Impact of HIV and AIDS in sub-Saharan Africa

Introduction

Roughly 70 percent of all people living with HIV live in sub-Saharan Africa, despite accounting for just 13 percent of the world's population.[1] [2]

The HIV epidemic has had a number of impacts on this region with the most obvious effects being ill health and the number of lives lost. In 2012, there were 1.6 million new HIV infections and 1.2 million AIDS-related deaths.[3] As well as heathcare and households, HIV and AIDS have impacted significantly upon the education sector, labour and productivity and the wider economy.

However, since 2001, the annual number of new HIV infections in sub-Saharan Africa has decreased by 34 percent. This is largely due to the scaling up of antiretroviral treatment (ART) across the region, which reduces the chance of onwards transmission.
For the first time, in 2011, over half of all sub-Saharan Africans in need of ART were receiving it (56 percent),[4] in 2012, this increased to 68 percent.[5]
It is widely acknowledged that increasing access to ART will dramatically decrease the impact of HIV in this region.[6]

A grandmother in Zimbabwe works in her garden. She also looks after seven orphaned grandchildren because their

HIV and poverty in sub-Saharan Africa

The link is often made between poverty and the spread of HIV but the relationship is very complex and research remains inconclusive.

In 2010, 48.5 percent of people living in sub-Saharan Africa were living below the poverty line ($1.25 a day). [7]

For a long time, it was believed that poverty drives the HIV epidemic, particularly in sub-Saharan Africa. Indeed, in 1997, the World Bank reported that: "widespread poverty and unequal distribution of income that typify underdevelopment appear to stimulate the spread of HIV"[8]

Poverty can force people to leave home in order to find work. For women in particular, this can make them vulnerable to exploitation including early marriage and force some into sex work.[9]
However, this argument has since been challenged by a number of studies. For example, one study of 24 countries in sub-Saharan Africa found a higher concentration of HIV and AIDS among wealthier individuals. [10] This is thought to be due to a number of factors including greater mobility and multiple partners. [11]

Poverty alleviation does have a role to play in preventing the spread of HIV in sub-Saharan Africa. However, the relationship between HIV prevalence and wealth is not direct and is influenced by a number of underlying social and cultural factors, which also need to be addressed.

Life expectancy

At the height of the HIV epidemic in sub-Saharan Africa between 1990 and 2000, average life expectancy stagnated at 49.5 years. [12] In 2006, it was reported that in many countries, HIV and AIDS had wiped 20 years off life expectancy. This impact on life expectancy was attributed largely to child mortality, associated with an increase in the mother-to-child transmission of HIV during pregnancy. [13]

In the period 2002-2012 life expectancy increased by 5.5 years due mainly to the dramatic scaling up of antiretroviral treatment. However, life expectancy in many countries remains very low. Swaziland, which has the highest HIV prevalence in the world, has a life expectancy of just 48.9. Lesotho's is equally low at 48.7 years. [14]

The table below shows current life expectancy of people in countries in sub-Saharan Africa worst affected by the HIV and AIDS epidemic. [15] [16]

Country	HIV prevalence (%)	Life expectancy (years)
Botswana	23	50
Lesotho	23.1	48.7
Malawi	10.8	54.8
Mozambique	11.1	50.7
Namibia	13.3	62.6
South Africa	17.9	53.4
Swaziland	26.5	50
Zambia	12.7	49.4
Zimbabwe	14.7	52.7

Households and livelihoods

The HIV epidemic has had a severe and wide ranging impact upon households in sub-Saharan Africa. Many families have lost their chief income earners, who have died, or are too sick to work. This puts a heavy financial burden on families who have to pay ever increasing medical costs, forcing many into poverty. As a result, many families have to provide home-based care, further reducing their earning capacity and placing more demands on their resources.

In many cases, households simply dissolve because parents die and children are sent to relatives for care and upbringing.

Parents and children

The majority of adults newly infected with HIV are in sub-Saharan Africa. At the height of the HIV epidemic, there were an estimated 2.2 million new HIV infections annually, this had fallen 35 percent by 2011 (1.5 million). [17] Despite an on-going decline in HIV and AIDS cases as well as deaths, 17.3 million children have now been orphaned by the epidemic globally, 88 percent of this number, in this region. [18]

As a result of the slow progress made in treatment, care and support to mothers living with HIV in the mid-2000s, roughly 3.4 million children under the age of 15 were living with HIV globally in 2011, due to mother-to-child transmission. 91 percent of this number (3.1 million) were in sub-Saharan Africa. [19]

However, the situation is improving largely due to much greater access to antiretroviral treatment. Since 1995, most of the children who have averted HIV infection live in sub-Saharan Africa. In 2011, the number of children who acquired HIV in this region was 29 percent less than in 2009. [20]

Household income and basic necessities

The HIV and AIDS epidemic in sub-Saharan Africa can seriously impact upon a household's ability to generate income.

