

How can we assist in the fight against AIDS in Africa?

by **Brendan Mc Namara***

1. Background

We have witnessed dreadful tragedies in the opening years of this millennium - 9/11, Darfur, wars in Iraq and Afghanistan, famine in Africa, the Tsunami, hurricanes in the Caribbean and in the Southern States of the USA, the earthquake in Pakistan. Bad as these were, they are overshadowed by the continuing ravages inflicted by the AIDS pandemic on the peoples of the developing world. Not since the Black Death hit Europe in the 14th century has the world experienced such human devastation. Its worst effects are seen in Sub-Saharan Africa and in India but recent reports indicate that the disease is also on the increase in China, Burma, Russia and Eastern Europe.

Since 1981, more than 25 million people have died of AIDS related diseases, 3 million in 2005 alone. 5 million were infected in the past year bringing total cases to over 40 million. 45 million new infections have been projected in the period to 2010. 6,000 children a day are infected, mainly through mother-to-child transmission.

No cure for AIDS is in prospect, although the impact of the disease may be delayed, sometimes for many years, by antiretroviral (ARV) drugs that are now widely available in developed countries but much less so in Africa and other Third World countries.

The AIDS Syndrome (*Acquired Immunodeficiency Syndrome*) was first reported in 1981 while 2 years later HIV (the *human immunodeficiency virus* which causes AIDS) was identified. At that time, the virus was mainly associated in the US with male homosexuals and drug addicts. Increasingly, however, women have become infected over the years and, in Sub-Saharan Africa, account for most of the victims of the disease. Heterosexual contact is now the principal source of infection, notably in developing countries.

AIDS manifests itself through attacking the immune system leaving the infected person open to attack from other infectious diseases such as malaria and tuberculosis and, indeed, other sexually transmitted diseases, all of which are rampant in developing countries. Another important factor adding to vulnerability is the widespread poverty in Third World countries.

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The epicentre of the AIDS epidemic is South Africa where:

- 6.4 million of the total population of 46 million are infected¹, 57% of them women;
- The rate of infection rose from 1% to 25% of the population in the decade to 2000;
- One third of pregnant women are HIV positive;
- The country has over 600,000 AIDS orphans;
- Without AIDS, life expectancy at birth would be 64 years. With HIV/AIDS, it was 51 years in 2004. Without an active programme of ARV drugs, it will be 48 years by 2015. About 85% of those infected have not so far received ARV drugs. UNAIDS has estimated that if current infection rates continue and there is no large scale treatment programme, up to 60% of to-day's 15 year olds will not reach their 60th birthday.

2. The social and economic impact of AIDS

Statistics, however, reveal only the tip of the iceberg of the disaster. Behind each person living with HIV/AIDS are a family and community who share in the suffering of the infected person. Since AIDS is predominantly a disease of young people – half of new infections occur in the 15-24 age group, its impact on society is immense. Families are broken up by the illness and death of parents. Older children are landed with the responsibility of caring for younger siblings and, as a result, often miss out on education.

A huge social stigma attaches to the disease in Africa. This has contributed to an undermining of the strong protective extended family tradition that characterised the continent up to now. Stigma and discrimination simultaneously reduce the effectiveness of efforts to control the global epidemic and create an ideal climate for its further growth.

Economic activity in the community is disrupted by high incidence of absenteeism and rapid labour turnover. Special worker training programmes are necessary to replace skilled personnel who contract HIV. Families headed by children are less likely to develop the skills that will reinvigorate the weakened public sector. The AIDS crisis is emptying the African fields and reducing the supply of food, a supply that is already under threat due to famine conditions in parts of Southern Africa. It has been estimated that incomes in Southern Africa will decline by half over the next three generations.

At the root of the AIDS crisis in Africa is a macho culture in which men are frequently promiscuous from their early teens; where, as in Southern Africa, many men spend long periods working away from home and return to their families as carriers of the disease. HIV either by rape, By contrast, women are subservient to their men folk and are at high risk of contracting the disease by rape, which is widespread, or by normal conjugal relationships.

