Africans and the Incidence of HIV/AIDS: The Role of Educational Institutions

Kunirum Osia
Maryland State Department of Education, USA

Abstract

The rate and number of HIV/AIDS infection in Africa is alarming and worsening. The design of effective prevention strategies hinges on an understanding of the multifaceted causes of the pandemic, or its regional epidemics. On this score, the role of educational institutions becomes imperative. This paper will examine available data to gauge the enormity of the HIV/AIDS epidemic in Africa. The investigation will be country-specific, namely, Botswana, Ethiopia, Nigeria, South Africa, Tanzania and Zimbabwe. Greater emphasis will be placed on the youth who appear to be much more vulnerable than adults. This paper argues that appropriate education about HIV/AIDS will go a long way to assist in the control of the epidemic. Schools are an important and indispensable forum for conveying norms and societal values that encourage young people to avoid taking the risks that make them vulnerable to HIV/AIDS.

Keywords

HIV/AIDS, Seroprevalence, Health, Africa, NEPAD, Educational Institutions

INTRODUCTION

Out of the 8 goals enunciated by the world body, this short presentation will consider just one, or indeed part of one of the goals. With all that goes on in Africa, one is tempted to ask: can anything good ever come from Africa? When one talks of or reads about famine, one does not have to go far, to find that it is abundant in Africa. When one talks of endlessly roaming refugees, where else do you find them but in Africa? For clearer focus, we will confine our discussion to sub-Saharan Africa (hereafter called Africa). In a fuller discussion about HIV/AIDS we will narrow our discussion and give six country-specific examples to illustrate the enormity and urgency of HIV/AIDS in Africa.

Africans have on their own been setting goals for their development, going as far back as 1963 with the creation of the Organisation of the African Unity (OAU). Since then until the transformation of OAU into African Union (AU) no decade passes without each being described "decade for African development." The decade of 1970s was described "UN decade for African development". 1970s have come and gone. 1980 to 2000 was defined as African decade for economic growth and development. Specifically, it was called the Lagos Plan of Action. This plan set the goals of self-reliant, food self-sufficiency, industrialized and economically unified Africa by the year 2000 (Osia, 1987). When nothing was really achieved, in 2001, a new African initiative was adopted. This was called the New Partnership for African Development (NEPAD). NEPAD is a pledge by African leaders, based on a common vision and a firm and shared conviction that they have pressing duty to eradicate poverty and to place their countries, both

individually and collectively, on a path of sustainable growth and development. This initiative is anchored on the determination of Africans to extricate themselves and the continent from the malaise of underdevelopment and exclusion in a globalising world. It is a call for a new relationship between Africa and the international community to overcome the development chasm (Our Rights, 2002).

The initiative is premised on African states making commitments to good governance, democracy and human rights, while attempting to prevent and resolve situations of conflict and instability on the continent. Coupled to these efforts to create conditions conducive for investment, growth and development, are initiatives to raise the necessary resources to address the development chasm in critical areas such as, infrastructure, education, health, agriculture and information communication technology.

While these efforts on goals are certainly commendable; and while now that the UN Millennium Development Goals add another impetus to solving world problem, especially that of Africa, one wonders how many Africans would be left when the so many goals have actually been achieved. This question is important because the ravaging of Africans by HIV/AIDS is alarming. African youths and women seem to be particularly vulnerable.

AFRICA AND HIV/AIDS

In the year 2000, The Miami Times captured the chilling situation in Africa regarding HIV/AIDS. Officials of international aid programmes then described the AIDS crisis in Africa as a catastrophe since the bubonic plague—one of the largest health crises in world history. These characterizations may in fact understate the enormity of what Africa has been facing. AIDS is now the leading cause of death in Africa for adults between the ages of 15 and 49. Looking at the statistics from the World Health Organization and UNAIDS, the Joint United Nations Programme leading the international effort to deal with HIV/AIDS in Africa, as presented by The Miami Times, reveal the extent of this catastrophe:

