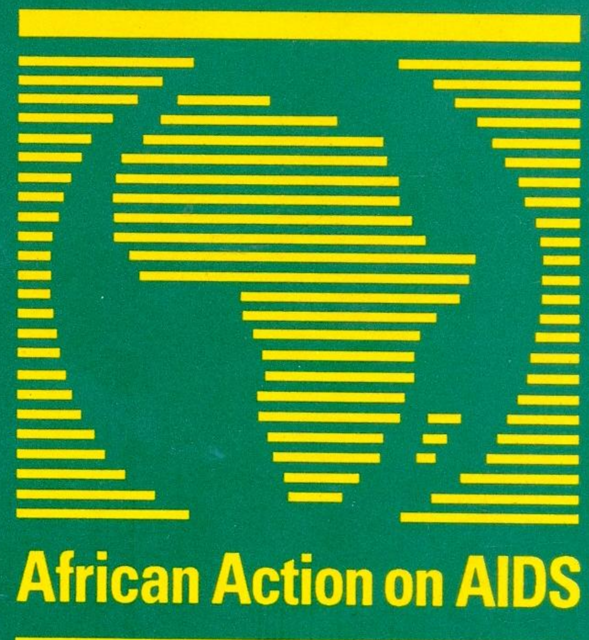


AIDS in Africa

Select Articles

MESSAGE FROM
THE PRESIDENT

To Our Friends:

For centuries Africa has been a beleaguered continent, ravaged by the slave trade and colonialism, afflicted with recurring drought, famine and poverty and constantly battling the thousand natural and unnatural shocks that have become a part of African existence.

Africa is now faced with yet another, and perhaps one of the gravest, obstacles to health and well-being: AIDS.

According to a U.S. Bureau of Census Forecast, it is projected that by the year 2015, there will be more than 70 million AIDS cases in countries south of the Sahara. The World Health Organization now estimates that one out of every 40 adult Africans is infected by the HIV virus that leads to aids. This figure is far beyond being a remote danger affecting only a limited few. The virus affects people across the board, regardless of sex, age, economic well-being, or over-all health. Families are disrupted, torn apart, children are orphaned or afflicted themselves. The loss of a mother or father could well mean the loss of all income and food, the loss of yet another productive member of a struggling and fragile economy.

For example, in one town in Uganda, 60 people involved in various aspects of trade were struck down by AIDS, leaving behind large families with no means of support. In Tanzania, 5 engineers in one ministry were lost to the disease, a debilitating blow to the local administration.

And what about the future of Africa, her children? In only one hospital in Burkina Faso, 17 per cent of the malnourished children brought in for treatment tested positive for the HIV-1 virus. This is in addition to the millions of boys and girls suffering indirectly by being either orphaned or abandoned by one or even both afflicted parents.

AIDS is a calamity that cuts across all boundaries: international, national and local. In addition to international efforts, each community must organize and plan to sustain its own survival. These community organizers are the brave frontline fighters.

African Action on AIDS (AAA) was created in 1990 for the purpose of supporting and promoting actions initiated by

local African communities in the control and prevention of AIDS.

This collection of articles, essays and news briefs, is intended to draw the attention of Africans and friends of Africa to the fight against a tragedy that is slowly enveloping the continent, a tragedy that demands immediate and positive action by all.

The African AIDS effort is now surviving on the tireless efforts of a few African pioneers and a large measure of hope. African Action on AIDS is determined to keep that hope alive. We need your help in nourishing those frontline fighters: through encouragement, promotion and resources.

AAA's first project builds on the faith and hard work demonstrated by the Africans themselves. The AIDS support organization (TASO), an organized community response to AIDS in Uganda, promotes "living positively with AIDS." TASO provides care, counselling and support to people with AIDS and their families. As a starting point, the African Action on AIDS will support TASO in this pioneering mission.

In conclusion, we would also like to give our most gracious thanks to the United Nations Development Programme (UNDP) for their generous and constant support since the inception of this group.

WON'T YOU PLEASE JOIN US? ACT NOW!

Ruth Bamela Engo-Tjega

President

African Action on AIDS

25 September 1991

MESSAGE FROM
UNDP

Acquired Immune Deficiency Syndrome (AIDS) is emerging in the 1990's as one of Africa's most serious diseases. A conservative estimate of the population carrying human immunodeficiency (HIV) in sub-Saharan Africa is at least 5 million people or more than half the estimated global total. It is estimated that one in every 40 adults is already infected. In some eastern and central African countries, AIDS is expected to reduce the population growth in young children and those aged 15-49 by over 30% and the adult mortality rate will more than triple. This is in addition to an adult death rate already more than eight times higher than in industrialized countries.

The nature, extent and impact of the HIV epidemic to governments and communities is yet to be charted. With the progression of the disease, people infected with HIV some years ago are increasingly becoming ill, creating demands for treatment and support that cannot be satisfied, and in some cases, bringing the first realization of the true scope of this disease. HIV related illnesses and deaths will have a more adverse impact on families and communities than other fatal diseases as the clustering of AIDS deaths can be especially devastating. In many places, human and community survival is already threatened with women, children and the elderly being the most vulnerable groups.

HIV/AIDS will change communities in Africa for generations to come. It will have far reaching social, economic, ethical and legal ramifications. It challenges prevailing social and cultural values and raises fundamental questions about health, human rights and social obligations.

The combination of sex, disease and death is a powerful one. It attaches a symbolism to HIV/AIDS that sets it apart from other diseases. People with HIV must cope not only with the knowledge that they may soon die but also with the stigma, discrimination and social alienation born of other people's fear and prejudice about HIV. The disease threatens human rights as profoundly as it threatens public health.

The extraordinary complexity of the issues surrounding HIV/AIDS poses unique challenges to the formulation of effective and ethical policy responses. A policy on HIV/AIDS should address such diverse elements as education about HIV, changes in behavior, testing,

discrimination, health care, counselling and community based support to people with HIV and their survivors.

Above all, the response to HIV/AIDS must show a sensitivity to the multitude of ways in which this epidemic is changing the lives of people. Only by understanding the human dimension of this disease can individuals, communities, governments and the international community begin to address the many, urgent and compelling needs that this disease has created. Community-based prevention, care and support programmes are essential, particularly in high incidence areas, where the extent of morbidity and mortality associated with this epidemic will not be able to be met by institutionally based services.

Promoting a greater awareness and understanding of HIV/AIDS as it impacts on African People, is extremely important in order to cope with the disease, reduce its spread, and confront its social and economic impact. The United Nations Development Programme (UNDP), which is providing technical cooperation to African nations in their HIV/AIDS prevention, cares and supports programmes to combat the social and economic consequences of this disease and welcomes the creation of the African Action on AIDS, made up of Africans and Friends of Africa. This group promotes self-help initiatives by community organizations and NGOs. We can translate this glimmer of hope into victory over this deadly disease if we join forces.

