

INTRODUCTION

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The HIV/AIDS epidemic – the epidemic of Acquired Immune Deficiency Syndrome that results from infection with Human Immunodeficiency Virus – is perhaps the worst crisis facing Africa today. Within the last twenty years this fatal disease has spread to every country on the globe. By the end of 1998 it had taken the lives of almost 14 million people. A further 33 million were living with the virus, 22 million of whom were in Africa.

More than any other disease, HIV/AIDS is as much a social as a medical problem. Primarily transmitted through one of the commonest human activities, sexual intercourse, it brings protracted illness and early death to men and women in the prime of their lives, kills newborn children and leaves their older brothers and sisters in emotional and physical misery. The epidemic feeds on the deep divisions within our societies – illiteracy, ignorance, poverty and inequality between the sexes – and deepens those divisions by making our communities poorer.

In all but a few countries, the response to AIDS has been inadequate. Millions of men and women who are fully aware of the threat of HIV are unwilling or unable to protect themselves and their partners. Community, religious and political leaders have failed to understand the extent and the complex nature of the epidemic and have failed to provide the leadership required to protect their citizens' lives and livelihoods. And all too often the reaction towards those affected by the disease has been fear, hatred and contempt instead of the compassion and assistance that they and society as a whole require.

Since the beginning of the epidemic, the media have both reflected and moulded the

often confused response to AIDS, sometimes spreading fear and hostility, sometimes providing cool and accurate analysis. All too often the media have reported uncritically the statements of governments, non-governmental organisations and individuals. This can change. At the start of a new millennium, there is an opportunity and a need for all the media to provide the leadership that will encourage the public and the leaders of our communities to take positive steps to overcome this disease.

These steps will differ from country to country. There are many Africans, from farmers on the banks of the Nile to miners in the Copperbelt of Zambia, from prosperous businesswomen to homeless and impoverished refugees, from the active young to the resting old. Our cultures, languages, traditions, landscapes and histories are rich and varied; our potential without limit. This resource book cannot reflect such variety and wealth; it can, however, speak to our common humanity, helping us to share our experiences and unite our response. HIV/AIDS can be defeated; it needs only the common will to do so.

HIV: WHAT IT IS, WHAT IT DOES

HIV is a virus – an organism too small to be seen by the naked eye. Viruses survive by entering and reproducing within the living cells of larger organisms. HIV belongs to the class known as retroviruses, whose reproduction is based on RNA (ribonucleic acid) rather than DNA (deoxyribonucleic acid).

HIV enters and replicates within a type of blood cell called CD4 cells. These normally form part of the body's immune system, circu-

lating in the blood and attacking disease organisms. As it replicates, HIV destroys CD4 cells, reducing the body's immunity to other diseases. Eventually these other diseases, known as opportunistic infections, overcome the body's resistance and the patient dies. Although an individual whose immune system has been compromised by HIV is subject to any disease, some opportunistic infections are more common than others. These include *Mycobacterium avium* complex (MAC), which causes tuberculosis; *Pneumocystis carinii*, which causes a severe form of pneumonia; herpes viruses; toxoplasmosis and a range of bacterial infections.

Although tests are available to indicate whether an individual has contracted HIV, they are not widespread in many parts of Africa. That means that many people only discover they have contracted the virus when they fall ill with an opportunistic infection which may not respond to regular treatment. Others learn the fact when a recently born child falls ill. Because the virus can be transmitted from mother to new-born, diagnosis of AIDS in the infant confirms that the mother, and probably also the father, is HIV-positive – living with the virus. Depending on the severity of the illness and on how far advanced the HIV infection is, the individual may recover. Inevitably, however, with their immune system weakened, without treatment they will fall ill again and eventually die.

HARD TO CATCH

It is not easy to contract HIV. The virus has to enter the body through the bloodstream and that only occurs in clearly defined circumstances. The commonest is sexual intercourse, when the virus in seminal fluid enters the bloodstream through the mucous membrane of the vagina or rectum, or when the virus, present in vaginal fluid or in blood in lesions in the rectum, enters tiny lesions in the penis. Worldwide, about 90% of cases of transmission occur this way.

HIV can also be transmitted from a mother with the virus to her new born child in the womb, during birth or through breast-feeding.