¹ There is some dispute as to total numbers infected in South Africa. The figure quoted is that recently provided by the country's Dept. of Health.

It is little wonder that Archbishop Desmond Tutu has referred to AIDS as the “*new apartheid*” with its “*devastating consequences on individuals and society... the end of this plague is still not in sight; the worst still lies ahead of us*”²

3. Possible actions to help relieve the AIDS crisis

Actions for assistance of those living with HIV/AIDS can be categorised under 4 broad headings:

- Prevention,
- Treatment,
- Support,
- Anti-poverty measures

3.1 Prevention

The main causes of the spread of HIV in Africa are a combination of ignorance and perverse cultural behaviour. Education is necessary to inform the target population of the risks of indiscriminate sex and of the need to change behaviour in order to avoid HIV infection. Young men must be weaned away from irresponsible sexual behaviour while women, single and married, must be empowered to resist sexual pressures that put them at risk of infection. Older, married men must avoid transmission of disease to their wives. Means other than prostitution must be found to assist young women with family responsibilities caused by AIDS to put bread on the table for their younger siblings. Children must be protected against abuse that puts them at risk of HIV infection.³

Actions to prevent infection involve programmes of education of both children and adults, counselling and guidance programmes, publicity and advertising campaigns, all designed to inform the target groups of the nature and dangers of HIV/AIDS and to bring about changes in lifestyles and sexual behaviour. Such programmes have already contributed to significant reduction in HIV infection in Uganda⁴

Active government policies aimed at preventing AIDS are essential. Unfortunately, the present government of South Africa has consistently dragged its feet on the AIDS issue and President Mbeki has, up to recently, demonstrated almost total denial on the whole question of AIDS, notwithstanding that his country is at the heart of the crisis.⁵

3.2 Treatment of HIV/AIDS

Treatment of those infected with AIDS involves diagnosis, distribution of retroviral drugs as well as hospital and hospice care. Diagnosis is a major issue in communities where the

² Cf. Foreword to “AIDS and South Africa – the Social Expression of a Pandemic” ed. KD Kauffman & DL Lindauer. Palgrave Macmillan 2004.

³ One of the myths in Africa is that sex with a virgin will cure AIDS!

⁴ There are new worries that rates of infection in Uganda are again rising.

⁵ Cf. Virginia van der Vliet “South Africa Divided against AIDS: a Crisis of Leadership” in “AIDS

knowledge and awareness of the disease is poor. Improved information as part of a prevention programme should focus greater attention on diagnosis.

The major treatment issue is the distribution and control of ARV drugs. Until recently, these were too expensive in developing countries, but are now becoming increasingly available. There is a massive need for such drugs. In Sub-Saharan Africa as a whole, 3.8 million people need treatment but, as of June 2005, only 500,000 were being treated.

There are considerable obstacles in the way of implementing an ARV programme. First, there are issues surrounding the choice of drugs to be used, including the substitution of drugs where those originally used become ineffective as a result of mutation of the HIV infected cells. The control of those drugs to ensure observance of the strict disciplines to be observed by patients in respect of the treatment is another problem. In undertaking decentralised treatment programmes, special importance attaches to prevention of mother-to-child transmission of HIV.

The difficulties involved in managing the roll-out of ARV therapy are complicated by the shortage of medical and nursing personnel – in 2001, some 25,000 South African health professional practitioners (10% of those registered) were working overseas. The position is particularly serious in remote rural regions where lifestyles are difficult. Doctors and nurses are not attracted to such areas. The Church in South Africa is now playing a significant rôle in implementation of ARV therapy.

