otta, and Kaduna.

The oil firms cluster around the coastal cities of Port Harcourt and Warri, while the tin mining firms are found around the plateau city of Jos. These cities have high rates of prostitution and a considerable number of brothels, which delineate the sexual network of businessmen, people working in mining, and industrial and financial services.

The oil and solid minerals sectors of the Nigerian economy operate a global market, which is highly competitive and sensitive to increases in production costs. The workforce in these sectors is built on skills, teamwork and performance-based compensation systems. This will be undermined by HIV/AIDS.

Impact of HIV/AIDS on firms and businesses

HIV/AIDS affects these firms and businesses by increasing expenditures and reducing revenues. The main sources of increased expenditures are:

- medical costs (prevention, treatment and care);
- lay-off / death-in-service benefits;
- burial fees;
- cost of recruitment and training of potential replacements;
- overtime costs;
- absenteeism due to illness, funeral attendance and/or to nurse relatives;
- reduced productivity;
- rapid labour turnover, and;
- reduced output growth.

These costs reduce company and business profits. The responses of businesses and companies to the difficulty of recruitment and maintenance of high quality labour, is to favour 'utility' labour and plant automation. Specialist labour, absenteeism, rewards and management of employee morale, pension/gratuity, lay-offs, retrenchment and reimbursement of medical expenses are generally considered the responsibilities of corporate strategists.

The impact of HIV/AIDS on traditional business structures is that one-man businesses, which characterise the small- and medium-scale enterprises, may not survive in the medium- and long-term as the epidemic peaks. Nigeria's epidemiological data shows that the HIV prevalence may peak in Nigeria in the next three years. Also, corporate enterprises, such as the oil companies, iron and steel, aluminum smelter, beverage, drugs and chemical companies which depend on a technological memory, will fail if they train and depend on the availability and efficiency of professionals who may be vulnerable to HIV/AIDS. Furthermore, the degree of exposure to the risk of HIV/AIDS among the various categories of the core workforce and the outsourced labour is correlated to the general performance of the business. This is typical of Nigeria's food and beverage companies, which depend on their larger retinue of marketing and sales staff that always travel to cities to market their products.

Corporate strategy versus public health strategy in HIV/AIDS control

HIV/AIDS is obviously a new phenomenon among the corporate risks within the portfolio of businesses and firms in Nigeria. The response of firms to the impact of HIV/AIDS in Nigeria is perceived to be inadequate. There is a noticeable silence on HIV/AIDS as a public health issue in Nigeria's workplaces. Firms and businesses are mainly concerned with profits and the core of their corporate strategy is the management of risks that reduce or increase profits. The silence of firms on this risk is because HIV/AIDS is perceived as a risk which can be managed within the framework of their corporate strategy rather than as a public health strategy. Still, human resource management is a core issue, which requires strict control over quantity and quality. The mix of labour and capital required for productive operations is crucial. Corporate institutions in Nigeria favour labour over technological production because it is cheaper and adaptive. It is not limited by the uncertainty of technological dislocation. Therefore, a lack of stability and performance increases the cost of labour and the operation of the productive unit to which it is applied. Three main determinants of the use and efficiency of labour are the health of the workforce, their natural and physical ability, and the level of cognitive and vocational skills they embody.

Rates of infection in Nigeria's workplaces reflect that of the wider population, with an adult prevalence of more than 5.4% and about 1.7 million cumulative AIDS-related deaths by 1999. This means that by 2004, in just three years, HIV/AIDS will impact the most sophisticated corporate strategy of industrial and business firms operating in any sector of the economy. To deflect the worst of this disaster, it is vital to open firms and businesses to public health strategies in disease prevention,
health promotion and community participation in HIV/AIDS control. The challenge is to establish new partnerships between corporate firms and businesses and their workers before extending interventions, education and support into surrounding communities.

Conclusion

Managers of firms and businesses in Nigeria should be made aware of the issues. It requires openness and sustained co-operation of private and public sector efforts to effectively combat its effect on the country’s business and investment terrain. Firms and business operators must be made to recognise their vulnerability and urgently initiate effective, orchestrated control programmes to mitigate HIV/AIDS in the workplace.