When the income earners become too sick to work or simply die, children can be forced to abandon their education, and in some cases, women may turn to sex work as a source of income, increasing the risk of HIV transmission. [21] [22]

The loss of income, in addition to rising medical costs, reduces the ability of people giving care to work themselves, pushing HIV-affected households deeper into poverty. [23]
"She then led me to the kitchen and showed me empty buckets of food and said they had nothing to eat that day just like other days." [24]

Food security

Food insecurity can be a factor behind the spread of HIV. As a coping strategy, some people are forced to engage in transactional sex, which subsequently increases the risk of transmission. [25]
At the same time, the epidemic can create food insecurity and malnutrition by increasing medical costs and reducing the productivity of the workforce, impacting heavily upon people's livelihoods.

"Our fields are idle because there is nobody to work them. We don't have machinery for farming, we only have manpower - if we are sick, or spend our time looking after family members who are sick, we have no time to spend working in the fields." - *Toby Solomon, commissioner for the Nsanje district, Malawi* [26]

Food insecurity and malnutrition among people living with HIV has also been found to affect someone's adherence to ART. One study from Uganda has identified the relationship between food security, quality of diet and nutritional status and quality of life among HIV-positive people. [27] Moreover, those with access to nutrient-rich foods have been found to have stronger immune systems with their bodies more effective at fighting HIV. [28]

Food security and good nutrition are regarded as key components of HIV treatment programmes. [29]

Coping strategies

Households adopt a range of different strategies in order to cope with the impacts of the HIV and AIDs epidemic in sub-Saharan Africa.

Selling productive assets

A decline in labour and productivity in households can lead many families to sell their assets or shift to employment with lower earning potential in order to look after affected family members and to pay for medical treatment. Often, these types of strategies undermine the long-term financial stability of a household.

One study on the economic impact of HIV and antiretroviral treatment (ART) on individuals and households in Uganda reported that two-thirds of HIV-affected households had to sell at least some of their land, capital or household property to pay for treatment. Moreover, 67 percent required financial support from their family during treatment, with 38 percent still requiring this help after treatment. [30]

Research from Zambia and Kenya found that while increased access to ART in sub-Saharan Africa is alleviating some of the stresses the epidemic places on households, it throws up other challenges. For example, many people who were able to fall back on their assets during their illness did not envisage a future, and therefore did not plan for one. As a result, by the time they were on an effective drug regimen, they often had to rely on loans from friends and relatives. [31]

Restructuring households

As well as a decline in the number of adults of working age, the HIV epidemic has created a gender disparity, whereby women take on a growing burden of household responsibilities.

Grandmother and her orphaned grandchild

Upon a family member becoming ill, women typically assume the role as carers, providers, as well as income earners, as they are forced to step into roles outside the home. [32]

"I used to stay with the children, but now it is a problem. I have to work in the fields. Last year I had more money to hire labour so the crops got

weeded more often. This year I had to do it myself." - *Angelina, Zimbabwe* [33]

As a result, the epidemic has led to a rise in the number of female-headed households. In rural areas, research has shown how because of cultural reasons, households led by women are in danger of losing land ownership and livestock upon the death of their spouse. [34]

In other cases, the death of a family member often forces poorer households to remove their children from school. School uniforms and fees become unaffordable for these families with the child's labour and income-generating potential considered more valuable.

"Because I'm a poor African woman, I can't raise enough money for three orphans. The one in secondary school, sometimes she misses first term because I'm looking for tuition. The others miss schools for two or three days at a time. I had a cow I used to milk, but as time went on the cow died, so I can't find any other income…" - *Barbara, Uganda* [35]

Help from relatives

Relatives, particularly grandparents, are typically responsible for looking after orphaned grandchildren or children who fall ill as a result of the epidemic. They share in the burden of providing economic, emotional and psychological support at a time when they would themselves be expecting to receive more support in their older age.

This is a problem in places like rural Malawi where hand hoeing for subsistence agriculture is vital for food production, and requires workers to be physically strong. One study from this region found that 69 percent of elderly people sustained themselves through farming and similar activities. It also found that 79 percent of elderly people looking after orphaned grandchildren had limited or no information on HIV and AIDS, and that 31 percent of elderly people with these circumstances, were themselves, found to be dependent on their relatives for support. [36]

Religious and cultural coping strategies

One study from Uganda has highlighted the importance of spiriituality as well as local service providers and social support to households affected by HIV and AIDS. In fact, 85 percent of women reported that spirituality played at least some role in helping them cope with the epidemic. 43 percent of this group indicated that spirituality, including support from other believers, prayer and trusting in God was the most important factor keeping them going. [37]

Healthcare

In all severely affected countries, the HIV and AIDS epidemic continues to put pressure on the health sector. As the epidemic evolves, the demand for care for those living with HIV rises, as does the toll on healthcare workers.

