PECIAL REPORT

Denial, objection to sex education hinder Aids war

Peter Lamptey, a Ghanaian, rently the director of the AID-funded AIDSCAP project a senior vice president of nily Health International, has n involved in public health earch, health care services very, teaching and policy rm for over 20 years. He was ntly in Kenya to attend an SCAP workshop and meet try advisers from 17 African ntries in which AIDSCAP is lved in Aids prevention grammes. In this interview, Staff Writer *PATRICK UGI*, Dr Lamptey speaks of threat of Aids epidemic in ica and other continents and the organisation is uggling to contain it.

estion: What is AIDSCAP and at are your objectives?

r Lamptey: AIDSCAP stands Aids Control and Prevention ject, a department of Family lth International, funded by United States Agency for rnational Development SAID), and the main goal of the ject is to provide technical assance and funding to develop- countries' Aids prevention grammes. We work in 34 ntries in Africa, Asia, Latin erica and the Caribbean and work towards improving the acity of these countries to pat the Aids epidemic.

Q: What kind of budget does DSCAP have and how does it end the money.

A: USAID has different mechams. AIDSCAP is one of these echanisms. They also fund er programmes as far as fam- planning and other proammes are concerned through e USAID missions in the couns that we work in. But we ceive our funding directly from SAID.

On the average we have about large programmes and we end anywhere from $1 million $3 million per year a country terms of prevention activities the 15 countries and anywhere om $500,000 to $1 million per ar for the other 20 countries or to be precise.

We work in 17 countries in rica out of the 34, and 50 per nt of our resources is spent on rica.

Q: What is the response to your rvices and how do you assess ur success and aceptability?

A: Prior to AIDSCAP, we had a roject funded by USAID called IDSTECH. What we have done the last eight years especially Africa is to convince policy akers and the population that ere is an epidemic. In the last ve years we had to start a lot of ilot programmes, with sex orkers or with the clients, ansport workers. The aim at at time was to try and convince eople that there is a problem id we need to do something bout it. With AIDSCAP most ountries have been convinced hat they have a problem and what we need is to establish large cale programmes targeted at he population to try and slow down the epidemic. For example, here are three things we do in ll our strategies. One is to try nd change behaviour and there s a whole spectrum from bstenance among youth to reduction of sex in normal partners, promotion in condom use, mutual fidelity.

Affordable

Second is to make sure that the sexually transmitted diseases (STDs) are properly treated because if you can treat an STD it reduces a person's chance of getting HIV. And the third is to make sure that condoms are available and affordable. I would say that perhaps the biggest accomplishment of AIDSCAP is promoting this technical approach towards Aids prevention.

The second achievement is that despite the amounts I have mentioned appearing large, they are quite inadequate for most Aids prevention efforts and therefore we get resources not only from other donors, private sector service sector, from the community to make sure that more resources are provided for Aids prevention efforts and I also believe that we have helped highlight the seriousness potential social and economic impact of the epidemic through the social studies we have done in various countries.

Q: Could you give figures to show how prevalent the epidemic is in Africa, like how many people are suffering from this disease and which countries are most affected.

A: The estimated HIV infections in the world at the end of 1994 was nearly 20 million people. Of these roughly 13.5 million cases are estimated to have occurred in Africa since the epidemic started. The countries that are probably most seriously affected – these are countries where at least up to 20 to 30 per cent of the adults in the urban areas are reported to have been infected – include Uganda, Zimbabwe, Rwanda, Tanzania and Botswana. These are some of the examples, and I can name at least up to 10 to 12 countries in Sub-Sahara Africa where the epidemic is very serious. Even in some parts of West Africa like Ivory Coast, Aids has now become the commonest cause of death among both males and females. So you are talking about an epidemic which in the last 10 years has increased (spread) from commercial workers and now the general adult population and in the countries I have mentioned somewhere between 30 per cent or more of pregnant women attending ante-natal clinics have been infected. When you reach that stage you realise that you have a real problem on our hands. It is unfortunate that we have known about this for more than ten years but most countries wait until the problem gets out of hand; its sad but we can do nothing about it.