There is a 25% to 40% chance of this happening. That figure is significantly reduced if the mother takes Zidovudine (AZT – other drugs are also under development for this purpose). About 3% of cases worldwide are the result of mother-child transmission; the rate in Africa is about 8%.

HIV can also be transmitted in transfusions of blood products if they are not screened (tested) and through injections of medicinal or recreational drugs if the injecting equipment is not sterilized. It can also be transmitted in any other situation where the blood of an individual with the virus enters another's bloodstream. This occasionally happens in hospital accidents, when a syringe with infected blood accidentally pricks a nurse, doctor or other patient. It may happen during shaving and male or female circumcision (also known as genital mutilation) if the cutting implement is not sterilized between use. It can also be the consequence of a road or other accident where several people's blood is spilled.

The virus is not transmitted by mosquitoes, bed lice or other insects, nor by sharing cooking or eating utensils, nor by physical contact such as hugging, kissing or sharing a bed, toilet facilities or other aspects of home life.

SEX AND RISK

Even though sex is the commonest means of HIV transmission, it does not occur in every sexual act. A number of factors influence whether or not the virus will pass from one person to another and it is impossible to estimate the extent of the risk in each individual act of intercourse. All that can be said is that the more often an individual has unprotected (without a condom) sex with a partner with HIV, the more likely they are to contract the virus.

In general, however, in any act of intercourse a woman is more liable to contract HIV from a man with the virus than vice versa. This is because the virus is present in greater quantities in semen than in vaginal fluid and because the epithelium (the layer of cells) of the vagina and cervix appear more subject to minuscule rup-

tures than the penis. In the absence of other factors, such as other sexually transmitted infections and how recently the infected partner contracted the virus, a woman is twice as likely to contract HIV during vaginal intercourse than a man. Anal intercourse – which is practised by men with women as well as with other men – is a much higher risk for both partners.

The presence of sexually transmitted infections (STI's, often known as STD's), such as chancroid or gonorrhoea, which result in sores or lesions, significantly heightens the risk of infection. The rapid spread of the virus in much of Africa is at least partly the result of high rates of untreated STI's; in 1996, there were 65 million cases of treatable STI's in Africa, representing one case for every five adults on the continent.

THE ROOTS OF AN EPIDEMIC

Diseases, like plant and animal life, evolve. Every so often a virus that has lain dormant or undiscovered for years suddenly appears: recent examples include legionnaires' disease, first observed in the United States in 1976, and Ebola, discovered in the same year in Zaire.

We may never know the point at which HIV ceased to be a harmless virus infecting Central African chimpanzees to become a worldwide killer of men and women. The first cases of AIDS were reported in June 1981 in the United States and in 1983 in Uganda, but there is evidence to suggest cases in the United States in 1969, in Europe in the 1950's and in what is now the Democratic Republic of the Congo in 1959. More speculatively, there are suggestions of HIV infection in different parts of Africa dating back to the 19th century. There is no truth in the rumour that the virus was artificially created – it has existed since long before the development of technology to manipulate genetic material.

In the early days it was suggested that specific groups of people – gay men in the United States, sex workers (prostitutes) in Africa and African men and women in Eastern Europe and South Asia – were either “responsible” for the epidemic or were the only people who could

contract the disease. In fact HIV can be contracted by anyone who has sexual intercourse or comes into contact with contaminated blood, and experience has shown that the result of allocating “responsibility” for AIDS is often to lull those most at risk into a false sense of security.

THE GLOBAL EPIDEMIC

By mid-1999 HIV had spread to every country on the planet. Sex between men is the predominant means of transmission in some countries, such as the United States and the Scandinavian countries. In other countries or regions, such as Russia or the state of Manipur in India, shared syringes or needles in recreational drug injection are the predominant means of transmission. Worldwide, however, the virus is most often transmitted during sex between men and women.

Because women are physically more vulnerable to HIV than men, and because men, on average, have more sexual partners than women, the rate at which women worldwide are contracting the virus is rising faster than men. Between 1997 and 1998, the number of men believed to be living with HIV rose by 7% (from 17.2 million to 18.4 million); in the same period, the number of women with HIV rose by 13% (from 12.2 million to 13.8 million).