References


Reginald Chima works for the Policy Project Nigeria, an initiative of The Futures Group International.
Current trends in HIV

The first South African survey was conducted in 1990 and the methodology has changed twice since this time. The first methodological changes were taken in 1995 to improve laboratory and field procedures and to include investigations into HIV prevalence rates among private sector clinic attendees. Second generation surveillance activities are to be introduced during 2000/2001, adding behavioural indicators to the biological and socio-demographic indicators already being collected. The 2000 survey results are based on women who presented themselves at public health facilities for the first time during that current pregnancy (National HIV Sero-prevalence Survey, South Africa).

The Swaziland Sero-prevalence Survey is based on data collected from three population groups; female ANC attendees, male and female TB patients and STI clients. All those sampled volunteered for a blood sample and an interview. Since the first report in 1992, sero-prevalence surveys have been conducted at regular intervals (7th HIV Sentinel Sero-surveillance Report).

Botswana has the highest prevalence rates, reaching nearly 40% in 2000. Namibia’s prevalence rates are the lowest for 2000 (around 20%) even though South Africa and Namibia had almost equal prevalence rates in 1996.

The trend lines above appear to follow the classical epidemiological sigmoidal curves, and would usually be entering the leveling off period followed by a rapid decline in new infections. However, the HIV epidemic does not follow this classical curve because of the long incubation period of HIV, which allows the epidemic to be fuelled by a constant supply of new susceptible lives (Muhr, 2000).

Surveys and the results they produce are not only passive indicators of an epidemic. Rather these statistics have the potential to facilitate the detection of emerging health problems, enable interventions to be aimed at and specifically tailored for those most in need of them and can help policymakers to predict where care burdens will arise (Nicoll et al, 1996). This process is aided through the simultaneous collection of biological and socio-demographic indicators. Age-specific prevalence (as represented by Table 1-4) indicates when people first come into contact with the epidemic and when they are most vulnerable. This is important in terms of designing and assessing the effectiveness of intervention strategies as well as implementing policies and plans to cope with the ramifications of the epidemic. Tables 1 to 3 indicate age-specific trends in HIV prevalence in women attending antenatal clinics.

As can be seen from all of the above tables, women in their twenties display the highest prevalence levels. The prevalence in the 15–19 year old age grouping is generally stabilising in Namibia, South Africa and Swaziland, but increasing in Botswana for the first time since 1995. This may indicate that intervention strategies are effective but the increases in prevalence for women in their twenties indicates there are shortfalls in terms of sustaining these benefits throughout the life cycle. The use of second generation surveillance techniques, which integrate biological, socio-demographic and behavioural indicators may help to identify the reasons for this.

The information produced by country surveillance systems not only provides a “snapshot” of the epidemic, but can potentially be used to generate a public response to the epidemic while the epidemic is still composed of largely invisible HIV positive cases rather than AIDS cases.

Unfortunately this has not been done. Another important function of surveillance data is to assist in the planning of responses and targeting of prevention activities. The statistics produced can be used to make projections about the future course of the epidemic, enabling planners and policymakers to make informed decisions and implement strategies to mitigate against the impact of the epidemic. As second generation surveillance techniques build on current surveillance systems (outlined by the South African Sero-prevalence surveillance methodology shift), the statistics produced will provide more comprehensive information regarding those most vulnerable. They will also help to identify more appropriate strategies, based on variations in socio-demographic, behavioural and biological information, to tackle the epidemic.

References

Regional Focus


Su Erskine is the MSD Research Intern at the Health Economics and HIV/AIDS Research Division, University of Natal, Durban.

Table 1  Botswana HIV prevalence amongst women attending antenatal clinics according to age

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Table 2  Namibia HIV prevalence amongst women attending antenatal clinics according to age

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Table 3  South Africa HIV prevalence amongst women attending antenatal clinics according to age

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Table 4  Swaziland HIV prevalence amongst women attending antenatal clinics according to age

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The infamous Pharmaceutical Manufacturers’ court case has passed. The United Nations General Assembly on HIV/AIDS (UNGASS) is over. The Global Health Fund has been launched and quickly – if temporarily – beached. All that remains is a global hangover, an accumulation of Voyager Miles for the AIDS set, and a lot of people with HIV and AIDS waiting for news about whether life-saving medicines will reach them in their lifetime.