Most people affected are between the ages of 15 and 39. The peak is around people in their twenties and early thirties. That is where you have the greatest concentration. However if you look at Aids infections that we are getting, we find it is the early adults anywhere between 15 to 25 because they are just entering sexual activity. These have the highest number of new cases. We need to focus our attention on adolescents and young adults because they are most vulnerable.

Policy

Q: Why have many countries had to wait until the problem got out of hand?

A: It is difficult to say, but the possible explanation is all over the world – denial. The fact this has happened in other countries we don't think it can happen to us. It is denial at both government policy level and on individual basis. We all know that even though we have seen people die of Aids for some reason, we don't think that it will affect you; so denial is an important reason.

The second one is obviously, especially in Africa, there is a lot of competing needs – health and development needs – so the decision to allocate resources for Aids is always competing with other demands and therefore that decision is not made.

The third factor is inadequacy of resource whether it is donor resources or the public sector. A lot of countries have started some action but they have not put enough resources to make a difference in the national level.

Q: How effective is AIDSCAP Aids prevention programme in Africa?

A: We have been very effective. There are different ways of measuring effectiveness. One is changing policy and making sure we are working with countries that are very interested in establishing large scale programmes. I think we have succeeded in doing that.

The second way of assessing the impact is through the use of what we call process and outcome data, for example how many condoms are we selling; how many people are we reaching; how many people have we trained to diagnose STDs better and treat them. We have lots of statistics to show how successful we have been.

For example, five years ago less than one million condoms were being sold or distributed in Africa. Over this period of time we have increased this to close to 50 million condoms. And this is the continent where people said African males don't like condoms. That is an indicator of some of the success we have had. The ultimate though, is to either look at the normal people who have changed their behaviour and therefore its import on the HIV incidents. That takes a little while to obtain.

Q: Is research considered an important area in your organisation?

A: We do research, but most of our resources are spent on providing service, working with the implementing agencies in the country to implement a programme to prevent Aids. The limited research that we do is primarily in the behaviuor area to better understand the behaviours that put people at risk, because one way to change behaviour is to understand what they are already doing, some of the social norms, and therefore changing them or finding ways of changing them.

Q: With the spread of Aids taking the centre stage, the spread and devastating effect of STDs is more or less getting forgotten. How is AIDSCAP aiming to keep the issue of STDs on its agenda and what programmes do you have for STD management?

A: It is unfortunate that we haven't paid a lot of attention to other STDs in the past, because HIV is also an STD. It is even most unfortunate that even with HIV we have not done as much as we should, we can geve a lot of reasons why, because in the past other governments or programme managers said people who get STDs deserved them because of their behaviour. The services that had been provided were extremely poor; but with the advent of Aids, it is even more important because if you can change the behaviour that result in the transmission of STDs, those are the same behaviour why people get HIV.

The second reason is that the presence of an STD increases someone's chances of getting HIV by as much as from four to 10 times.

Recent studies in Tanzania funded by the Overseas Development Assistance programme (ODA) of the British Government and European Community indicate that if you are able to treat these bacteria STDs effectively, you can reduce the transmission of HIV by 50 per cent. That is probably one of the most important information that has ever come out in Aids prevention and we need to double our efforts in treating STDs and I am afraid that is one of the biggest weakness in any Aids programme.

Q: What are the cultural problems that constrain African's from getting involved in the prevention programme, and how does AIDSCAP aim to overcome the problem?

A: The way we work in any country is that we don't actually send our staff to design any programme. We provide funding to organisations that are local, that are working in the country, that understand the culture, and they are therefore the ones that design the programmes. So they design the programme around the prevailing cultures with the understanding of what is feasible and what is not feasible. We work with both the Government sector as well as those in the PV Community, the NGO community or sometimes the private sector. So the programmes are designed by those who are already culturally sensitive.