> *Home to only 10 percent of the world's population, Africa contains nearly two-thirds of the World's HIV/AIDS-infected population and three quarters of HIV/AIDS death to date. Of the 16.3 million people who have died from this virus worldwide, more than 11 million have been Africans. 21 million Africans are currently infected; as many as 6,000 individuals contact the disease through heterosexual sex. Most infected Africans do not know they have the virus. 95 percent of Africans infected with HIV live in abject poverty, with no hope of obtaining today's expensive "cocktail" of drug therapies in the western world to extend patients' lives. About 87 percent the world's HIV-infected children live in Africa. Africa has nearly 7.8 million orphans as a result of the epidemic. By 2001, the number of orphans will reach 13 million. Without intervention, in a decade, 40 million African children will be left without parents.*

This is an observation one would consider old. What 2004 statistics show is much more chilling for the situation in Africa has grown progressively worse regarding the HIV/AIDS epidemic. Isolating the youth of Africa, we would get a better focus on the enormity of the problem. Although young people suffer the most from HIV/AIDS, the epidemic among youth remains largely invisible, both to young people themselves and to society as a whole. Young people often

carry HIV for years without knowing that they are infected. As a consequence, the epidemic spreads beyond high-risk groups to the broader population of young people making it even harder to control (MacDonald et al., 1994)

THE YOUTH AND HIV/AIDS

Of the more than 60 million people reported globally to have been infected by HIV in the past 20 years, about half became infected between the ages of 15 and 24. Nearly 12 million young people are living with HIV/AIDS. Young women, the literature states are several times more likely than young men to be infected with HIV (Population Reports, 2001). In nearly 20 African countries 5% or more of women ages 15 and 24 are infected (UNAIDS, 2000). Such statistics underscore the urgent need to address HIV/AIDS among the youth, especially in Africa. AIDS has become generalized among the youth in almost half of sub-Saharan Africa, to the extent that HIV epidemic of 5% or more of young women are infected (Ainsworth and Over, 1997).The question that comes to the fore is: why are the youth so vulnerable? The immediate answer, apart from total ignorance is the youth's sense of infinite duration, boundless horizon, world without end. In other words, physical, psychological, and social attributes of adolescence make young people particularly vulnerable to HIV and other sexually transmitted diseases. Adolescents often are not able to comprehend fully the extent of their exposure to risk. Societies compound young peoples' risk by making it difficult for them to learn about HIV/AIDS and reproductive health. Moreover, many youth are socially inexperienced and dependent on others. Peer pressures easily influence them—often in ways that can increase their risk. This is where academic institutions come into play by providing instructional materials and instructions that portray in vivid colours the dangers of HIV/AIDS.

This brief reference to the risks that the youth run as far as HIV/AIDS is concerned becomes problems of adults as these young men and women grow with HIV/AIDS into adulthood for those lucky to make it that far. Let us cite just a few validated examples of HIV/AIDS in a few African countries. The choice of countries to be looked at is not by randomization but arbitrarily. For this presentation we would look at six African countries.

COUNTRY-SPECIFIC EXAMPLES

Botswana: Botswana is a country of 1.6 million inhabitants. It is experiencing one of the most severe HIV/AIDS epidemics in the world. When statistics began to be compiled in 1992, 18.1% of pregnant women tested positive for HIV, increasing to 35.4% by 2002. This trend peaked in 2000 at 38.5% and has declined slightly but not significantly, in the last two years. It is estimated that in 2002, 258,000 people aged 15-49 years were living with HIV in the country. Based on the data from the Central Statistics Office, about 18% of all deaths were attributed to HIV/AIDS, making it the leading cause of death among women, men, and children. It is estimated that by 2010 life expectancy could drop to as low as 29 years. If nothing is done to halt this epidemic, one third of Botswana's adult population could die over the next 8-12 years (CDC Global AIDS Program, 2004a).