Pierre-Claver Damiba

Assistant Administrator and Director
Regional Bureau for Africa, UNDP

25 September 1991

AIDS in Africa: An Atlas of Spreading Tragedy

Continued ...

Most Severely Affected

Malawi

In Blantyre, the largest city, 22% of pregnant women are infected, up from 2% in 1984.

Rwanda

30% of pregnant women in Kigali. In Butare region, 13% of city women and 5% of rural women, indicating a rapid rural climb.

Uganda

Government estimates one million people infected, of national population of 16 million. 24% of pregnant women in Kampala in 1989 survey.

Zambia

22% of pregnant women in Lusaka, up from 11% in 1987. Half the nation's population is urban, but some rural rates are also high: 8% in one southern hospital.

Urban Rate 10% to 20%

Burundi

A 1988 study found 16% of urban adults infected.

Ivory Coast

AIDS pushes into West Africa: in Abidjan, 7% of adults carry HIV-1, 3% more carry HIV-2 or both viruses, and AIDS is now the leading cause of adult deaths. 5% of rural people have one or both viruses.

Tanzania

Infection in blood donors in Dar es Salaam rose from 7% in 1986 to 11% in 1987; in 1988, 39% of Dar es Salaam barmaids. High rates in the northwest corner of the country.

Zimbabwe

Limited data suggest at least 10% of urban adults, in a country with high urban-rural mobility. Especially high rates along Lusaka-Harare highway.

In Mutare, staging area for troops fighting in Mozambique, sexually transmitted diseases have multiplied fivefold in five years; AIDS is implicated in half of child deaths in provincial hospital.

Urban Rate 5% to 10%

Central African Republic

In Bangui in 1988 and 1989, 7% to 12% of blood donors; in 1989, 8% of pregnant women.

Congo

6% to 8% of adults in Pointe-Noire, 4% of adults in Brazzaville.

Guinea Bissau

Hard hit by HIV-2, which infects nearly 10% of urban adults. HIV-1 infection is low.

Kenya

5% of pregnant women at two Nairobi hospitals, 8% at a third, and rates climb each year. 80% of prostitutes in slums. More than 5% of women in coastal city of Mombasa and more than 10 % in western city of Kisumu.

Zaire

A rare glimmer of hope: Infection among pregnant women in Kinshasha appears to have stabilized at 7% to 8%. In a large Kinshasha hospital, AIDS is the leading cause of hospitalization and deaths.

Rates are higher in towns along the eastern side of the country.

Finding in 1989 that 18% of prostitutes in Equateur region are infected suggests AIDS is spreading with commerce up the Zaire River.

7% of blood donors in 1988 in Lumumbashi.

Ominous Signs

Angola

In 1988 in northeastern city of Dundo, 14% of patients at sexually transmitted disease clinic had HIV-1, 14 % had HIV-2, with overlap.

Burkina Faso

17% of severely malnourished children brought to the hospital in Bobo Dioulasso from mid-1989 to mid-1990 were infected with HIV-1. In Banfora, near Ivory Coast, infection in pregnant women jumped from 2% in 1987-88 to 5% in 1989.

Sample of adults in small northern town of Gorom-Gorom finds 3% infected with HIV-1, some of same individuals with HIV-2 as well. A gold rush in the late 1980's has spawned mining settlemen and prostitution.

Mali

In 1987, 38% of Bamako's prostitutes carried HIV-1, HIV-2 or both, but only 1 of the general population. HIV-1 in blo donors jumped from 2% in 1987 to 4% 1988.

Ethiopia

In Addis Ababa, 2% of blood donors infected, and 10% of women (including prostitutes) attending clinics for sexual transmitted diseases.

Ghana

In 1987, one in four urban prostitutes carried HIV-1.

Namibia

In 1988, 3% of blacks in Eastern Capri AIDS has appeared among former guerrilla soldiers who returned recently from camps in Angola after independence.

Nigeria

General rate in Africa's most populous country is still below 1%, but both virus have appeared in several regions, and HIV-1 is rising.

Senegal

Famed traders of northern Senegal, wh travel often through Central Africa, are bringing AIDS home. Study of 258 traders found 27%, and 11% of their wives, infected, most with HIV-1, a few with HIV-2 or both.

In Dakar, about 10% of prostitutes carry HIV-2, but 3% have HIV-1, and rate is rising fast. In the last 3 years HIV-1 has appeared in prostitutes in several Senegalese towns.

Sierra Leone

In 1989 report, 4% of Freetown blood donors carried HIV-1, 5% HIV-2.

South Africa

AIDS is beginning to spread heterosexually in black population. In 1989 in a sexually transmitted disease clinic in Durban, 3% of women and 2% (men were infected; infection rate is doubling every 8.5 months. In whites, AIDS is largely confined to gay men.

KEY TO THE MAP

The shadings on this map indicate the percentage of sexually active adults believed to be infected with the AIDS virus in major urban areas. Rural rates tend to be much lower. The numbers are based on the latest available data, which may understate current rates. Blank spots do not necessarily mean an absence of AIDS.

- Infection rates less than 5 percent or data not available.
- At least 5 percent to 10 percent.
- At least 10 percent to 20 percent.
- At least 20 percent.

The virus causing AIDS in the United States, Europe and most of Africa is HIV-1. In the mid-80's a second, related virus, HIV-2, was discovered in West Africa. Evidence suggests that it spreads less easily and does not tend to attack the body as quickly as HIV-1 does, but it clearly can cause disease and death. In the listings that follow, percentages refer to rates of infection with HIV-1 unless otherwise noted.

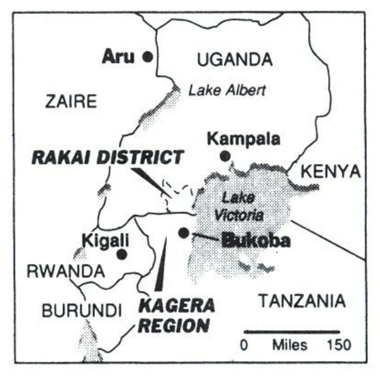
SOURCES

Data in this chart are drawn from numerous sources including published reports and estimates made by governments or international health officials. Source of many pre-1990 studies is the HIV/AIDS Surveillance Data Base of the U.S. Bureau of the Census. Only studies that used accepted HIV antibody testing methods, including confirming tests, are cited.

Surveys of subgroups are useful but must be interpreted with caution. Urban infection rates cannot be extrapolated to rural areas. Rates among prostitutes, soldiers, hospital patients and patients at clinics for sexually transmitted diseases tend to be far higher than in the population at large. Blood donor figures may overstate prevalence if donors are recruited among high risk groups or understate it if efforts are made to avoid high-risk donors. Often, surveys of pregnant women visiting prenatal clinics are considered the best indicator of infection among the adult population.