Probably not, if things continue the way they’re going. In South Africa, for example, the affordability of medicines continues to be a cause of delay for brave HIV/AIDS treatment interventions tantalizingly held out by companies such as Anglo American, where high rates of HIV infection among employees necessitate access to cheaper medicines.

After all the action of 2001, a stasis has emerged. The major protagonists (UNAIDS, pharmaceutical companies, generic companies and activists) have locked against each other, looking for a magic pill that will catalyse a durable solution to the problem of the affordability of medicines.

One of the formulae getting increasing attention is that of a system of ‘equity’ or ‘differential’ pricing of drugs between developed and developing countries. The purpose of this article is to argue that this approach will not work, and that in fact there are simpler, quicker, fairer means of making medicines accessible to the poor – if only the powers that be would set the market free! Differential pricing refers to a system whereby it is conceded that medicine makers should retain their high prices in developed countries, but are expected to dramatically reduce prices for poor countries. The rationale behind this is:

(a) to allow the companies to continue to reap the profits “necessary” to encourage future investment and recover research and development costs (R&D), whilst
(b) admitting to the needs of the poor (others would say the rights) whose purchasing power either as individuals or via their governments leaves them outside the ‘mainstream’ market.

Thus for example, Pfizer would sell its anti-fungal medicine, Diflucan, for $8 per 200mg pill in the United States, but at less than $1 per pill in Africa. Similarly, with drugs such as GlaxoSmithKline’s recently registered triple combination antiretroviral pill, Trizivir. On the surface this seems a reasonable solution. UNAIDS, together with a range of developmental organisations such as Oxfam are buying into it. But there are several looming problems.

The pharmaceutical companies expressed concern over preventing low-priced medicines from being sold back to high-price markets – thereby undercutting profits, and knocking Humpty Dumpty off the wall. Preventing this requires either country by country negotiations and agreements and/or measures, such as that adopted by Pfizer with its South African Diflucan donation – the making of an identifiable donation tablet! These conundrums explain the sluggishness with which the UNAIDS sponsored access to affordable medicines initiative (based upon differential pricing) has got off the ground. From the perspective of health providers in poor countries, however, the concern is over the time that it will take to make such a system, the conditionalities it will necessitate, and the lives that will continue to be lost during the wrangling.

Even if such a system was constructed, it is inevitable (and justifiable) that consumers of medicines in developed countries – many of whom are also poor – would begin to question why they pay such high prices. The answer from pharmaceutical companies is likely to be that they are “subsidising the poor”. This could unleash resentment and racism. But, most importantly, it is just not true. This brings us to the heart of darkness: differential pricing is justified on a set of false premises. These are:

- that the high pricing of medicines (made possible through patents that create market exclusivity for many years) is necessary to recover R&D;
- that patents on medicines encourage investment that brings new medicines to the market; and
- that the pharmaceutical companies promote public health and there fore deserve a measure of protection.

All of these premises are demonstrably untrue. Papers which were filed in the litigation between the PMA and the SA Government illustrate how many medicines, particularly for cancer and HIV, are rarely the sole product of an individual’s or companies’ intellectual property. For example, research has shown that the molecular compounds from which the active ingredients of medicines originate are often discovered in publicly funded research institutions. The clinical trials which validate these compounds take place either on people of goodwill, or people in great need. Finally, the science on which medicine advances is part of a repository of understanding built up over the ages. Into this pot, companies do pour an invaluable oil that brings some medicines to market – but they are part of a system of invention and improvement, rather than its beginning and end. New medicines are therefore not products deserving of the same level of patent protection that rewards unique inventions. They are also distinguishable from many other commercially exploited inventions insofar as they are linked to the dignity, health and life of millions of people.

It is on this basis that it seems increasingly ludicrous for the WHO and governments of developed and developing countries to prevaricate and pussy-foot around the simplest and quickest mechanism that would necessitate, and the lives that will continue to be lost during the wrangling.