Hospitals

At the height of the epidemic in sub-Saharan Africa, HIV was putting a serious strain on hospital resources. In 2006, people with HIV-related illnesses were occupying more than 50 percent of all hospital beds in the region. [38]

However, in recent years, the dramatic scaling up of antiretroviral treatment in this region has reduced the burden of the HIV epidemic on hospitals. In one of South Africa's largest hospitals, in the 15 years preceding 2009, HIV prevalence among children admitted remained constant, peaking in 2005 (31.7 percent). By 2011, this had fallen, to 19.3 percent. [39]

Healthcare workers

Home based care workers at the Missionvale township, South Africa

The epidemic also generates a demand for healthcare services, but large numbers of healthcare professionals themselves are directly affected.

In the Democratic Republic of Congo, as well as an increasing demand for HIV services, there is a shortage of HIV and AIDS-related training and resources. Moreover, healthcare workers are at greater risk of HIV transmission if exposed to blood and other bodily fluids in the workplace where necessary precautions are not in place. [40] Likewise, a survey of 1000 healthcare workers in three hospitals in South Africa showed how 20 percent of participants were at risk of HIV, tuberculosis and hepatitis from needle stick injuries or unprotected exposure to bodily fluids. [41]

This is a particular problem in a region where the number of healthcare workers is already limited. Excessive workloads, poor pay and migration ('brain drain') to developed countries are among the factors contributing to this shortage. [42]

Education

Schools have a vital role to play in reducing the impact of the epidemic. Between 2001 and 2012, HIV prevalence among young people fell by 42 percent in sub-Saharan Africa. [43] Education is also one of most cost-effective means of preventing HIV transmission.

"Without education, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach." - *Peter Piot, Director of UNAIDS* [44]

Schools and pupils

A decline in school enrolment is one of the most visible effects of the HIV epidemic in sub-Saharan Africa.

Children may be removed from school to care for affected parents or family members, or they may themselves be living with HIV. Many are unable to afford school fees and other such expenses – this is particularly a problem among children who have lost their parents (the income earners) to HIV and AIDS. At the height of the HIV epidemic in Swaziland and the Central African Republic, it was reported that school enrolment fell by 25-30 percent. [45]

HIV/AIDS prevention sign outside a school in Botswana

However, access to treatment can vastly improve this situation. In rural Uganda, a direct link has been made between the CD4 count (a measurement to see how strong a person's immune system is) and school attendance. The study found that children in households of adults with CD4 counts above 350 cells/mm3 had 20 percent higher school enrolment rates than children in households of adults with CD4 counts of less than 200 cells/mm3. In fact, households of adults with high CD4 counts resembled those of HIV-negative participants in their ability to work and send their children to school. [46]

Research has shown how education can have specific HIV-related benefits, especially if children have completed secondary level schooling that includes sex education and HIV education. They are more likely to know how to protect themselves from HIV infection, as well as delay first sex, marriage and childbearing. [47]

Teachers

HIV and AIDS have had a severe impact on the already limited supply of teachers in sub-Saharan Africa. In some countries, more teachers die of HIV and AIDS related illnesses than are being trained. In 2007, the epidemic claimed the lives of 2000 teachers in Zambia. [48] A study from 2006 in South Africa found that 21 percent of teachers aged 25-34 were living with HIV. [49]

Teachers who are affected by HIV and AIDS are likely to take periods of time off work. Those with affected families may also take time off to attend funerals or to care for sick relatives, and further absenteeism may result from the psychological effects of the epidemic. In this situation, their class may be taken on by another teacher, combined with another class, or simply left untaught. Even when there is a sufficient supply of teachers to replace lost staff, there can be a significant impact on the students.

This is particularly concerning given the important role that teachers can play in the fight against HIV and AIDS. One study showed how teachers can act as an important resource by referring affected children to available health and social resources by forming partnerships between the children and families, community volunteers and organisations. [50] However, many studies continue to highlight how many sub-Saharan African schools are overcrowded, underfunded and poorly run as well as characterised by poor communication between parents, guardians and teachers. [51]

An HIV-positive teacher with some of her students, Zimbabwe

Labour and productivity

The vast majority of people living with HIV and AIDS in sub-Saharan Africa are aged between 15-49 - in the prime of their working lives. Employers, schools and the healthcare sector are regularly training staff to replace those who become too ill to work. In 2012, a reported 4.7 percent of people in this demographic in sub-Saharan Africa were living with HIV. [52]

The epidemic damages businesses through absenteeism, falls in productivity, labour force turnover, and the subsequent added costs to operations. Moreover, company costs for healthcare, funeral benefits and pension fund commitments rise as people take early retirement or die from AIDS-related illnesses.