An AIDS Crossroads

One of the highest concentrations of AIDS in Africa is in southern Uganda, northwestern Tanzania, eastern Zaire, Rwanda and Burundi. A recent study in Rakai district of Uganda found 12% of rural adults, 35% in trading-center towns, infected; tens of thousands of children in Rakai have been orphaned. A 1987 survey in neighboring Kagera region of Tanzania found 12% of adults infected, 33% in Bukoba town. A 1987 study of 160 adults in a market-town area of Aru district in Zaire found 11% with HIV.



Sudan

In Juba, in war-affected south, 16% of prostitutes, and 4% of male and 2% of female outpatients at clinics. Large-scale movements of refugees and soldiers prompt warnings that HIV may be introduced via southern Sudan to northern Africa.

Sara Krulwich/The New York Times

Dangerous Traffic

The highways of East and Central Africa, such as this one west of Kampala, Uganda, have been major conduits for AIDS. A study in Kenya of 317 truck drivers of varied nationalities found that three-fourths frequently visited prostitutes but that only 30% ever used condoms. One in four was infected with HIV. In 1986, 35% of drivers studied in Kampala were infected. Most prostitutes and barmaids along trucking routes are infected.

AIDS
The big threat

More and more children are being orphaned by AIDS

AIDS. The four letters thrust upon us 10 years ago have been overturning lives and societies ever since, for this sexually transmitted malady affects man at his most intimate. The erudite terms behind the plain initials are not important. All that counts is the verdict that our societies are increasingly forced to accept — disease, decay and death, with no appeal, a sentence originally only passed on marginals in the homosexual community and among intravenous drug addicts, but which can now strike anyone. For today, the main source of infection is heterosexual contact.

World Health Organisation figures suggest that there are now something like 8 million HIV carriers spread across almost all the countries of the world. And although the occasional AIDS sufferer may get short periods of remission from some rare drug, we are far from having a cure or a vaccine to stop infection spreading.

So the one really efficient way of fighting the disease is to prevent it, above all by providing the fullest possible information — the only weapon with which to combat the ignorance which causes fear, discrimination and rejection. The first aim of this dossier therefore is to provide the latest details of this dreadful scourge and the research now being devoted to it. The second is to generate in-depth thinking on the economic and social repercussions of the epidemic, particularly in the hardest-hit countries where more and more children are being orphaned by AIDS. And the third is to look at the international campaign master-minded by WHO and take stock of the projects being run in the ACP countries with the European Communities' help. ○

Amadou TRAORE

THE COURIER
March-April 1991

The social implications of AIDS

by E.P.Y. MUHONDWA (*)

AIDS in Tanzania is about young adults; men and women dying prematurely, most of them before they reach the proverbial age of 40 when life is said to begin. Death announcements in the newspapers describe them as dying 'after a long illness'. It is about lost opportunities for academic achievement — an important gateway to success in the modern society — for young children who are now orphans; it is about an elderly couple who have to resume economic activity because their son or daughter who supported them has died; it is about a very sick person being discharged from the referral hospital because there is nothing that biomedicine can do for him; and it is also about institutions, departments and offices losing their highly trained and experienced staff who in the existing conditions of scarce high level manpower cannot be replaced easily.

All the above scenarios highlight different dimensions of the impact of AIDS. And the list is not exhaustive.

The social impact

The AIDS epidemic has changed the health status profile of youth. They are no longer the healthiest population category as can be seen from the accompanying figure which depicts the rate with which people in different age and sex groups in Tanzania are affected with AIDS. The elderly in the Kagera area lament that they are now burying the very people who under normal circumstances should have buried them. But AIDS is not a disease with a predilection for young chronological age as such. Because of the predominance of the heterosexual mode of HIV transmission in our country, AIDS threatens people with social positions that give them access to a multiplicity of sexual partners, or those in marginal social positions that make them potential 'possession', of those in high status positions.

In other words it is inherent in our social structure that some social positions carry with them differential access to desirable scarce resources including sexual partners. One study in rural areas in Uganda found that middle aged men and old men were in this position and had higher prevalence rates of sexually transmitted diseases. It so happens that in our towns it is younger men with economic power who are in that position and are at particularly high risk of HIV infection as the figure shows.

There are of course, specific cultural practices that facilitate the transmission of HIV in particular areas once the virus has been introduced. Such circumstances as male circumcision or rather the lack of it, foreplay methods which induce copious vaginal secretions while causing abrasions on the glands, and the sharing of wives by age-mates or close relatives have been incriminated as facilitating HIV transmission in some parts of Africa. Within urban areas, AIDS has been explained in terms of a loosening of norms governing premarital sex, lack of realistic negative sanctions against promiscuity, and the numerous opportunities for making contacts with potential sexual partners within a setting of anonymity and freedom to 'misbehave'.

AIDS and social institutions

The AIDS pandemic has hit sub-Saharan Africa hard. There is, quite understandably, a plethora of speculation as to its impact. Some of the speculation being bandied about takes the form of baseless forecasts. There are those of us in Africa who take comfort in the fact that ours is a continent of survivors. Our societies have survived natural calamities, famine, internecine tribal wars, slave trade and diseases. We like to think that our present societies will evolve appropriate ways of coping with AIDS. There are already signs that social institutions are changing in response to this onslaught.

Kagera is one area in Tanzania which has so far been badly hit with AIDS. Many people in the area have died. The social institution of mourning the dead has changed. People will come together for burial, but instead of staying there for a number of days without engaging in serious economic activities they now disperse immediately after burial to go back to their work. Mourning in its traditional form would be dysfunctional.

Secondly, while traditionally orphans were absorbed into the extended family network, the excessive adult mortality means that there are too many orphans to be cared for by the extended family. People in Kagera have already instituted a form of mutual assistance for the collective care of the orphans of the village. Besides, orphanages are now being given serious consideration.

AIDS is also opening the eyes of the African to the limitations of biomedicine.