Ethiopia: With a population of approximately 70 million, Ethiopia is among one of the African countries most heavily affected by the HIV/AIDS epidemic. It contributes about 4% of the world's total AIDS load. The Ethiopian Federal Ministry of Health estimated that 2 million adults and 200, 000 children were living with HIV in 2001; representing an adult HIV prevalence rate of 6.6%. More than one million cumulative deaths have been attributed to AIDS and over one million children have been orphaned. The principal routes of HIV transmission are heterosexual sex and mother-to-child (CDC Global AIDS Program, 2004b).

Nigeria: With an estimated population of over 120 million, many risk-factors contribute to HIV epidemic in Nigeria, including mobility of commercial sex workers, polygamy and multiple sex partners, high risk practices among itinerant workers. Youth and young people in Nigeria are particularly vulnerable to HIV. Recent estimates from the 2003 National HIV/Syphilis seroprevalence sentinel survey by the Federal Ministry of Health (FMOH, 2004) indicate an HIV prevalence rate of 5.4% for individuals aged 25 to 29; 5.6% for individuals aged 20 to 24, and 4% for those aged 15 to 19. HIV infected number 3, 200,000 – 3, 800,000. AIDS deaths (reported as AIDS) number 170,000. Listen to this AIDS Orphans number 1,000,000 (CDC Global AIDS Program, 2004c).

South Africa: With a population of 43.8 million and with a well-developed health infrastructure relative to other African nations, one would have hoped that the HIV/AIDS situation in South Africa would have been much less. But not so when one reads the following statistics: Estimated HIV Infected number 4.8 million. In 1999 alone the estimated AIDS deaths numbered 250,000. Estimated AIDS orphans number 420,000. 11% of South Africans are HIV-infected. It is estimated that by 2010 HIV prevalence could reach 25%. Statistics present an alarming number estimated number of 1,600 HIV infections daily; two thirds of these infections aged 15 to 20. By 2008, 1.6 million children will have been orphaned by AIDS.

There is a substantial amount of international and donor interest in South Africa. In 2005 the population is expected to be 16% lower than it would have been in the absence of AIDS. By 2015 population loss to AIDS-related deaths will be 4.4 million. In 1998 South Africa had approximately 100,000 AIDS orphans, and by 2008, 1.6 million children will have been orphaned by AIDS. An estimated 50% of all tuberculosis patients are co-infected with HIV. In some hospitals, the prevalence in tuberculosis patients is higher than 70 percent. If South Africa that is really an advanced country in perception and reality is having this horrendous problems and that has all the facts and statistics to support its reports, what about those African countries that even the Millennium Development Goals are certainly going to bypass? (CDC Global AIDS Program, 2004d).

Tanzania: Tanzania with an estimated population of 35 million has a high prevalence of HIV/AIDS. It is estimated that Tanzania has 1.3 million HIV-infected individuals. In 1999 estimated deaths by AIDS were 140,000. 1.1 million have been orphaned as a result. In 1998, the Ministry of Health reported that the HIV seroprevalence among pregnant women in four districts ranged from 12% to 24%, and that HIV seroprevalence among men and women blood donors was 9% and 12%, respectively (CDC AIDS Program, 2004 and UNAIDS, 2004e)

Zimbabwe: With a population of 11.6 million, the HIV/AIDS situation, is indeed pathetic. As of 2003, HIV-infected individuals number 1.8 million. AIDS-related deaths number 200,000.

Orphans as a result of AIDS number 761,000. What is very perturbing about Zimbabwe's condition is the proven-fact that the number of new HIV infections, new AIDS cases, and AIDS-related deaths continues to increase. Hetero-sexual contact is the most common made of HIV transmission in Zimbabwe, with some vulnerable populations affected disproportionately by the epidemic. A survey done between 2001-2002 by the Zimbabwean Young Adult Reproductive Health and HIV/AIDS, collected HIV prevalence and behavioural data on a representative sample of men and women aged 15-29 years between September 2001 and February 2002. Results indicated that the HIV prevalence among Zimbabweans aged 15 to 29 years was higher among women (with 21.8%) than men (with 10.3% and that the highest prevalence was found in the 25-29 year age group for both women (34.7%) and men (24.4%). A seroprevalence survey among pregnant women attending antenatal clinics from mid-October through December 2002 reported 25.7% HIV prevalence among pregnant women in Zimbabwe. Little difference was found in HIV prevalence by area of residence for women (23.0%) prevalence in urban and 21.0% in rural areas or men (11.8% in urban and 9.3% in rural areas (CDC AIDS Program, 2004f)