Geographically, the epidemic is worst in Africa, with up to one in four adults in some cities being HIV-positive. Rates in Asia are much lower, with perhaps fewer than one in 100 adults living with HIV, but the speed with which the virus is spreading and the far greater population in Asia suggests that, unchecked, the epidemic may equal the intensity of Africa and surpass it in terms of numbers affected sometime in the next 20 years.

Elsewhere, numbers are static or increasing more slowly. In North America roughly one in 200 adults has contracted the virus, compared to one in 400 in Western Europe. Rates in Latin America are similar to North America and hover around one in 1,000 adults in the rest of the world.

AFRICA AFFECTED

In 1998 alone, 4 million adults and children in sub-Saharan Africa contracted HIV and by the end of the year almost 23 million people were believed to be living with the virus, a million of whom were children. Across the region, 8% of adults – approximately one in twelve – were HIV-positive.

These figures mask substantial differences between countries. In terms of intensity of the epidemic, Southern Africa is worst affected with up to one in four men and women between the age of 15 and 50 being HIV-positive in some areas. In terms of absolute numbers, South Africa was worst affected by the end of 1997 (the latest date for which country estimates are available), with 2.9 million people living with the virus. Ethiopia followed with 2.6 million and Nigeria had 2.3 million.

In North Africa and the Middle East the figures were much lower: 19,000 new infections in 1998 and a total of 210,000 living with the disease. About one in 800 adults in the region were believed to be HIV-positive.

MEN, SEX AND POWER

The spread of HIV primarily depends on patterns of sexual behaviour – how often men and women have sex and who they have sex with. Not everyone's sex life is the same and patterns of sexual behaviour are strongly influenced by social, cultural and psychological factors over which men and women have little control. In addition to sexually transmitted infections, described above, two factors in particular lie behind the epidemic in sub-Saharan Africa and many other parts of the developing world: male attitudes and poverty.

Concepts of masculinity are changing. Nevertheless, men are generally expected to be strong, to be leaders, to be the primary provider of their families' food and shelter and to defend themselves, their families and their societies from aggressors. Virility – the ability to perform sexually – is an essential component of masculinity in almost every society. Young men are expected to prove their sexual prowess and there is wide-

spread belief that a man's need for sex is beyond his control. For many men anything that appears to interfere with their sexual lives, such as an appeal to abstinence or use of a condom, is a threat to their masculinity.

Impelled by these attitudes, men, on average, report more sexual partners than women. In a study of 12 African cities, men reported casual sex (with more than one partner in the previous 12 months) up to 18 times more frequently than women. The implications of this are that women are likely to contract HIV but less likely to transmit the virus to other sexual partners while men are more likely to contract and transmit the virus. In the long-term, this means that more women than men will contract HIV.

Compounding this situation is the fact that many men do not consider sex as a consensual activity; sex has to take place when the man decides and without a condom if he chooses. Wives are often beaten or ejected from their home if they refuse to submit to their husbands and many women are at risk outside the home. South Africa sees an estimated 1.3 million rapes a year – one for every nine sexually active men. In such circumstances, many women find it impossible to protect themselves from infection with HIV or other STI's. [Rape is not confined to women: in prisons or other single sex environments some men rape other men either as a substitute for sex with a woman or to establish power over their victim. In other situations, however, sex between men may be an expression of mutual desire or the result of one's desire and the other's financial need.]

Not all men behave this way – at any one time only one in three or one in four men have casual sexual relationships. Some men respect their partner's wishes, and factors such as lack of confidence prevent other men from having frequent sex without protection. It is, however, this general expectation that men can insist on intercourse on demand and without use of a condom, which places both men and women at risk of infection. Men do not protect themselves because male attitudes tell them not to; women do not protect themselves because men do not allow them to.

WOMEN AFFECTED

Women are affected by HIV/AIDS, directly through their vulnerability to the disease and the fact that they may pass the infection to their newborn children, and indirectly in many ways.

Women are the chief carers in a community, both in hospitals and the home; they are often expected to take such a role even when they themselves are sick with HIV. Women whose husbands die of AIDS may be expelled from their homes accused by the man's family of causing his death even when, as is most likely, the man contracted the infection elsewhere and passed it to her. Old women find themselves taking care of grandchildren when their sons and daughters die, at a time when they expected to be looked after in their old age.