However, some companies have implemented successful programmes to deal with the impacts of HIV and AIDS. A cost-benefit analysis of providing antiretroviral treatment to HIV-positive employees in a large mining company in South Africa projected financial savings of up to 17 percent between 2003 and 2022. The company saved money through less absenteeism, more consistent production and reduced expenditure on sick pay, death-in-service benefits and training new staff. Similar schemes are thought to have potential in many parts of sub-Saharan Africa, however they may be difficult to implement in countries with particularly low wages and will depend on a company's benefits policy. [53]

HIV and AIDS have also impacted upon labour and productivity of the rural economy. A decline in agricultural productivity can reduce the nutritional status of all household members. Households with low levels of capital, agricultural productivity and labour are particularly vulnerable to a deterioration in their quality of life. [54]

Economic development

The combined impact of HIV and AIDS on households, healthcare, education and productivity in the workplace has stagnated, and in some places, even reversed economic and social development in sub-Saharan Africa.

From 1960 to 1990, increasing life expectancy in sub-Saharan Africa was estimated to be adding 1.7 percent to 2.7 percent yearly to gross domestic product (GDP). [55]

However, the HIV and AIDS epidemic is thought to have reduced economic growth by 1 percent annually in some countries in sub-Saharan Africa. This is due mainly to people leaving the workforce because of illness as well as lower overall productivity, leading to a fall in economic output and fewer tax receipts. This, coupled with the rising costs of healthcare, has put serious pressure on government finances in the region. [56] One study indicates the cost of HIV and AIDS programs in six countries will exceed 3 percent of GDP by 2015. [57]

Economic development in this region depends much upon the ability of these countries to diversify their industrial base, expand exports and attract foreign investment. By increasing labour costs and reducing profits, the epidemic limits the ability of countries to attract industry and investment. [58]

The true impact and cost of HIV and AIDS on the economies of sub-Saharan Africa is difficult to measure. The worst affected countries were already struggling with a host of other development challenges, debt and declining trade before the epidemic started to impact upon the region. The HIV epidemic has exacerbated many of these issues.

The future of HIV and AIDS in sub-Saharan Africa

The severity of the epidemic in sub-Saharan Africa is linked to many other issues including poverty and a general lack of development. Efforts to fight the epidemic must take these realities into account, and look at ways in which the development of sub-Saharan Africa can progress. The HIV epidemic acts as a serious barrier to development. Wider access to HIV prevention, treatment and care services is needed in order to break down these barriers.

This page has outlined just some of the impacts of the HIV and AIDS epidemic in sub-Saharan Africa. Although both international and domestic efforts to tackle the epidemic have strengthened in recent years, particularly in the provision of antiretroviral treatment, sub-Saharan Africa will continue to feel the effects of HIV and AIDS for many years to come.

Religion and HIV/AIDS: defining issue of our time

Compilation of findings of three case studies and literature for the Knowledge Forum on Religion and Development Policy.

By Piet Kuijper (Cordaid)

"Spirituality and religion are part and parcel of the culture of Zimbabwe. It is therefore expected that help also addresses the spiritual needs of people. Offering help is not only offering practical help, but it is also meeting spiritual needs. Christian organisations have this 'holistic approach' due to their Christian character and belief, which includes the spiritual needs of people. Due to this drive, there is no place for a technical "hit and hop away" approach."

Darija Kupers, Prisma ('Religion as driver of change: case study of two Christian HIV/AIDS organisations in Zimbabwe')

1. Introduction

Twenty-five years into the epidemic, AIDS has become one of the defining issues of our time. A truly global problem, AIDS affects every region and every country of the world, challenging health systems and undermining our capacity to reduce poverty, promote development and maintain national security. Since 1981, 65 million people have been infected with HIV and 25 million have died of AIDS-related illnesses.

Global facts and figures:

- A total of 39.5 million people were living with HIV in 2006 (2.6 million more than in 2004). The number of new infections in 2006 rose to 4.3 million in 2006 (400 000 more than in2004).
- Sub-Saharan remains the most affected region in the world. Two thirds of all people living with HIV live in this region—24.7 million people in 2006. Almost three quarters of all adult and child deaths due to AIDS occurred in sub-Saharan Africa—2.1 million of the global 2.9 million deaths due to AIDS.
- The number of people living with HIV increased in every region in the world in the past two years.
- The most striking increases have occurred in East Asia and in Eastern Europe and Central Asia, where the number of people living with HIV in 2006 was over one fifth (21%) higher than in 2004.
- Globally and in every region, more adult women (15 years or older) than ever before are now living with HIV. The 17.7 million women living with HIV in 2006 represent an increase of over one million compared with 2004.
- Access to treatment and care has greatly increased in recent years. Through the expanded provision of antiretroviral treatment, an estimated two million life years were gained since 2002 in low and middle-income countries.
- The centrality of high-risk behaviours (such as injecting drug use, unprotected paid sex and unprotected sex between men) is evident in the HIV epidemics of Asia, Eastern Europe and Latin America.
- Although the epidemics also extend into the general populations across the world, they remain highly concentrated around specific populations groups.