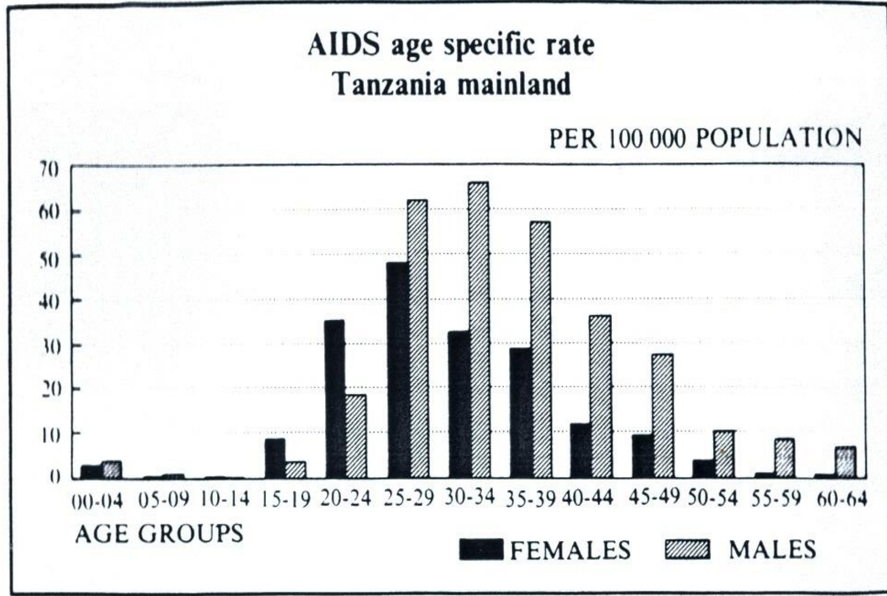
The hitherto unrivalled efficacy of biomedicine is being challenged. This questioning of biomedicine is a new phenomenon in sub-Saharan Africa where the thrust has since the colonial era been towards the vilification of traditional medicine and concerted moves to replace it with biomedicine. There is now an avalanche of advertisements in local papers in Tanzania by traditional healers who claim to treat not just AIDS but also cancer — while doctors stand helpless and meekly admit that there is neither a cure nor a vaccine for HIV infection and AIDS.

It is noteworthy that relatives of many AIDS patients do not accept the hospital discharge as the end of the road. They spend a lot of money going from one traditional healer after another. Some have sent their relatives to Zaire for the MM1 drug or to Kenya for the KEMRON drug at great expense. Once in a while some patients experience remission. Such temporary reprieves of varying duration only serve to fuel traditional healers' claims that they can cure AIDS, thereby causing another dent in the faith that people are enjoined to have in biomedicine.

Because the doctor has nothing to offer in the management of AIDS beyond the treatment of opportunistic infections, he is forced to open up to collaboration with other professionals — the clinical psychologist and the social worker.

One AIDS research project in the country has instituted an AIDS management model in which the social worker is an equal partner with the physician. She obtains the patient's consent for HIV testing, provides pre-and post-test counselling, draws the blood sample, codes the identity of the patient, labels the sample appropriately, takes the sample to the

(*) Head of the behavioural sciences department — Muhimbili medical centre, University of Dar ES Salaam



laboratory, collects the results, decodes the identity of the patient and shares the information with the doctor and the patient. Of much more importance, she works with the AIDS patient to evolve a method of coping with the disease. The physician is having to open up to real multidisciplinary team work. The question as to whether physicians and social workers can collaborate has been asked in other contexts but in the case of managing AIDS the collaboration can only enhance the quality of health care for patients with AIDS.

The individual's response

AIDS is acknowledged as posing a serious threat to global security. Even though AIDS was not the first subject for a special programme within the World Health Organisation, it was the first to feature prominently on the agenda of, and the debates in the General Assembly of the United Nations Organisation. It threatens global security in ways that the so-called tropical diseases do not. Indeed developed countries are largely immune to those diseases.

After the initial hullabaloo of reactions to racist accusations that AIDS had its origins in Africa most governments in sub-Saharan Africa launched AIDS control programmes which have health education campaigns as a major component.

In Tanzania the AIDS health education campaign is unprecedented both in terms of targeting only one disease, and in the extent to which it is a concerted multimedia and multi-sectoral endeavour. In the three years that the campaign has been running, it has created a high level of awareness of the problem of AIDS among the general population. Thus a nationwide sample survey carried out this year found that almost 100 % of the population covered were aware of AIDS and a good percentage of them knew about the salient aspects of HIV transmission, including the anomalous one of 'apparently healthy carriers' of the infection. The survey also found that over 70 % of the respondents claimed to have made changes of relevance for reducing the risk of HIV infection. Most of them said they had reduced the number of sexual partners and others said they used condoms. Some respondents reported that they no longer sought injections outside the formal health care setting. Another survey involving traditional healers which was done this year found that even these people seem to have accepted explanations about the hazards of HIV transmission inherent in scarification and use of skin piercing instruments so that they now demand that their clients bring their own razor blades or they ask them to pay for new blades that the healers provide.

With specific reference to promiscuity, perhaps it is worth noting that some observers of the social scene in Africa now see some evidence that the implications of AIDS are having an inhibiting effect on the sexual behaviour of younger, more educated people. They suggest that a new type of conservative sexual revolution is commencing. AIDS related issues have become very salient in the popular press, including the readers fora. This can only serve to raise the level of consciousness concerning the disease and how to prevent its transmission. Indeed it has been suggested that people who continue to indulge in high risk behaviour are either manifesting a death wish or they believe that they are already infected and see no point in closing the door when the horse has already bolted.

The challenge for health educators and the social and behavioural scientists working in the areas of high risk behaviour, perception of risk, explanatory models and communication for behavioural change is to identify the triggers for the kind of behavioural and social changes that will bring down the incidence rates of HIV infection.

Profound changes

It is in the nature of optimists to look for some positive thing that could come out of calamities, even the calamity of the AIDS epidemic.

Ministries of Health are increasingly becoming conscious of the fact that health education is about behavioural change, not just imparting knowledge. They are re-examining the practice of health education in different fields in order to make it effective.

AIDS has made counselling a valued service. One hopes that other areas, such as terminal care, management of chronic conditions like diabetes and hypertension, and family planning will benefit from the renewed interest in counselling services. In other words, AIDS has highlighted the shortcomings of health care delivery in general, and is forcing a re-examination of policies and practices.

Above all AIDS is forcing our societies to re-examine their values. People are beginning to wonder whether it makes sense to round up prostitutes from the streets of capital cities without addressing the factors that aid and abet prostitution. They are also wondering why it should be acceptable for 'successful' men to engage in casual sex, to have many lovers, to keep mistresses and concubines. Such behaviour is increasingly being labelled as promiscuity and hence a hazard not just to the men concerned but through them to their wives and to their unborn children.