Women who challenge the status quo, by raising the issue of women's vulnerability and trying to organize means of prevention, may be accused by men of addressing issues that the leaders do not consider appropriate or which threaten the status of men as community leaders.

THE IMPACT OF POVERTY

Poverty exacerbates the inequality between the sexes in a number of ways. Unable to find a steady independent income, many women enter sexual relationships they would not otherwise choose.

Many women who are single or widowed, or whose husbands have migrated in search of work, find it difficult to provide themselves and their children with food, shelter and clothing without the assistance of men. Some men provide gifts in exchange for sex, but usually on their terms. This exchange can take many forms. The couple may be a sex worker and her client, a teenage girl and a businessman who pays for her school uniform or books, a middle-aged widow and a migrant salesman who visits her two or three times a month or any other situation where a woman's need matches a man's desire. For some, the relationship will be no more than the exchange of sex for money, but for others there may also be a long-term emotional bond.

Poverty leads many men and women to migrate in search of work, to cities or large projects in their own country or abroad, in formal or informal employment. In new environments, separated from families and friends, where the language and culture may be very different, sex may provide a means of alleviating loneliness for both men and women or a much-needed source of income.

THE BURDEN OF STIGMA

Perhaps the greatest problem confronting those living with HIV and those working in AIDS care and prevention is the stigma attached to the virus that arises from the powerful combination of disease, apparent illicit sexual intercourse and death. Stigma prevents many from recognizing they are at risk of infection; it prevents many others from admitting they are HIV-positive, which in turn prevents them from seeking physical and psychological support and from protecting their partners; and stigma prevents a compassionate response from individuals and society at large to the disease.

Stigma feeds on itself. Fear of saying "I have HIV" leads to denial and adds to the secrecy and shame that surround the disease. Denial too feeds on itself; the more people who deny they have HIV or are at risk, the easier it is to believe that society itself remains unaffected, even when hundreds a day are dying of the disease.

A few women and men, such as the Ugandan musician Philly Lutaaya in the late 1980's, have had the courage to combat stigma and help educate their fellow citizens by being open about their HIV-positive status. Sometimes, however, the stigma and hostility are overpowering; in December 1998 Gugu Dlamini was stoned to death by her neighbours in a South African township after she tried to help others with the virus by publicly announcing that she was HIV-positive.

SOCIAL AND ECONOMIC CONSEQUENCES

In May 1999 it was announced that AIDS was now the world's fourth leading cause of death – and it led to more mortality than any other infectious disease.

The social consequences of the epidemic are staggering. Those most at risk, sexually active adults, are the most productive members of every society, earning incomes for themselves, their families and their communities by tilling the fields or manufacturing goods, transporting, buying, selling and exporting products or providing other services. Furthermore it is adults who raise children, provide for them and teach them to become productive members of society.

When a child or grandparent falls ill and dies, it is a tragedy for the family, but when adults fall ill and die, that tragedy is compounded by repercussions that affect the whole community. If a mother falls ill, not only is her income lost, but the household tasks that women traditionally perform – such as cooking and taking care of the children – are neglected or performed less well by the husband, if present and healthy, or by the older children. Cultivation is less efficient and livestock eat less well. Children lose schooling if they have to stay at home to look after a sick parent or if there is no money to pay for fees or transport.

Eventually grandparents, older siblings or aunts and uncles take over running of the household, but age or inexperience often mean these tasks are performed less well and income is either severely reduced or lost. The children's emotional stability may suffer not only from the death of the parent(s) but from the new environment in which an aunt or uncle may be disinclined, or a grandparent unable, to provide the love and attention that came from their parents. Although still uncommon in Africa, in many cases children find themselves homeless, either placed in orphanages or scavenging on the streets.

Despite this grim scenario, some experts, including the World Bank, believe that the overall economic impact of the disease in Africa will not be severe. Populations will grow more slowly, but are unlikely to go into decline, while high rates of unemployment may mean that a rise in deaths will not affect overall economic production. Others paint a gloomier picture and factors such as social unrest may yet have to be taken into account.

TREATMENT

In the last five years HIV/AIDS has highlighted one of the most glaring differences between the industrialized and the developing worlds: a disease which responds to successful treatment in Western Europe or North America almost invariably leads to death in Africa and Asia. The reason is simple: the high cost means that treatment is only available in those countries and to those individuals who can afford it.