Which brings us back to AIDS. At a recent conference in London hosted by the Royal Institute for International Affairs, and attended by many of the grandees of the conference circuit spawned by AIDS, it was admitted that a successful or unsuccessful compulsory licence application is what is needed to move things forward. This is because many of the drugs that would help to combat the effects of HIV infection are already available as high quality generics. In South Africa, Aspen Pharmacare,
a local pharmaceutical company has struck a deal with an Indian supplier of active ingredients, and offered to tender at cost to the South African government medicines for malaria, TB and HIV. In August the Indian generic company, Cipla, will apply to the Commissioner for Patents for compulsory licences for seven patented medicines. Although the debate over mechanisms for differential pricing will go on, it is likely that compulsory licensing is where the battles will now lie.

The tragedy is that there should need to be a battle at all. The casualties of the current attrition are people, and as their numbers mount, societies. As the pharmaceutical companies correctly argue the price of medicines is not the only issue: the improvement of health infrastructure is equally important. But the conflict over price is one that could be quickly cleared out of the way. Protestations to the contrary place them in an even worse light.


Providing health care to HIV patients in Southern Africa

In July 2001 a conference on The Economics of Essential Medicines was held at the Royal Institute for International Affairs in London. Among the papers presented was one by Markus Haacker of the International Monetary Fund in Washington. He compiled a table showing several indicators for the quality of health services in Southern Africa. In the next issue of AIDS Analysis we hope to present additional material from this paper – here we reproduce the table of indicators. Total health expenditure per capita ranges from US$ 9 (for Malawi) to US$ 203 (for South Africa). If the purchasing power of the US dollar differs across countries (owing to lower prices for services and nontraded goods in lower-income countries), health spending in terms of US$ is not a good indicator for the quality of services. Therefore, Table 2 also gives health expenditure per capita in terms of US$ at purchasing power parity (PPP). PPP exchange rates are estimated based on the prices of a bundle of goods and services different from goods and services relevant for the health sector, which means that this adjustment is rather crude. At PPP exchange rates, total health expenditure per capita ranges from US$ 45 (for Malawi) to US$ 552 (for South Africa), corresponding to between 0.9 and 11.1 percent of U.S. per capita health expenditure. The differences in spending on health services across countries mainly reflect differences in GDP per capita. As a percentage of GDP, health expenditure ranges from 3.4 percent (for Swaziland) to 7.5 percent (for Namibia).

Table 2

<table>
<thead>
<tr>
<th>Total health expenditure per capita</th>
<th>Physicians</th>
<th>Nurses</th>
<th>Hospital beds</th>
<th>Access to essential drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>In US$, 2000</td>
<td>In PPP US$, 2000</td>
<td>In % of GDP, 1997</td>
<td>Per 100,000</td>
<td>Per 100,000</td>
</tr>
<tr>
<td>Botswana</td>
<td>155.0</td>
<td>198.1</td>
<td>4.2</td>
<td>23.8</td>
</tr>
<tr>
<td>Lesotho</td>
<td>21.0</td>
<td>88.8</td>
<td>5.6</td>
<td>5.4</td>
</tr>
<tr>
<td>Malawi</td>
<td>8.9</td>
<td>44.8</td>
<td>5.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Mozambique</td>
<td>12.7</td>
<td>55.4</td>
<td>5.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Namibia</td>
<td>113.7</td>
<td>394.1</td>
<td>7.5</td>
<td>29.5</td>
</tr>
<tr>
<td>South Africa</td>
<td>203.0</td>
<td>552.3</td>
<td>7.1</td>
<td>56.3</td>
</tr>
<tr>
<td>Swaziland</td>
<td>42.6</td>
<td>129.6</td>
<td>3.4</td>
<td>15.1</td>
</tr>
<tr>
<td>Tanzania</td>
<td>13.0</td>
<td>30.2</td>
<td>4.8</td>
<td>4.1</td>
</tr>
<tr>
<td>Uganda</td>
<td>11.7</td>
<td>56.5</td>
<td>4.1</td>
<td>n.a.</td>
</tr>
<tr>
<td>Zambia</td>
<td>19.8</td>
<td>58.7</td>
<td>5.9</td>
<td>6.9</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>33.2</td>
<td>127.0</td>
<td>6.2</td>
<td>13.9</td>
</tr>
</tbody>
</table>