In effect AIDS is ushering in profound social changes and not all of them constitute negative impact. ○ E.P.Y.M

Reflections on the AIDS orphans problem in Uganda

by Christine OBBO (*)

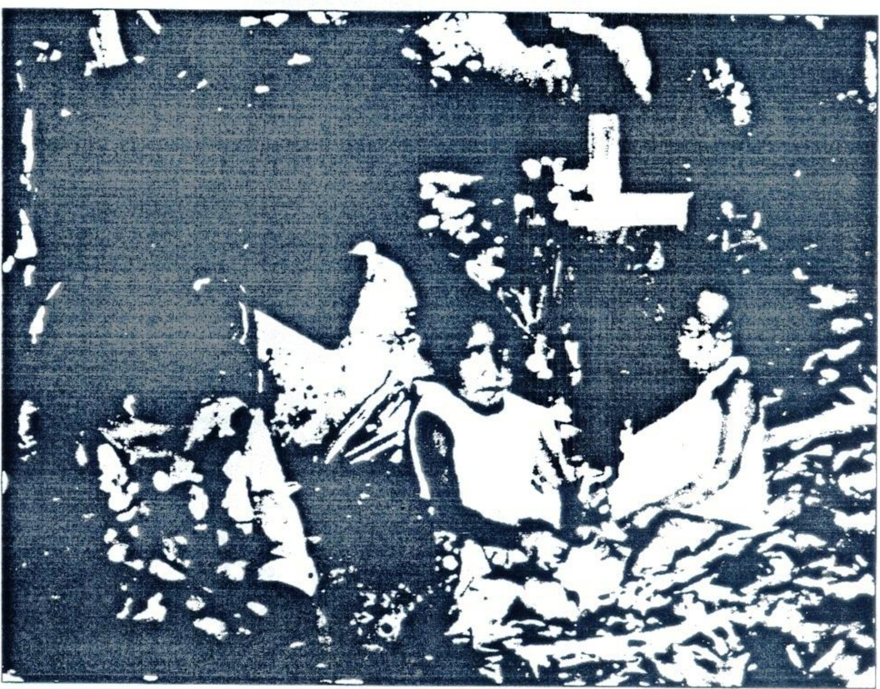
Rakai district has suffered most from the AIDS scourge and for some communities there the problem of AIDS orphans is a grave one. Rakai is just ahead in experiencing what most Uganda communities will have to cope with in the near future. The grassroots efforts and solutions will need support and invigorating from the central government. In this brief account the perspectives and visions of an amateur counsellor are reflected in the plans she persuades her clients to make when they have got over the shock and anger of being afflicted with HIV. It takes time to raise the consciousness of patients with a fatal disease to continue leading economically productive and socially meaningful lives, she finds. It takes determination and commitment to focus their attention upon the survivors — women and children. Both rich and poor need reminding to plan for the survivors.

It has been estimated that there are 24,524 AIDS orphans in Rakai (Save the Children Fund, March 1989). This study estimated that 12.6 % of all children in Rakai are orphans. That 13 % of the children under 15 years were orphans of which 48 % had lost their fathers only, and 12 % had lost mothers only, 30 % had lost both parents, and for 10 % there were no details. Children are defined as persons under 18 years of age. Officials would prefer to regard as orphans only children who have lost both parants. But the local communities define as orphans children who have lost a father or both parents because women have been outliving their husbands by six months to two years only and so fatherless children are perceived as potential orphans. The number of AIDS orphans increases daily in Uganda and the situation is going to be worse in districts where the rehabilitation of war orphans has not been completed.

The limitations of poverty

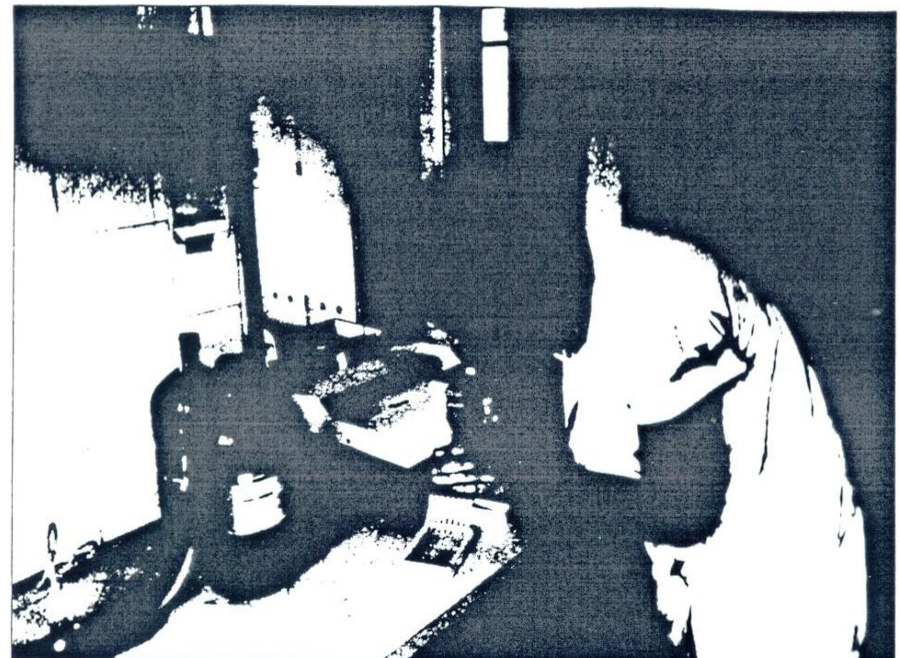
It is a widely held view that according to African tradition the extended families will absorb the orphans. The reality of the situation is that the problem is so enormous that the extended families cannot cope as they used to. Further, those afflicted with the HIV virus and dying from AIDS are in the economically productive years — 15 to 40 — and the survivors are predominantly children and elderly people whose productive capacities are low. However, the problem of orphans cannot be regarded in isolation from the social and economic changes that have taken place in Uganda in the last century. The introduction of cash crops enabled cultivators to earn money with which they could improve their material living conditions, they could pay for Western education, and they could purchase land. Those in areas not favoured by climate or official policies for cash crop production sought wage employment in other parts of the country or in towns. The result of this incorporation in the cash economy was the development of individualistic tendencies irrespective of whether people came from societies which emphasised corporate lineage land ownership and localised clan residence, or whether people came from societies in which clans were not localised and residence depended upon patron-client type arrangements. Over the years people have increasingly looked after themselves and their immediate families while minimizing their involvement in the demands of their poor relatives. The AIDS epidemic followed a decade and a half in which the Ugandan economy deteriorated so much that poverty became a reality and a threat to many families. Thus with regard to the orphans, the extended families are doing all they can but poverty limits what they can do: and in some families individualism, wealth, and personal dispositions have inhibited closeness and sharing.

A Makerere University Professor and Head of Department (hereafter called Joy), is worried about the social and economic realities of the majority of Ugandan women especially in relationship to AIDS. Women rarely control valuable resources such as land and livestock, and often have little claim or entitlement to the labour of others except their small children. As a consequence, widowhood represents impoverishment in general but in the case of AIDS widows, they may even have to pay off the debts incurred during the prolonged nursing of their husbands. Joy encourages her clients to plan in anticipation of the problems the widows or orphans are most likely to face. The following illustrative cases are taken from following Joy for a fortnight. When not at University, or meeting the demands of her young children and busy husband,



This grandmother sitting in front of some of her children's graves, is the only support for some twenty orphans

(*) Ugandan national. Associate professor of Anthropology at Wayne State University



Using ELISA tests in Uganda

Joy visits AIDS patients and survivors at the hospital or in their homes. Joy is a TASO (The AIDS Support Organisation founded in 1986) counsellor-volunteer. TASO provides pre- and post-HIV testing, advice on safe sex, positive living and good nutritional habits. It also offers practical support and training for people with AIDS and their survivors. In theory each volunteer covers a radius of 20 miles from Kampala, but in reality Joy has clients whose families live as far as 100 miles away.