HIV/AIDS requires two types of treatment – antiviral (also known as antiretroviral) therapy, which combats HIV itself, and treatment for opportunistic infections. Antiviral drugs are not a cure for HIV, but when administered in conjunction with regular monitoring of the individual's health, they reduce AIDS to a long-term manageable disease for many people. This condition is similar to diabetes, which also cannot be cured but can be kept under control. Unlike diabetes, however, HIV can be transmitted and individuals with the virus who take antiviral drugs can still pass the virus to others.

MEDICINAL DRUGS

By mid-1999, 15 antiviral drugs had been approved by the US Food and Drug Administration (FDA) and a similar number were under trial. HIV antivirals are generally divided into three types: nucleoside analogues, non-nucleoside reverse transcriptase inhibitors and protease inhibitors. Treatment with only one type of antiviral, such as Zidovudine (commonly known as AZT) is generally not beneficial; it is combination therapy – a combination of drugs, sometimes known as a 'cocktail' – which prevents the virus from replicating. This combination may include up to 20 pills a day, which must be taken at specific times, before, during or after meals, depending on the drug. The cost of such a combination can reach US \$10,000 per patient per year.

Ensuring that patients receive the right antiviral treatment depends not only on the ability to pay for the drugs, but on access to doctors with equipment to measure the extent of viral

activity and the body's immune response. That information confirms whether the current combination is working or whether another combination should be tried.

Antiviral drugs are available on a very limited basis in Africa, as part of drug trials or imported by wealthy individuals. For the vast majority of Africans, however, antiviral drugs will not be available in the foreseeable future. Furthermore, the crisis in health care funding facing much of the continent means that even the cheaper drugs that cure or provide relief from opportunistic infections such as fever, diarrhoea and pneumonia are often unavailable.

TRADITIONAL HEALERS

Lack of access to the appropriate medical services and a long history of indigenous medicine have led many Africans to consult traditional healers to relieve symptoms and, many have hoped, to cure AIDS. While traditional healers can often alleviate pain and other symptoms, the claims by some that they can cure the disease has been problematic. On the one hand, such claims lead members of the public to be sceptical of Western medicine and diagnosis, and, on the other hand, the fact that none of these "cures" has proved effective leads some supporters of Western medicine to be sceptical of all traditional healers.

Given the lack of adequate medical facilities in much of Africa, there is a role for traditional healers to provide services, particularly in alleviating the symptoms of opportunistic infections. In some countries there is consultation between practitioners of Western medicine and traditional healers; in others, however, co-operation is proving more difficult.

MOTHER TO CHILD

The one area where antiviral drugs are increasingly available to the African public is the prevention of transmission of HIV from mother to her newborn child. Limited doses of Zidovudine reduces the likelihood of the child contracting the virus from about one in three or four preg-

nancies to about one in 10 or 12. Financial assistance from the French, US and other Western governments has allowed thousands of pregnant women access to Zidovudine across the continent and at the time of writing another cheaper drug, nevirapine, is proving effective in trials.

However, the stigma attached to AIDS prevents large numbers of women from taking the drug, since they may not wish their husbands or birth attendants to learn they have contracted HIV – even when their husbands may be the source of infection and the birth attendants are close members of the family.

VACCINATION

The difficulty in persuading sufficiently large numbers of people to change their behaviour, the high cost of antiviral drugs and the general belief that prevention is better than cure, all lie behind the drive to find a vaccine that will either prevent individuals from contracting HIV or prevent the virus from replicating once it is in the body.

Developing a vaccine is not easy, however, and the process is made more difficult by the fact that there are various strains of HIV, which are common in different parts of the world. Strain B is commonest in Western Europe and North America, for example, while strains A, C and D are commonest in Africa.

Financial and ethical considerations also play a role. In the early 1990s, pharmaceutical companies devoted almost all research to potential vaccines against the B strain in anticipation that there would be a market for such a product in the industrialized world. Proposed testing of a candidate B strain vaccine in Uganda led to widespread protest when it was alleged that not only would such a vaccine bring no benefit to that country if developed, but that those on whom the candidate would be tested had not been fully informed of the potential risks.