Source: UNAIDS, December 2006

Churches, mosques and faith-based organisations play a (potential) valuable role in the international AIDS response. Unfortunately policy-making organisations, international donors and other stakeholders often lack sufficient knowledge and understanding of religious dynamics and the role of religious institutions and therefore often look at this role in a simplistic and reductionist manner. In this chapter an effort is made to help create a greater mutual recognition between churches and faith based organisations on the one hand and policy-making organisations, international donors and more actors on the other.
We present the findings of three case studies about the contribution of religion and religious organisations in the international AIDS response. Moreover, existing research reports and literature are used. This article mainly addresses aspects of traditional, Christian and Islamic faith-based perspectives regarding their AIDS response in an African context. This, of course limits the perspective in both geographical and religious terms. However, the presented outlines are likely to have a broader application.

2. HIV-prevention: a three-layer framework

The factors fanning the HIV pandemic and making individuals and communities vulnerable to infection with this virus are many and complex.
HIV prevention strategies, if they are to be effective in the immediate as well as the long-term, need to take account of this complexity and to mobilise multi-faceted responses involving all sectors of society.
UNAIDS identifies five domains of context that are virtually universal factors in communications for HIV preventative behaviour: government policy, socio-economic status, culture, gender relations and spirituality.
In practice however, prevention strategies have, from the outset, tended to be reduced to "magic bullet" initiatives seeming to offer instant solutions. Such approaches place their protagonists in "pro-condom" or "abstinence/fidelity only" groups, which become diametrically opposed and mutually antagonistic. Discussions, strategies and prevention programmes become polarised and confrontational. They also reduce an understanding of prevention to being wholly concerned with sexual transmission of the virus and with promoting free choices by autonomous, empowered individuals.
The complex range of issues driving the pandemic is lost from sight as proponents of these "one-liner" over-simplistic solutions hold sway. The solutions proposed from either end of this polarised or reductionist approach could themselves become hijacked by covert political, religious or cultural agendas and fuelled by mutual distrust and prejudices.

The understanding of HIV prevention proposed in this paper finds its roots in the analysis and work of Cafod, Trocaire and Veritas. Especially the work of Ann Smith and Enda McDonagh has been important for the development of an internationally respected perspective on HIV/AIDS. It has strongly influenced the perspective on HIV/AIDS of UNAIDS, WCC and is reflected in the work and writing of progressive Islamic organisations.

An effective response to HIV/Aids requires a combination of initiatives that tackle three layers:

- **Decreasing vulnerability**: decreasing the personal factors such as unemployment, personal poverty, substance abuse, stigma, peer/social pressure etc. that increase an individual's vulnerability to infection and, deeper still, the society-wide factors that increase this vulnerability such as political, legal, cultural and religious factors as well as gender inequality, poverty (local, north-south), international trade and finance.
- **Risk reduction**: reducing the immediate risk of infection through the body fluids, (Blood, sex, mother-to-child)

- **Impact mitigation**: mitigating the effects for individuals such as, sickness, death, stigma, increased poverty, increased gender inequality, increased number of orphans & vulnerable children, etc as well as the wider social and economic effects on services, infrastructures and general development in countries worst affected by the pandemic

HIV prevention must be concerned with mitigating the impact, reducing the risks and decreasing the vulnerability factors that place people at risk. An understanding of prevention that excludes any of these layers is incomplete and can only be of limited effectiveness, even in the immediate term.

a) Decreasing the Vulnerability

Risk reduction strategies alone will not be sufficient to prevent HIV effectively, because an individual's personal strategies are conditioned by their social context. Hence the need to incorporate this third layer within a fuller understanding of HIV prevention

This third layer describes personal and societal factors that influence, and even dictate, the behaviours of individuals and communities. A key feature common to all of these factors is that they arise from and generate imbalances of power between men and women (gender relations), individuals, communities and countries. Such imbalances significantly curtail the behaviour choices of those who are disempowered and make them more vulnerable to HIV. Thus an overall HIV prevention strategy must also include initiatives that redress these imbalances of power that exist at personal or societal levels. To date, even where the influence of these factors is recognised, HIV prevention strategies are still too often interpreted as being solely concerned with immediate risk reduction. These deeper causative factors are consigned to completely separate response strategies by governments, international agencies and local civil society groupings alike. The result is a disjointed "parallel track" approach, which fails to make the connection in practical terms between HIV risks and the vulnerability factors augmenting those risks. Any initiative that seeks to address one or other of these vulnerability factors is, and must be recognised as an essential component of a wider HIV prevention strategy. These factors are irretrievably intermeshed and connected indicating once again the need for complementary and concerted responses.

b) Reducing the Risk

Risk reduction initiatives seek to provide individuals and communities with an accurate and full understanding of the risks to them and others of HIV infection. They also enable individuals to acquire the skills and resources to implement changes in their personal or professional lives in order to minimise these risks. Such initiatives are concerned with enabling individuals to adopt measures that afford them immediate protection, be it partial or complete.