Q: What would you say are the general problems your organisation has been encountering in meeting its objectives?

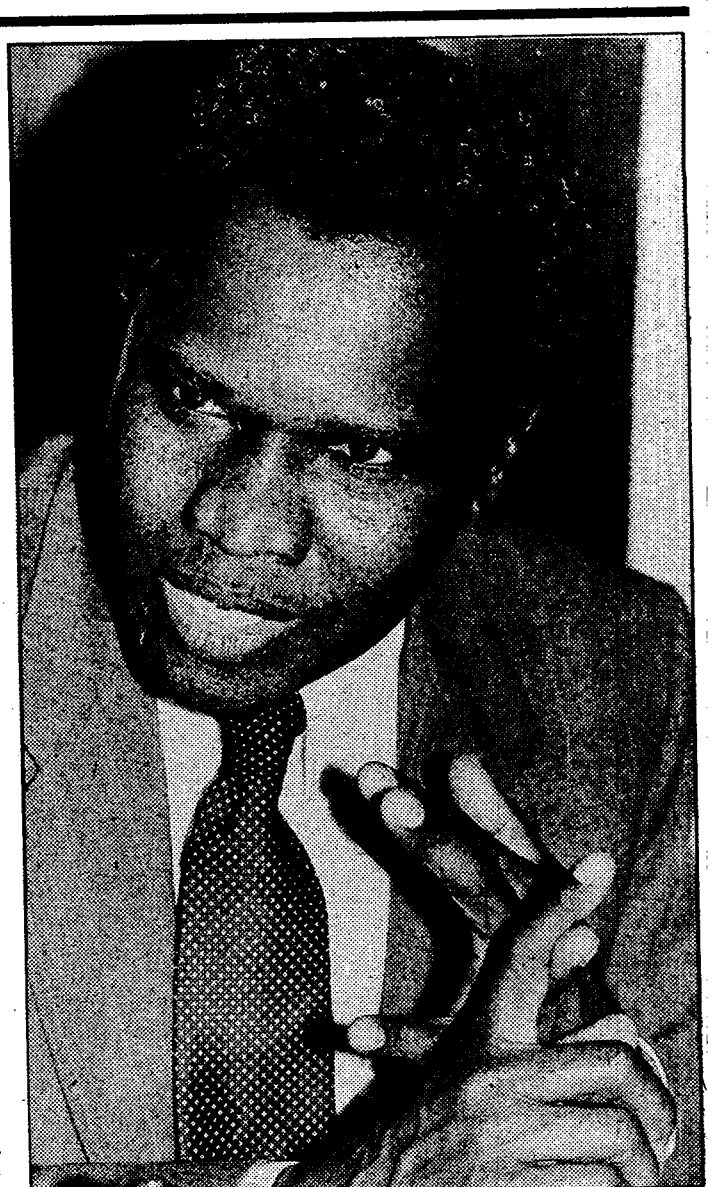
A: The most important by far I would say is the fact that we don't have enough resources to do everything that we need to do. A country like the size of Kenya in my estimation probably would need anywhere from $5 million to $10 million to have an effective Aids prevention programme including treatment of STDs, making sure that all the condoms that are needed are available. So if you compare to the size of a country like Nigeria which is much bigger in terms of population, we also have about $200 million per year. And in Nigeria we can only work in three states. Our efforts even though is larger than many other donor programmes is still very small. So even if we are successful in those three states in Nigeria, what about the other about 27 states? For me this is one of the biggest problem, and that is part of the reason why the epidemic keeps on spreading because the scale of our prevention effort is small. And this also applies to other larger countries we are working in such as Brazil or India, which has a population of 900 million. The state we are working in has a population of 50 million and even in that state we are only reaching a small proportion of that 50 million.