In the late 1990s, the financial support of Western governments and foundations such as the one established by Bill Gates, the founder of Microsoft, have enabled the New York-based International AIDS Vaccine Initiative (IAVI) to

establish partnerships between northern and southern research institutes. These are intended to develop vaccines appropriate for Africa and elsewhere in the developing world and to ensure that all trials are ethical and fair. At the end of 1998, two such initiatives were announced, one in Kenya and one in South Africa.

EMPHASIS ON PREVENTION

As long as antiviral treatment remains out of reach and until a vaccine is widely available, prevention is essential to bringing the disease under control. Prevention, whether abstinence, mutual fidelity or use of condoms, looks simple, but as the social and cultural context described above makes clear, it is not. Ensuring that 300 million sexually active men and women across Africa protect themselves and their partners during every act of intercourse, and ensuring that the 10 million African children who become sexually mature each year know how to protect themselves, is a difficult and complex task.

A number of conditions must be met to ensure widespread effective prevention. These include basic information about HIV transmission and means of preventing transmission; psychological support for men and women who wish to protect themselves from the virus; deep-rooted social change that will reduce the pressure on men to dominate their partners and enable women to have greater control over their sexual lives; poverty reduction schemes; and provision for the treatment of other sexually transmitted infections.

The severity of the epidemic has meant that most Africans are aware of HIV/AIDS and have some idea as to how to protect themselves. That does not mean, however, that they are sufficiently informed. Women tend to be less aware of the threat and, as has been seen, are less able to protect themselves than men. Men and women who are illiterate or have little access to the print or broadcast media are less likely to be informed than those who are educated or who have regular access to radio and the press; and each year a new generation reaches sexual maturity, often without the accurate knowledge they need to protect themselves and others.

Because sexual behaviour is not fully under our conscious control, information in itself is not enough to ensure change in sexual behaviour. Individuals at risk not only need to learn what behaviour change to make, but need the psychological support to make that change. This support generally comes from one's peers, in formal or informal groups. While both men and women "network", in the fields, at the well, in offices, at market, in bars, women are more likely to use these opportunities more to discuss the emotional and health issues that lead to a desire to change behaviour. Men are less likely to discuss such issues and are, therefore, at a disadvantage – a disadvantage that has repercussions on their partners. Establishment of mechanisms which help men in particular to change behaviour – e.g. discussion groups in the workplace – is, therefore, a critical factor in preventing further spread of HIV.

It is likely, however, that deeper structural changes are needed to ensure the reduction in the spread of HIV in Africa and elsewhere in the developing world. Inequalities between men and women must be tackled at a broader level than HIV and, because poverty lies behind some women's sexual behaviour, they require economic support to reduce their dependence on men. Finally, widespread treatment of other sexually transmitted diseases will severely reduce opportunities for HIV to spread.

OPTIONS FOR CHANGE

Options for people who wish to protect themselves and their partners from HIV are: abstaining from sex; ensuring mutual fidelity with their long-term partner; using condoms with all sexual partners; non-penetrative sex; or masturbation. Insistence on only one or other form of prevention, such as abstinence or fidelity, is likely to fail, because it does not take into account the context of people's lives.

Each of these options has advantages and disadvantages. Abstinence and non-penetrative sex are not options for many men or their women partners. Fidelity is not a guarantee, because one partner may be faithful to a partner who is not.

Male condoms are widely available but, despite appearances, not simple to use; many men who would use them may be too embarrassed to admit that they need practice to do so. Female condoms are rare and often expensive. Masturbation as a form of sexual relief is still considered a taboo or weakness in many parts of Africa, although increasingly recommended as an option.

Discussion of sexual issues to resolve such problems is often difficult, whether between partners who have just met or couples who know each other well. As described above, workshops, discussion groups and other means of allowing individuals to explore and understand their own and their partner's sexuality are an essential component in tackling HIV/AIDS and other STI's.

THE POLITICAL RESPONSE

The political response to HIV/AIDS is similar across Africa, although the strengths of the various organizations may vary from country to country. The global response to the epidemic is co-ordinated by UNAIDS – the Joint United Nations Programme on AIDS – which is sponsored by seven UN agencies (see chapter on The ABC of HIV/AIDS). UNAIDS works with both governments and non-governmental organizations at both international and national level. National responses are usually co-ordinated by National AIDS (Control) Programmes, the composition and effectiveness of which varies from country to country.