Typical risk reduction strategies are listed in Box1. In practice the term "HIV prevention" is most often used to refer to one or a number of these risk reduction strategies. Such reductionist use of the term should be avoided, both because it denies the breadth and complexity of response that is needed if HIV prevention is to be effective, and because it far too readily leads to the polarisation of factions that becomes obstructive and destructive.

The listing in figure 1 might misleadingly suggest that risk reduction is about choosing one or other option, more or less at random or in rigid adherence to the dictates of social, cultural or religious pressures. This framework proposes a different interpretation. It requires us instead to think of a risk reduction continuum running from high-risk activities in an individual's personal or professional life, to those carrying low or even no risk of HIV infection.

Developing an appropriate risk reduction strategy, becomes a process whereby individuals identify their actual levels of risk and what changes are possible or desirable given their circumstances, which will reduce the level of risk.

Prevention of HIV: 1. Reducing the Risk

Involves strategies concerned with immediate protection:

- Abstinence
- Delay of first sexual encounter
- Mutually faithful monogamous long-term relationships
- Reduction in number of sexual partners
- Reduction in instances of casual sex
- Condom use
- Non-penetrative sex
- Harm reduction with drug injection
- Safer blood transfusions
- Universal precautions by health workers/carers
- Prevention of mother-to-child transmission
- Voluntary Counselling and Testing
- Prompt Treatment for STIs
- Prevention of forced sex with minors

Box 1: Typical Risk Reduction Strategies

Any strategy that enables a person to move from a higher risk activity towards the lower end of the risk reduction continuum is a valid risk reduction strategy. With appropriate support, the individual is enabled to establish the goal they can (or choose to) realistically aim for and to identify what level of risk this still carries for them (and perhaps how they might work at minimising this further, over time).

c) Mitigating the Impact

In making this an essential component of the framework, the inextricable link between prevention and care, support and treatment should be stressed. Any care, treatment, psycho-social support or livelihood initiatives that improve the physical health and economic and emotional well-being of people infected and affected by HIV must be seen as valid and valuable prevention efforts. Such initiatives enable people living with HIV to contribute to the stability and further development of families and wider communities thereby preventing the decline into poverty and stigmatization that so often fan the pandemic.

In conclusion: the combination of the three layers becomes a prevention cycle. Decreasing the vulnerability reduces risk, which mitigates impact, which in turn decreases vulnerability. A single institution, organisation or project will not normally address all aspects of this cycle. The challenge is for each actor to identify its part in the cycle and to know who else is contributing to it. In this way, the role and limitations of each actor can be clearly defined and respected, and different actors can work together in complementary, multi-sectoral initiatives contributing to a single HIV-prevention programme.

3. The role of Churches and faith-based organisations in the international AIDS response

A number of international donors and policymaking organisations have acknowledged the (potential) valuable role that faith based organisations play, or could play, in the international AIDS response. Especially when looking at their role from the broad prevention perspective described above. They are often active in areas of economic and social justice at local national and international level, so tackling power imbalances. They are among the most important providers of care, treatment, psycho-social support or livelihood initiatives that improve the physical health and economic and emotional well-being of people infected. They also provide individuals and communities with an understanding of the risks to them and

others of HIV infection and have clear messages, although not always providing the accurate and full information, regarding risk reduction.
Moreover, churches and faith-based organisations have more often than other actors, a long-term presence in regions and situations at risk, opting for the most marginalised and trusted by the local communities. Finally, churches and faith-based organisations also have the ability to influence the attitudes and behaviours of their community members by building on these relationships of trust and respect. Although they are not always uncontested as concerns their transfer of (religious) beliefs and values, but no easy generalisations can be made here.

At the other hand policymaking organisations, international donors and other actors often do not recognise that broad role churches and faith base organisations play in the international AIDS response. They look at the role of churches and other faith-based organisations from the reductionist prevention perspective, resulting in polarisation: "pro-condom" or "abstinence/fidelity only", placing their protagonists in groups, which become diametrically opposed and mutually antagonistic.