Q: In Africa we have over 40 countries. You are only in 17, why and how did you select those 17 countries?

A: Those countries were actually selected by USAID missions who are in those countries in colloboration with the governments of those countries. They made the decisions whether they have the resources and whether there is a need, good reception. We are also limited by the number of countries we can work in. Obviously if we try to work in all the countries in Africa, Asia and Latin America we will run out of funds, so there is determination in terms of which countries to work in.

Q: Can you tell us about your programme in Kenya and experiences here?

A: I can mention at least one programme which I am quite familiar with. It is designed to provide assistance to churches in Kenya to understand what their roles are in Aids prevention and care management and to provide assistance to the clergy for them to incorporate Aids education and messages to their parish. The programme is going on quite well. The church has a lot of influence and clout in terms of social norms and government policy but most specific on what people need to do in terms of Aids specially fidelity among adults and abstenance among the youth especially in adolescents. They (the church) are an important ally.



Dr Peter Lamptey outlines AIDSCAP programmes during the interview. *(Picture by YUSUF WACHIRA)*

Practices

Q: What are the social practices and norms that put Africans at greater risk of contracting HIV?

A: We know what risk factors are: having unprotected sexual intercourse, having multiple partners, having sex with a commercial sex worker and others such as the presence of an STD. The behaviours that Africans engage in are not unique to Africa, they occur in Asia, they occur in the United States but I think that historically we did not know about this epidemic for a long time because it had not been discovered and it was spread very quickly before we even realised that it was an epidemic. This is one of the major reasons why Africa has been affected so severely and a special consideration is because we don't have enough resources for an effective preventive effort including STD treatment.

So you have a continent that has a poor health infrastructure, it has poor resources and has competing needs in other development areas and is faced by the worst epidemic possible. Changing the behaviour is probably the most important message. It is happening but not fast enough. We need to change our behaviour otherwise this epidemic is going to get worse.

Q: In your opinion, has the organisation lived to its expectation for which it was formed?

A: Yes, I believe we have. Actually we have gone through an evaluation. USAID hired a separate organisation to come and evaluate our programme and one of the first major conclusion was that this was one of the best Aids prevention programme in the world. They also said that they believe that we are providing the right technical leadership in Aids prevention and that we are also a credible organisation in this effort. So I couldn't be happier in terms of our efforts. However, there is always room for improvement and something else we need to do better is the control of STD. We unfortunately cannot provide STD drugs and if you walk to any STD clinic in most parts of Africa, their greatest needs would be drugs.

Another area we need to move faster in terms of our programme because this epidemic is moving faster than we... Some of the other areas we need improvement is to work closer with the community based organisations. Seventy per cent of our funding goes to PVOs and NGOs (Private Voluntary Organisations) and we need to do a better job.

Q: What role does AIDSCAP play in enlightening the youth about the epidemic as they are the future adults?

A: I couldn't agree more... those are the future of every nation and if we don't do anything about it, 10 years from now they are the ones who will be getting infected. Generally we have programmes that try to give sex education, Aids education in schools and we have special programmes for youths who are out of school as well. Our biggest problem in this area has been opposition of some countries who don't support sex education in schools, because they believe sex is immoral and people would engage in it anyway. But by far the commonest reason is the false belief that if you provide sex education or education on Aids, or even condom, you will increase promiscuity among the youth, despite the fact that a lot of studies that have been done in most countries have shown that when you provide condoms and sex education to youth, the only thing that you do is that you actually improve condom use among the youth who are already sexually active; that you do not increase sexual activity among those who are not sexually active. But we dont seem to get this message across.

I think that if we want to save that generation we need to be practical, we have to look at the problems that we have, adjust our solutions accordingly. We cannot continue to bury our heads in the sand. and hope that the problem will go away because it won't. Opposition of religious leaders, political leaders, parents is a major constraint not only in Africa, but everywhere else, even in the US.