Non-governmental organizations (NGO's) have played a major role in fighting AIDS since the beginning of the epidemic. Frequently, they have drawn attention to key issues such as sexual behaviour that governments have been unwilling or unable to address. NGO's are funded from a variety of sources, including foreign governments and donor agencies. Given the proliferation of NGO's and of funding sources, it is not surprising that relations between NGO's and governments and between national and international or foreign institutions have sometimes been strained.

In many parts of the world some of the most effective NGO's have been those which are drawn from the communities most affected by the epidemic, in particular groups of people living with HIV/AIDS.

At the beginning of this new millennium it seems that African leaders are finally responding to the challenge of AIDS in their midst. The presidents of South Africa and Ethiopia have joined their Ugandan and Senegalese peers in recognizing the threat of the epidemic. The experience of Uganda, once the worst affected country on the continent but where rates of infection have dropped amongst young adults, and of Senegal, where rates have remained consistently low, indicates that where the will to combat the disease is universal, it can be overcome.

AND NOW

The HIV/AIDS pandemic in sub-Saharan African countries is a clear and present pernicious threat which demands urgent attention. An integrated approach using all relevant means and channels in society is required to confront the threat and the use of communication media is especially important in this respect. Bringing about positive results in the efforts to stem the prevalence of HIV/AIDS depends, among other things, on the existence of an informed public that is sensitive to the causes, spread and prevention of the epidemic. The mass media have a significant role to fulfil in creating and sustaining public opinion and the political will to deal with the problem.

The media can expose certain trends and phenomena in the community or society that facilitate the spread of HIV/AIDS and inform the public about them. They can also play a central role in educating the public about the importance of preventive measures and serve as signpost to dangers. They can help create public awareness and mobilise public opinion against trends, phenomena and practices which favour the spread of the epidemic. Active involvement of media organizations and communication practitioners in efforts to deal with issues of

HIV/AIDS is critical, if knowledge and awareness are to be increased and risk behaviours reduced among different population segments in African countries.

The challenge then is to prepare journalists and other media professionals for the task of using media resources to arouse, mobilize and sustain public opinion which support the efforts against the practices. The initial step in this process involves the generation of interest, awareness, knowledge and understanding among media practitioners themselves about the disease, its modes of transmission, its prevention and management as well as their commitment to the efforts to prevent and control the spread of the epidemic. In response to this challenge, UNESCO in 1998 initiated a project on preventive information based on investigative journalism and HIV/AIDS in East and Southern Africa. The project's objectives were to: (i) identify a few pertinent trends or phenomena in the region which contribute to the spread of HIV/AIDS; (ii) carry out in-depth investigation on the relationship between the phenomena and the prevalence of the disease; and (iii) study the extent to which the incidence of HIV/AIDS is reported in the media.

This publication presents the reports and papers prepared under the project. It contains practical and technical guidelines for media practitioners specializing or interested in HIV/AIDS issues. Part I presents a general overview of the HIV/AIDS epidemic and its demographic, social and economic impact in sub-Saharan African countries; common concepts, terms and definitions, ethical approaches to reporting on the disease as well as media functions in HIV/AIDS prevention and management.

Chapter 1 by Martin Foreman of the Panos Institute, London contains terms and acronyms commonly used in writing about HIV/AIDS. It presents definitions, explanations and examples of use to a wider audience as well as information of particular interest to the media. Martin Foreman also discusses ethical issues that media professionals need to consider when reporting on HIV/AIDS in Chapter 2. He notes that media

professionals must pay particular attention to the confidentiality of an individual's HIV status; use appropriate language which reduces or avoids stigma; be critical in their reporting of claims of effective cure or treatment; be careful about repeating misconceptions and irrelevant controversies; be diligent about verifying information and presenting a balance view of gender issues. Wambui Kiai of the University of Nairobi, Kenya, takes up the subject of media functions in HIV/AIDS prevention and management in Chapter 3. She stresses the need for the media to provide, on a regular basis, accurate and factual information on the epidemic and to demystify it by presenting its statistics in human terms. She calls for a pro-active approach in media coverage of the epidemic and calls for more intensive training, networking and building up of solid sources of information on the epidemic which are accessible to media practitioners.