It must also be said that often churches and other faith based organisation on their turn also look at their own role in the AIDS response in the same reductionist way. Moreover, they still score rather weak on the HIV/AIDS related attributes:

- Lack of policy to deal with HIV/AIDS within the church
- Rather little mainstreaming of HIV/AIDS into the theological functioning of the church
- Great difficulties in redressing issues of sexuality and patriarchy by and in the church
- Churches often under estimate the role and position of women with regard to HIV/AIDS. Women are most affected, which is not enough recognized by churches and faith-based organisations
- Great difficulties addressing the imbalanced power relations between men and women
- Lack of networking and collaboration
- Although changing for the better, stigma and discrimination is at times rife and the language used while dealing with the pandemic can in itself be stigmatising.
- The focus is still too often on individual sins not the structural sins (structural injustice) of the society/community
- The youth are the most vulnerable yet at the same time, there has been an outflow of the youth from the church because of the beliefs and the values held at leadership level of the churches.
- Lack of advocacy and activism

(Source : Research of the Ecumenical Hiv/Aids Initiative in Africa)

Aids competent churches

However, over the last five to six years the different churches and faith-based organisations have worked hard on their "theology in times of AIDS". The most perceptible outcome of these theology-oriented activities is a growing understanding among theological academics and church leaders of the relationship between scriptural messages around compassion, forgiveness and acceptance, and the presence and impact of HIV/AIDS in church communities. This understanding is affecting the way church leaders and their congregations for example, view and care for community members who are infected or affected by HIV and AIDS, and is affecting the way that people living with HIV/AIDS view themselves as accepted and supported by the community. Furthermore, church leaders themselves are beginning to focus on themselves as powerful role models in fighting stigma, discrimination and denial. Many Christian people living with aids have found support and comfort in bible-study groups, which focus on the life of Jesus Christ who stood up for the marginalized and stigmatized. Those groups often confront traditional church leaders with texts from the bible (Luke 3, Marc 1; John 8; Peter 4) and demand a 'living' – aids-competent - church with commitment, support and care for people living with aids.

1. HIV/AIDS IN AFRICA: A SOCIO-CULTURAL PERSPECTIVE

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- Culture is critical for the establishment of social order and stability in society. AIDS is a complicated global problem. It is a global health crisis. The answer to this problem is going to come from a wide number of people and perspectives. That is why UNESCO recognized, formulated and recommended a Socio-Cultural Framework in tackling the challenge of HIV / AIDS
- Health has always to be an essential component of development policies. However, health has a socio-cultural dimension. In this sense, culture has a fundamental role to play. There can be a cultural approach to HIV/AIDS Prevention and Care.
- UNESCO favours the comprehensive consideration of the specific cultures of the populations targeted by HIV/AIDS programmes. Such a socio-cultural approach ought to encourage mobilization of the cultural resources of populations in fighting the epidemic, in order to effect long-term behavioural change.
- There is need to emphasize a cultural approach to prevention and care in anti-AIDS campaigns in our various university campuses given that there are many different ways of contracting HIV /AIDS menace. There are just as many different ways of preventing HIV/AIDS as there are many different groups of people exposed to HIV/AIDS.

2. A SOCIO-CULTURAL PERSPECTIVE IN THE DEALING WITH AIDS

- The joint UNESCO / UNAIDS project of “A Cultural Approach to HIV/AIDS Prevention and Care” was launched in May 1998, with the aim of stimulating reflection and action for better application of "a cultural approach" in strategies, policies, projects and fieldwork in anti-AIDS campaign.

- UNESCO advocates for a multi-sectoral approach. There have been multi-sectoral community-based strategies in three principal areas. They are HIV/ AIDS health, agriculture, and food security.

- There are also many different ways of discriminating against people living with HIV/AIDS.

- Consequently, the WHYs, HOWs and WHOs of the issues pertaining to infectivity and affectivity change from culture to culture.

3. A CULTURAL APPROACH TO HIV /AIDS PREVENTION AND CARE

- The Cultural Approach to HIV/AIDS Prevention and Care. strategy engages populations in the fight against HIV/AIDS on the basis of their own cultural references and resources. The project was fully part of UNESCO's main response to the HIV/AIDS pandemic through prevention education.
- Indeed, UNESCO aims at integrating HIV/AIDS prevention education into the global development agenda and national policies, adapting preventive education to the diversity of needs and contexts, encouraging responsible behaviour and reducing vulnerability .
- Prevention education should always include culturally appropriate curricula and pedagogical methods for in-school and university education. On the basis of the Mexico Declaration of 1982, culture is broadly understood within UNESCO to include:

  (1) ways of life, (2)traditions and beliefs, (3)representations of health and disease, (4) perceptions of life and death, (5) sexual norms and practices, (6) power and gender relations, (7) family structures, (8) languages and means of communication and (9) arts and creativity.
- There is need for a comprehensive perception of culture. Our understanding of culture is sometimes superfluous.