Change the children's school

At Mulago Hospital, on her way to the counselling clinic, Joy stopped by the clinic to visit a 30-year old recent AIDS widower who is HIV positive and is nursing his one year old daughter with AIDS. Joy has taken him a kit with soap and bed sheets made by aids patients thanks to the donations of sewing machines and fabrics by the German Doctors' Foundation. His sister, who is looking after his two other children, is visiting and she reports that the children have adapted well to her home life and are friends with her three children. She also reports that she and her husband had had to take in three more children following the death of his sister who was survived by a bedridden husband.

At the clinic, Joy had a long session with Maria, a nurse who has tested HIV positive. She is an unmarried mother and does not want to tell her boyfriend. She threatens to commit suicide but Joy reminds her of her lovely children. (The subsequent meetings dealt with taking the children out of the expensive city school after the end of the school year and enrolling them in a village school near her mother and grandmother. Rakai district has the worst schools but it will be better than becoming working market children in the city. The village headmaster was aware of the orphan problem and has promised to commute the fees if Maria died.

One afternoon, Joy visited a bank executive in his office. George has AIDS. Mary his wife is a school teacher who does not earn much and therefore sells cloth at the market. They struggle to make ends meet. Their house accomodated six relatives whom they supported in school in addition to their four children. They occasionally visit the village relatives to take gifts to them and to see how those they support financially are getting on. All these efforts have earned 'us a right to well attended funerals but we do not expect anyone to look after our children after we are gone' according to George. He normally does things slowly but Joy had convinced him to speed up things. He has agreed to take a paid sick leave, to check and ensure that the fringe and insurance benefits are settled.

One Saturday, Joy made a 100 mile trip to attend the second funeral (a celebratory rite to ensure that the departed, spirit rests in peace) a month after her client had died. She was there, more importantly, to check on the fate of his children left with grandparents. The children are thriving and living with their four teenage uncles and aunts, the children of their grandparents who are in their 40s. The grandparents are glad to have their grandchildren. They are most concerned to ensure that the grandchildren, who are apparently very bright, get into good schools. Joy asks them to contact her if they face any problem.

The 'lucky orphans'

The issues that Joy tries to impress upon her clients seem obvious to most Ugandans but it is amazing how rarely afflicted people pay attention to them. Buying land and building a house is the dream of most Ugandans. Not wanting one's children to become uneducated destitutes is passionately shared by many people. But Joy insists that when people are faced with their mortality, they need to be reminded to shift their attention from self pity and to act in ways that would ensure the security of the survivors. An examination of the circumstances and coping abilities of different orphan families highlights the issues that Joy tries to impress upon her clients. Joy is of course aware that orphans cannot be planned for in all situations. But the following brief section shows that what parents leave in place makes a difference in the lives of orphans.

The lucky orphans are those taken by the 'extended' families but some families offer more potential for the future than others. Families of paternal and maternal aunts and uncles as well as grandparents below sixty years of age do not seem to suffer visible disruptions in their lives. These families are usually still in the child raising cycle in their lives and orphans do not constitute an assumption of new family burdens as happens in the cases of aged grandparents. Lucky orphans are also rescued by family friends. All these arrangements are traditional. In fact children are usually exchanged between families and raised in the above situation even when their parents are alive. However, mention must be made of a category not usually regarded as extended family the divorced step mothers. They have been rescuing orphans when both parents are dead and there is no one to take them. In some cases they may have had no children in that particular family and may have a new family. Again the children in these families appear happy. Hitherto it was not regarded as desirable to entrust parenting to grandparents or stepmothers because the former were indulgent and the latter spiteful.

Children alone families

An increasing number of orphans are left on their own for personal, economic and social reasons that prevent their relatives, if they are alive or live nearby, from taking them. Certain factors seem to favour the viability of 'children-alone' families left on a plot of land and in a house. The most viable families have at least a girl as the eldest child. Based on their early training in work, they manage to cook, grow food, and even make mats to generate income for basic subsistence needs and even school fees. Families with boys only or boys as elder children tend to resort to begging once the neighbours reduce the amount of help they can offer.

Viable 'children-only' families also need to be near relatives who, although they may not provide labour or other economic support nonetheless offer social and psychological support by including the children in the social celebrations. In families that are not coping well, the children typically show physical signs of lowered nutritional status. This affects their school attendance as they succumb to frequent colds and fevers.

One of the main problems faced by community leaders is providing food and medication for these children. In some active communities, Day Care Centres have been organised in the homes of widows, or in abandoned homes. Food is provided and volunteers feed and wash the children. In two instances, individuals had solicited supplies of food, clothing and medicine as well as cash and had set up informal orphanages. In one case the individual, who was a Reverend in his thirties, had managed to acquire land and set up his rescue mission which supports itself through agriculture. The officials were unaware of these until a researcher went and pointed out dangers observed in these houses.

The overcrowding in small living spaces of many children sharing a few eating and drinking utensils and toilet outlets was a health hazard. Many children had running stomachs, sore eyes and rashes on their bodies. They ate only small meals most days: except on days when members of assisting foreign NGOs were known to be coming. In both cases the individuals lacked the experience to set up good orphanages. Because the officials did not have the resources to re-allocate the orphans, some of whom had come from outside the district, the homes continue to operate but with increased support from the international NGOs. What is at issue in this instance is that there is a need to recognise that some orphans are indeed homeless and to plan for the kind of suitable home arrangements for them. The sentiment that the extended family is the ideal institution to take care of orphans under these circumstances needs to be channelled into realistic programmes. The orphans need security for themselves and their property, bodily comfort and shelter, growth through skills training and good health; and above all their social, cultural and religious needs must be fostered.