Part II presents case studies of investigative reporting on selected trends and social phenomena which are suspected to contribute to the spread of HIV/AIDS in five East and Southern African countries. These trends are migrant populations; certain persisting cultural practices; and high consumption of alcohol.

In Chapter 4, Rose Lukalo of the African Women and Child Features Service, Nairobi, Kenya, reports on patterns of migrant populations (refugees, internally-displaced persons, long-distance truck drivers, migrant workers including itinerant commercial sex workers, and tourists) and their links with the spread of HIV/AIDS in Kenya. Noting that population mobility brings into play certain conditions that encourage the spread of the disease, she calls for more thorough examination of the issue of mobility in HIV/AIDS intervention programmes. Charles B. Rwabukwali and his colleagues at Makerere University in Kampala, Uganda, report on similar patterns in neighbouring Uganda in Chapter 5. They observe that, in general, people who are on the move tend to lack the requisite level of knowledge, perception, awareness and precautions required to avoid infection and the spread of the disease. In

Chapter 6, Mkasafari Mlay, a freelance journalist in Dar es Salaam, reports on the same theme in Tanzania. She observes that people who are away from their homes are often tempted to do things they would not dare do at home.

Parkie Mbozie of the University of Zambia, Lusaka, reports on the impact of a number of cultural practices on the spread of HIV/AIDS in Zambia in Chapter 7. His investigation reveals that practices such as ritual cleansing; spouse inheritance; puberty rites; polygamy; and circumcision rituals contribute in some ways to the transmission and spread of the disease in the country. In Chapter 8, Rukee Tjingaete, a freelance writer in Windhoek, reports on his investigation into the social phenomenon of high alcohol consumption and its impact on the spread of HIV/AIDS in Namibia. He notes that high rates of alcohol consumption increases the likelihood of rape and unprotected sexual intercourse – both of which are associated with the transmission and spread of the disease.

Part III deals with findings and recommendations from content analytic studies of media coverage of HIV/AIDS in four East and Southern African countries during the period of January 1997 to June 1998. In Chapter 9, Lewis Odhiambo of the University of Nairobi analyses the coverage of the disease by the three leading newspapers in Kenya from “a moral panic perspective.” His study reveals, inter alia, that most of the stories reported in the print media were the product of local journalists’ initiatives; that the newspapers relied mostly on local writers and commentators; and that the main information sources were local organizations, researchers and scientists. The findings of Linda Nassanga Goretti’s analysis of the coverage of the epidemic by Ugandan print and broadcast media are presented in Chapter 10. Her study showed that HIV/AIDS was reported in the form of news stories, news analysis, feature stories and letters to the editor and the sources of information were mainly local, supplemented by foreign and international syndicate/feature services. She remarks that, although media practi-

tioners had high level of awareness of HIV/AIDS issues, the disease received little coverage in the Ugandan media during the study period.

In Chapter 11, Francis P. Kasoma examines the coverage of HIV/AIDS in Zambia’s leading newspapers. His findings show that, in general, the newspapers were more interested in giving their readers current information and hard facts about the disease than in features, and in presenting background information. The findings of the study by Kingo Mchombu of the University of Namibia of how the disease was covered by the leading newspapers and the national radio in Namibia are presented in Chapter 12. His findings lead him to the conclusion that Namibia’s media coverage of HIV/AIDS was generally low, superficial and not adequately sustained over a long period of time to create the necessary impact in terms of awareness and change in behaviour.

Taken together, the conceptual discussions, the investigative reports and the findings from the content analytic studies point to the need: for enhanced training for media professionals in East and Southern Africa on HIV/AIDS coverage; to create HIV/AIDS resources centres and databases easily accessible to media professionals; for workshops and seminars to sensitise editors, producers and media managers about the social and economic costs of HIV/AIDS and other major health risks in Africa; and for a more sustained and intensive use of media resources in support of efforts to prevent and manage the spread of HIV/AIDS in Africa

Through this publication, UNESCO hopes to contribute to the generation of the requisite interest, awareness, knowledge and understanding among media practitioners of the prevalence of HIV/AIDS in African countries and its immense social, demographic and economic impact. It is equally envisaged that the publication will stimulate efforts to integrate preventive information on HIV/AIDS in the regular fare of mass media in African countries.