In order to fill the gap in medical personnel, the international NGO, Médecins sans Frontières (MSF), which has AIDS clinics in both urban and rural areas in South Africa has proposed⁶ the training of semi-skilled people in the various tasks involved in ARV treatment – ARV adherence counsellors, pharmacists' assistants, clinic volunteers to do home-based care, voluntary counselling and testing, general clinic supporters. Other problems identified by MSF include the inefficiency of the pharmaceutical system, the need to develop management capacity at district level, training needs, simplified data management. As part of their work, MSF has developed a system of networking with other programmes, generation of a community response, mobilising the youth sector, participation in the treatment action programme against sexual violence.

3.3 General Support for those living with AIDS

As stated earlier, behind each person infected by HIV/AIDS is a tragic human situation. The havoc wreaked by the epidemic calls for a whole series of back-up supports – counselling, protection of vulnerable people, including young women on whom the care of families has been thrust, care of orphans, provision of necessary infrastructures, including day care centres, hospices.

The problem of orphans and vulnerable children (OVC) is particularly poignant. The following are some extracts from the UNAIDS 2004 report on the subject:

⁶ In MSF report “The experience from Lusikisiki. Activity Report 2003-2004”.

“Even those who work with orphaned children struggle to understand the emotional anguish a child experiences as he or she watches one or both...parents die...children often lose both parents in quick succession. An orphan’s caregivers may also succumb to AIDS with the result that children may suffer multiple bereavements. The child’s suffering is often complicated by being separated from...siblings”. Is it any wonder that *“many experience depression, anger, guilt and fear for their futures”* leading to serious psychological problems such as post-traumatic stress syndrome. The report continues *“Without the protective environment of their homes orphaned children face increased risk of violence exploitation and abuse...Ensuring access to education is critical...”*

A number of programmes are in operation in Catholic dioceses in South Africa in which groups of volunteer women provide home-based care for those infected with HIV/AIDS as well as for OVCs, many of whom are also infected. These programmes have, however, only basic facilities and need to be considerably extended. The Irish NGO, Friends in Ireland has, in association with MSF, initiated a medium term programme for provision of hospice and day-care centres in South Africa. These centres will be managed locally by faith-based bodies. The programme has been planned, and its implementation inspired and funded, by a small group of people living and working in Ireland.

3.4 Alleviation of Poverty

Grinding poverty goes hand in hand with disease and never more so than in the case of AIDS. Sub-Saharan Africa, the centre of the AIDS pandemic is also among the poorest regions in the world. Over 300 million people there live in extreme poverty (i.e. on incomes of less than 1\$ a day). A further 500 million have incomes of between \$1 and \$2 a day⁷. Actions for relief of HIV/AIDS must be accompanied by programmes for alleviating the awful burden of poverty. Help is needed in the form of money and assistance in developing economic projects. Provision of training facilities is needed for development of economic, social and technical skills; encouragement of business opportunities; promotion of trade and tourism can all contribute to the relief of poverty.

4. A new call for missionary action

The HIV/AIDS epidemic provides a new dimension to the problem of Third World development. If ever there was a missionary need, it is for the supply of trained people – doctors, nurses, teachers, builders, tradesmen and tradeswomen - to help raise up the people in Sub-Saharan Africa and elsewhere in the developing world who are being decimated by the curse of AIDS. The Irish rightly pride themselves on their missionary tradition. For well over a century we sent priests, nuns and other religious in large

⁷ Cf S.Chen & M Ravallion “How have the World’s poorest fared since the early 1980s?”; World Bank Observer Vol.19, No.2, Autumn 2004.