4. A CULTURAL APPROACH TO HIV /AIDS PREVENTION AND CARE CONTINUED

- From the foregoing definition, it is clear that culture influences attitudes and behaviour related to the HIV/AIDS epidemic.
- It is critical 1. in taking or not taking risk of contracting HIV, 2. in accessing treatment and care, 3. in shaping gender relations and roles that put women and men at risk of infection, 4. in being supportive towards or discriminating against people living with HIV/AIDS and their families
- Such activities as sexual intercourse and drinking have been taken out of their African cultural contexts. Consequently, they are abused and the dangers they pose to society

5. THE DIFFERENT LEVELS OF CULTURE

- The difficulty in establishing effective HIV/AIDS programmes comes from a lack of openness, in many societies, regarding:
  1. sexuality,
  2. male-female relationships,
  3. illness and death, taboo subjects deeply rooted in the cultures.
- Understanding what motivates peoples' behaviour, knowing how to address these motivations appropriately, and taking into consideration peoples' cultures when developing programs addressing HIV/AIDS are essential to changing behaviour and attitudes towards HIV/AIDS
- Culture should be taken into account at various levels:
  1. Culture as context – It constitutes an environment in which HIV/AIDS communication and prevention education takes place;
  2. Culture as content – It generates an ethical motif guiding the evolution of local cultural values and resources that can influence prevention education; culturally appropriate content of sensitization messages is mandatory for them to be well understood and received
  3. Culture as a method –It legitimates social practices which can be useful in enabling peoples' participation, and which can be harnessed to help ensure that HIV/AIDS prevention and care is embedded in local cultural contexts in a stimulating and accessible way.

6. THE NEED FOR A NEW MORAL PSYCHOLOGY DRIVEN BY OBJECTIV VALUES

- Sexuality influences every aspect of of our lives. Behaviour is a conscious process. driven by perceptions, after-images, private thoughts and dreams of which only person himself is aware.
- Objective values have three parts: (1)moral knowing, (2) moral feeling and (3) m behaviour. Our conscience is an inner voice. It is the realm of assurance and i peace. It is the realm of intention.
- Conscience-is the source of good moral conduct. It decrees oughtness and is therefo the driver of moral obligation
- Attitudes, personal behaviour and the challenge of AIDS
    1. Good health includes protecting your good current health status from deteriorating
    2. Good health involves demonstrating appropriate knowledge to maintain or improve your current condition
    3. Good health involves nurturing good attitudes to guide appropriate behaviour that will ensure sustained health in future
    4. Attitudes reflect an inward orientation and readiness to respond in a predetermined manner to a given object, concept or situation
    5. Attitudes determine performance. Determination is where availability, skills ar willingness intersect

14. CULTURE IS DYNAMIC AS A SOCIAL PROCESS

- **Culture also serves as a standard of judgment. We must begin to interrogate the university as an arena of sexual permissiveness. The difference between right and wrong, virtue and evil, even ethical and corrupt, are all conditioned by culture and we must begin to create new university cultures.**
- **There is need for the building of a new community conscience, a collective conscience. Conscience is the driver of moral obligation. We must adopt pragmatic education and prevention approaches across cultures.**
- **Culture also conditions how we communicate. Human beings are phenomenological actors. We cannot cannot restrict ourselves to cultural practices as explanatory evidence conceals the dynamics of cultural change because of the massive social changes in terms of urbanization and globalization and cultural diffusion.**
- **We may use cultural symbolisms and moralism to communicate certain clear messages to high risk groups who typify what is wrong in society. Nevertheless it is problematic to treat traditional practices as ready made predictors of the relative risk of HIV/ AIDS. Clear-cut policy is needed to assist in the creation of behavioural changes that could make a difference in scaling down the epidemic**
- **Culture has a key role in development. There is need to analyze the critical role of cultural concepts, traditions and practices in Africa's development. When we note that the disease is much more prevalent in cities and along transportation routes, the arguments based on traditional cultures become suspect. Instead of focusing on traditional cultures only, it is necessary to look at emerging cultural orientations and world views in urban areas and universities for example.**

18. CONCLUSION: HIV /AIDS AND HUMAN CAPITAL IN AFRICA

- Culture plays a central role in safe-sex behaviour. Some cultural practices may directly interact with bio-medical mechanisms of the disease transmission such as lack of male circumcision. This may affect the individual's chances of infection indirectly.
- Cultural rites of passage and other customary practices do influence attitudes and predispositions towards safer or more dangerous sexual behaviours.
- Clearly HIV /aids epidemic is devastating economic growth and development in Africa. It affects individuals and households and whole economies. It has been pointed out that when a country has a prevalence of 20% its GDP growth drops by an average of 2.6 % per year.
- The entry of HIV/ AIDS into universities poses a great threat to Africa's human capital. Human capital is that skilled labour that operates sophisticated machinery, that creates new ideas and new methods in economic activity. Human capital includes people's knowledge and skills acquired through education and through exertion of their strength and vitality.
- The biggest tragedy in Sub-Saharan Africa is the negative impact of HIV /aids on the development of human resources. The disease reduces the human capital stock and the ability to create human capital. Human capital plays a very important role in the development process.
- When the infected become ill, the value of their human capital is reduced and so is their capacity to produce more human capital by passing on knowledge and skills to others. There is a great challenge in producing enough capital to replace the lost capital. Capacities of institutions need to be strengthened so that they can be in a position to replace human capital lost to AIDS and produce more human capital for growth.