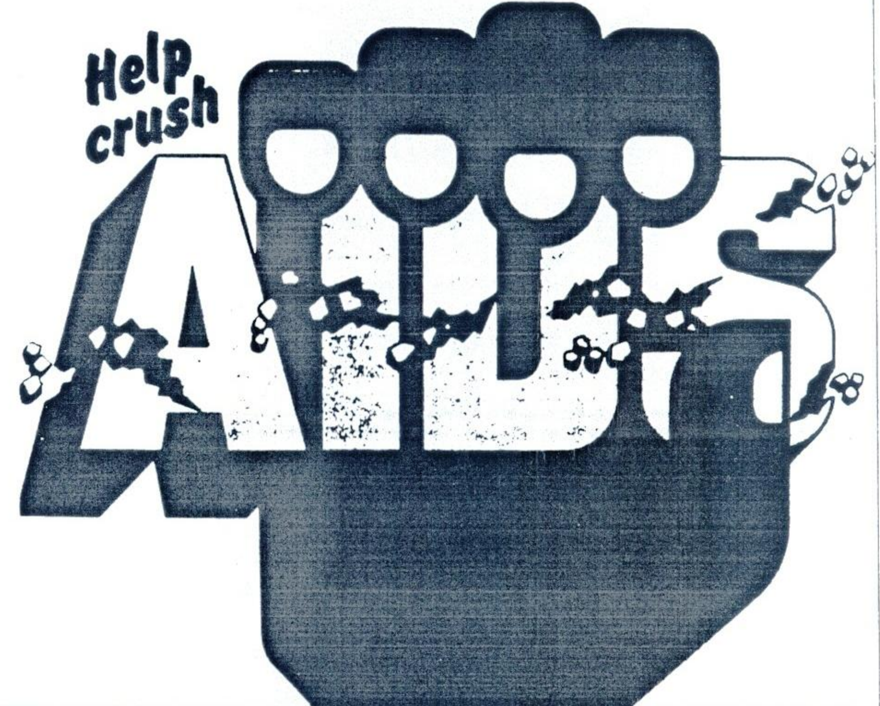
The local chapter of the Uganda Women's Efforts to Save Orphans (UWESO) together with interested Resistance Council members try to arrange for food, day care and school fees for the orphans but the few volunteers are always overworked so their impact is limited. In response to the Government's declared desire to reach the orphans through a community based system, the National Resistance Council Member for the worst hit county, Kakuuto, has proposed the formation of Orphans Community Based Organisation (OCBO) as an NGO based in Rakai which will coordinate locally the support and relief assistance programmes of the international NGOs. It will register the orphans and identify well-intended volunteers to be responsible for the orphans and to be answerable to the local Resistance Committees. C.O

2 Eneza ukweli ..sio hofu!

UKIMWI ni ugonjwa unaoenezwa katika ngono
Wanaume na Wanawake wanao shiriki ngono wako hatarini

UNAWEZA kupunguzia hatari kwa

- Kuwa na mpenzi mmoja
- Kujitenga na mapenzi ya makahaba au kwa kujitenga na wanaume wanao fanya mapenzi na makahaba
- Kutumia mfuko wa mpira au kusisitiza mwenzako autumie
- Kwa kumwona daktari mara tu unapopatwa na ugonjwa ulioambukizwa na ngono
- Kwa kusoma zaidi kuhusu ugonjwa huu na kuwafahamisha wengine juu yake



A wall poster of the Ugandan anti-AIDS campaign

Le SIDA, les femmes et les enfants: les faits

Les femmes et le SIDA

Le creuset du SIDA en tant que tragédie familiale est la femme infectée par le VIH. Sur les 6,5 millions de séropositifs recensés dans le monde, deux millions sont des femmes en âge de procréer.

La grande majorité des femmes séropositives ou atteintes du SIDA vivent dans le monde en développement, où l'infrastructure et les ressources financières nécessaires pour faire face à ce fléau qui détruit la vie familiale sont extrêmement faibles.

La femme atteinte du SIDA doit faire face non seulement à l'imminence de sa propre mort mais aussi à la menace que ce fléau représente pour sa capacité de procréation et ses responsabilités familiales. Il y a entre 25 et 40% de chances qu'elle transmette le VIH à son enfant durant la grossesse ou l'accouchement.

L'Afrique compte près de 1,5 million de femmes séropositives. Dans certains pays, de 10 à 30% des femmes vivant dans les zones urbaines sont infectées. Selon les estimations de l'UNICEF, chaque femme qui meurt du SIDA laisse en moyenne deux orphelins. Comme c'est essentiellement la mère qui s'occupe de l'alimentation, de l'habillement et de l'entretien de tous ses enfants, sa mort a d'énormes conséquences sociales et économiques pour les orphelins, et pour le mari s'il est encore en vie.

Les enfants et le SIDA

Les enfants déjà infectés par le virus du SIDA à la naissance ont 25% de chances de mourir avant l'âge d'un an et 80% de mourir avant l'âge de 5 ans (estimations de l'OMS). Bien qu'il soit difficile de diagnostiquer avec certitude l'infection à VIH durant les premiers mois de la vie, les taux de mortalité des enfants nés de mères séropositives sont systématiquement plus élevés que ceux des enfants dont la mère n'est pas infectée.

A six mois au plus tard, l'enfant contaminé cesse de croître ou commence à perdre du poids parce que son organisme est incapable d'assimiler efficacement les nutriments. Il devient anormalement susceptible aux maladies de l'enfance (maladies diarrhéiques et infections respiratoires aiguës), mais son organisme est moins à même de se défendre ou de réagir au traitement.

Bilan mondial du SIDA chez les femmes

Deux millions de femmes en âge de procréer sont maintenant infectées par le VIH. La plupart sont des femmes mariées qui ont une vie de famille tout à fait normale et cherchent à satisfaire les besoins et espérances du couple. Parmi les prostituées et les toxicomanes qui se droguent par voie intraveineuse, le taux de séropositivité peut atteindre 50%.

Proportion de femmes infectées par le VIH

Il y a dans le monde 1,25 milliard de femmes âgées de 15 à 49 ans, dont en moyenne 160 sur 100 000 sont séropositives. La proportion de femmes infectées varie considérablement d'une région à l'autre.

Nombre de femmes infectées sur 100 000

140	Amérique du Nord
200	Amérique du Sud/Caraïbes
70	Europe occidentale
5	Europe orientale
20	Afrique du Nord/Moyen-Orient
1,500	Afrique subsaharienne
5	Asie
70	Océanie

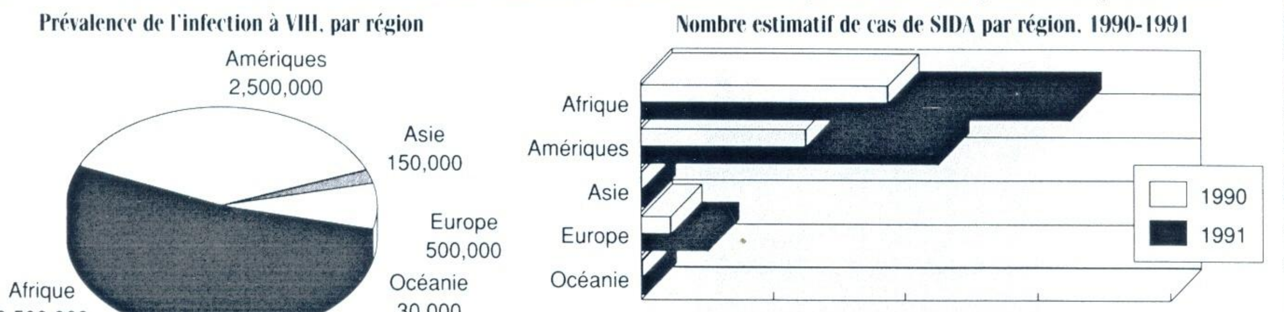
Nombre total de femmes infectées (estimations)

100,000 Amérique du Nord
60,000 Europe occidentale
4,000 Europe orientale
10,000 Afrique du Nord/ Moyen-Orient
30,000 Asie
4,000 Océanie
200,000 Amérique du Sud/ Caraïbes
1,500,000 Afrique subsaharienne

Source: OMS

Le VIH et le nombre croissant de cas de SIDA

Il y a aujourd'hui dans le monde 6,5 millions de personnes infectées, dont la moitié vivent en Afrique, le tiers dans les Amériques, et le reste dans les autres régions. L'OMS estime que les séropositifs sont dix fois plus nombreux que les malades du SIDA, la période d'incubation pouvant durer plus de 10 ans.