Although South Africa is classified statistically as an upper middle income country, the distribution of income and wealth there is among the most unequal in the world. 65% of the population – mostly black – are trapped in poverty (defined as incomes of less than \$55 per month). Most of these live in the urban “townships” or in the rural “former homelands” to which black people were banished under the apartheid régime.

numbers to participate in the conversion of Africa, Asia and Latin America. Apart from their pastoral roles, these courageous people contributed massively to the education of the local peoples and to the caring of those living in poverty and in need of medical attention. Sadly, however, the supply of Irish missionaries has dried up. To replace them in part, we now have a flow of expertise in the form of those working for non-governmental agencies. NGOs such as Trocaire, Concern and Goal are at the heart of the efforts to address the humanitarian problems of the developing world. However, given the gravity of the task of dealing with extreme poverty and of provision of assistance to peoples devastated by disease, wars and natural disasters, what the best efforts of NGOs can provide in terms of personnel is relatively small. As for the rest of us, while we are only too willing to provide voluntary donations to support the work in developing countries, when it comes to people, we are no longer in the van. Some efforts are being made by individuals and groups to build accommodation for the poor affected by AIDS, to provide hospice care and day care centres, to facilitate medical research and training of doctors, nurses and paramedical personnel. Such assistance while welcome, is, however, too little. We are faced also with the dilemma that key medical and teaching personnel who might be made available for anti-AIDS activities are also in short supply here.

The question is how can we as Christian communities help reinforce existing efforts and provide new ones? Could individual parishes in Ireland through linking up with dioceses and parishes in Africa sponsor activities aimed at helping deal with the HIV/AIDS problem? A number of Irish parishes and communities are already twinned with communities in developing countries. These usually emanated from contacts with Irish religious working in these countries. They focussed, at least initially, on raising money for Church development. In some cases, the emphasis changed over the years to educational and cultural projects and, with greater knowledge of the problems of the developing country, to economic support and relief of poverty.

What is proposed here involves focussing twinning actions on HIV/AIDS. In doing so, it is useful to contrast our relative strengths now with those that prevailed in the past. The missionaries in the last century depended largely on their own resources – apart from family and religious order help – in carrying out their work. Levels of education were relatively low here and communications with developing countries were poor. By contrast, parishes in Ireland to-day – notably many urban parishes - consist of highly educated people covering a wide range of professions and skills. Communications are vastly improved - internet access, good, cheap telephone links, relatively inexpensive travel. Suitably organised, these advantages could be put at the disposal of AIDS relief projects in developing countries. Moreover, organisation and implementation of twinning programmes can, to a considerable degree, be managed from Ireland.

Development of parish twinning would demand establishment of suitable organisational structures within parishes here and, depending on the number of parishes involved, possibly at diocesan levels. At parish level, it is envisaged that a group would be set up in each parish to select a parish/diocese in Africa with which they would wish to be twinned. Following consultation with the African parish and local bishop, the group would then prepare an outline strategy for the work to be undertaken. This strategy

should cover such matters as finance, possible projects to be developed, inventories of skills that might be put at the disposal of the project and possible involvement of people with those skills. Implementation of the strategy would demand the start of a consultation process with all those involved – those on the ground, public and voluntary agencies, as well as Church authorities- leading to the preparation and implementation of appropriate action plans.

An overriding principal in developing a twinning programme is that assistance from us in relation to all anti-AIDS programmes must recognise the need to empower local people to solve their own problems. In announcing in 2002 their policy on HIV/AIDS, the Catholic bishops of Southern Africa stated:

*“Local initiatives are key. Local communities know what they are able to offer... Imported programmes often fail because they fail to address local conditions... Local initiatives need encouragement, capacity building and financial support..”*⁸

5. Conclusion

The AIDS pandemic is the greatest human crisis facing the world to-day. Its centrepiece is in Southern Africa and survival of that region demands massive resources from the rest of us, not least from the Irish people who have a long tradition of working in developing countries, notably in Africa. What is proposed here is that the institutional Church in Ireland should establish, in close association with its counterparts in Southern Africa, a programme for twinning parishes in Ireland with those in the countries in Southern Africa aimed at helping in the fight against AIDS. In organising parish twinning programmes, it would also be worthwhile to involve other Christian communities in participating parishes.

⁷ Cf. www.Cafod.org.uk