Data sources:
Cols. 1-2 are extrapolations for 2000, using 1997 WHO data on expenditure shares (col.3). WHO Estimates of Health Personnel for cols. 4-5, most data refer to 1995 or 1996. For Malawi and Mozambique, the data on health personnel are from the World Bank, World Development Indicators, 2001. World Bank, various sources and South Africa Ministry of Health for col.6. World Bank, World Development Indicators, 2001, for col. 7.1. Public hospitals only.

2For example, GlaxSmithKline’s Preliminary Results for 2000 reported less than 1% of annual sales in Africa, compared with 78% in Europe and the USA.

3These views are most clearly articulated by Medecins sans Frontieres. See Pills and Pocketbooks: Equity Pricing of Essential Medicines in Developing Countries, April 2001, available at www.accesmed-msf.org.


5The Economics of Essential Medicine, 10 July 2001

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Electronic Media

HIV climbs to record levels in Swaziland

Finding locally relevant information is an important consideration for researchers short on time and money. Whilst the international agencies’ websites (such as UNAIDS, WHO, World Bank) are useful portals for generic documents and global statistics, often the most useful information can be found on websites in our own backyard. This article provides the contact details of a few of the Southern African sites providing online services of one form or another.

Equinet
The Network on Equity in Health in Southern Africa (Equinet) is a network of research, civil society and health sector organisations seeking to influence policy on health in Southern Africa. Equinet aims to build alliances leading to positive policies on health both at local and regional levels by disseminating information and stimulating an informed debate on equity in health in Southern Africa. Equinet’s regular electronic newsletter known as Equinet-l is produced by Fahamu - learning for change (http://www.fahamu.org/). The newsletter often features news on HIV/AIDS initiatives in the region, and is an important resource for links to other research organisations. To subscribe to the Equinet electronic newsletter, use the form on http://www.equinet.org.zw/newsletter/subscribe.php or write to <info@equinet.org.zw> with the word ‘subscribe’ in the subject line or in the body of the message.

Health Systems Trust
In South Africa, the Health Systems Trust supports a large number of electronic discussion lists as a free service to health workers and researchers. Their weekly electronic newsletter, Healthlink Bulletin provides updates on developments in the health system. More information on this and other services offered by the organisation can be obtained from the Health Systems Trust website.

Child AIDS Services
http://www.childaidsservices.org
In December 2000, the Child Health Policy Institute of the University of Cape Town, was commissioned by Save the Children (UK) to establish a national directory of services for children and youth infected and/or affected by HIV/AIDS in South Africa. Child HIV/AIDS Services provides information on organisations and key government contacts working with and for infected and/or affected children and youth. It is hoped that the directory will enhance our efforts to address the impact of HIV/AIDS on children in South Africa by providing a resource that facilitates collaboration, information sharing and research. The directory is also available in hard copy and can be obtained from Save the Children UK on telephone +27 12 341 1889 or fax +27 12 341 1889 or email saveuk@scluk.co.za.

The South African AIDS Directory
http://www.sahealthinfo.org/aidsdir
The Directory is compiled by the Systems Development and Corporate Communication Divisions of the Medical Research Council, and the HIV/AIDS and STD Directorate of the Department of Health and the Beyond Awareness Campaign. Services offered include a number of research databases, publications, projects, disease information and more.

The Southern African AIDS Information Dissemination Service
http://www.safaids.org
Established in 1994, SAF AIDS helps strengthen capacity to address the socio-economic impact of AIDS and to promote HIV prevention in Southern Africa. SAF AIDS’ flagship is a computerised HIV/AIDS Resource Centre with a growing internationally accessible database. The Resource Centre offers literature searches on HIV/AIDS, including published research, resource directories, “grey” literature and training material. The Resource Centre has access to Medline and holds the following databases: AIDS CAP Electronic Library, AIDSLine and the HIV/AIDS Surveillance Database. Visitors have access to a technical workstation that will allow them to conduct their own electronic literature search.