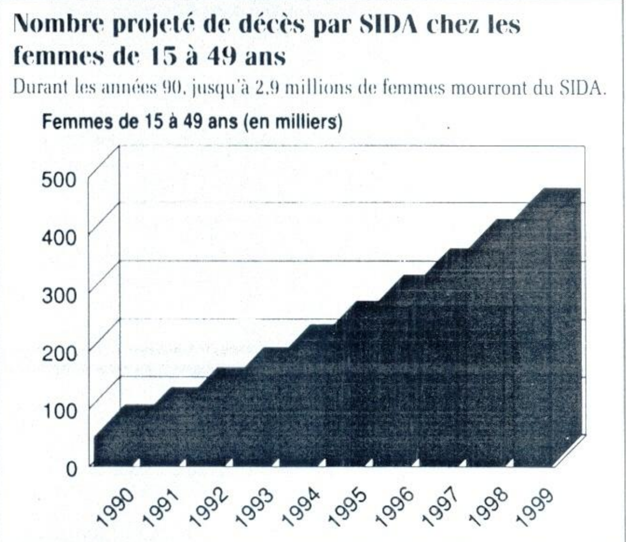
Source: Dossier SIDA mondial de l'OMS, mai 1990

La désintégration prochaine de la vie familiale en Afrique

Dans 10 pays d'Afrique du Centre et de l'Est, les progrès récemment accomplis dans le domaine de la survie des enfants risquent fort d'être réduits à néant par les ravages du SIDA, qui provoqueront durant les années 90 une augmentation sensible de la mortalité chez les femmes et les enfants de moins de 5 ans.

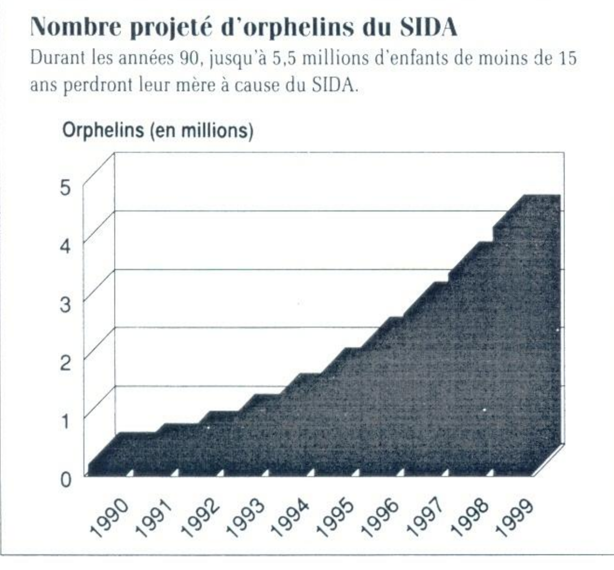
Nombre projeté de décès par SIDA chez les femmes de 15 à 49 ans

Durant les années 90, jusqu'à 2,9 millions de femmes mourront du SIDA.



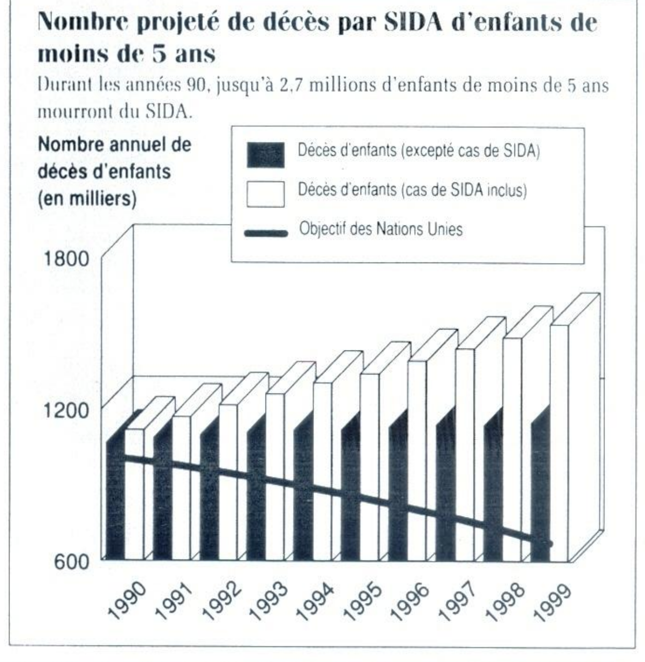
Nombre projeté d'orphelins du SIDA

Durant les années 90, jusqu'à 5,5 millions d'enfants de moins de 15 ans perdront leur mère à cause du SIDA.



Nombre projeté de décès par SIDA d'enfants de moins de 5 ans

Durant les années 90, jusqu'à 2,7 millions d'enfants de moins de 5 ans mourront du SIDA.



Source: Social Science & Medicine, Vol. 31, No. 6, 1990.

"La mère atteinte du SIDA doit essayer de s'assurer que sa mort prochaine ne ruinera pas l'avenir de ses enfants."

médical, mais être aussi axés sur de nombreux autres aspects du problème. Dans la plupart des cas, elle doit compter sur une parente - mère, soeur, fille ainée, ou autre épouse de son mari - pour la soigner et l'aider à s'occuper de ses enfants. Lorsque ses forces déclinent, elle a également besoin d'une aide pour les activités économiques et les tâches ménagères: entretien de la maison, approvisionnement en eau et en combustible, travaux agricoles et stockage des aliments destinés à la famille.

Enfin, la femme atteinte du SIDA porte un lourd fardeau sur le plan psychologique. On lui reproche souvent injustement le malheur qui s'est abattu sur la famille, et les réactions d'ostracisme dont elle est l'objet. Alors que ses forces faiblissent, elle doit vivre avec la certitude que sa mort compromettra les perspectives d'avenir de ses enfants. Dans beaucoup de familles, les enfants dépendent de leur mère non seulement pour les soins dont ils ont besoin, mais aussi pour leur alimentation, leur habillement, les frais de scolarité et autres dépenses. D'une manière ou d'une autre, la mère atteinte du SIDA doit essayer de s'assurer que quelqu'un s'occupera de ses enfants et que sa mort prochaine ne ruinera pas leur scolarité ni leur avenir.