All of the above information and statistics paint a picture that sends chill through one's spine. They leave us wondering and asking: what next will come out of Africa? We looked at just six countries. 48 other countries have their numbers too. What role should academic institutions in Africa in particular play to stem the tide of the spread and infection of HIV/AIDS so that African countries can achieve the UN Millennium Development Goals by 2015?

THE ROLE OF EDUCATIONAL INSTITUTIONS

It is not going to be easy. HIV/AIDS is the fourth largest cause of death globally and the leading cause of death in Africa. Despite its widespread reach, the epidemic is still in its early stages. Public health officials estimate that the illness and deaths to date represent only 10% of the eventual impact. Researchers project that by 2010 HIV/AIDS will reduce average life expectancy in some African countries to around 30 years.

AIDS today is widely seen as a social crisis as well as a problem of individual behaviour. Culture and society have powerful effects on behaviour and often increase young people's vulnerability to HIV/AIDS. Young people are not able fully to comprehend the extent of their exposure to risk and the potential dangerous results. The AIDS epidemic is complex, and thus only a combination of approach can succeed. It is increasingly clear, however, that the youth must be at the center of strategies to control HIV/AIDS. Academic institutions, the world over, including in Africa, have the youths. They must be committed to educate and communicate to the youths the dangers inherent in risk- taking when it comes to their sexual encounters. Education and communication programs, projects and instructional materials must go beyond merely offering information for taking tests at the end of a semester; these must include fostering risk-avoidance skills as well, such as delay of sexual debut, abstinence, and negotiation with sex partners.

Components of HIV/AIDS Education

HIV/AIDS education should begin early, even before children become sexually active. From elementary school, to the secondary school and to the tertiary or academic institutions teachers must be frank and un-abashed about the dangers of HIV/AIDS in their teachings. The teaching

should not be left to the school of public health. Professors of Engineering, Physics, Mathematics, Language and literature should have the ability to sneak into their presentations points that would warn their students about the risks and ultimate price for indulging in activities that cause HIV/AIDS.

Important components of HIV/AIDS education for the youth should include peer pressure and norms that encourage risky behaviour. Changing young people's risk-taking behaviour requires going beyond information provision to helping them acquire the ability to refuse sex and negotiate with sex partners. Researchers have identified key elements of HIV/AIDS education programmes, largely from the US-based studies (Kirby, 1999 & 2001). These education elements include but not limited to:

- Focusing on reducing specific risky, sexual behaviours;
- Using theoretical approaches to behaviour change that have proved successful as a basis for programme development;
- Having a clear message about sexual activity and condom use and continuously reinforcing this message;
- Providing accurate basic information about the risks of young people's sexual activity and about methods of avoiding intercourse or using condoms against HIV infection;
- Dealing with peer pressure and other social pressures on young people to be sexually active;
- Providing modeling and practice of communication, negotiation, and refusal skills;
- Using a variety of teaching methods that involve the participants and help personalize information;
- Selecting as teachers people who believe in the programme and then training them to be effective.

Furthermore, HIV/AIDS education programmes carried out in educational institutions should be age-appropriate, that is, instructions for young people should focus on avoiding or delaying sex, while those for older people should include discussion of condoms and other contraceptives in addition to urging abstinence (Ainsworth and Over, 1997, Collins, 1997 and Kirby et al., 1994). Of course, education cannot help those who are not in school or do not see the need of knowing more about the risks involved in HIV/AIDS or those who traffic in prostitution for a living. Teachers should also use the mass media by engaging in public discussions about the danger inherent in reckless unprotected sex. The mass media, especially television and radio reach large numbers of young people and have enormous influence. Most young people, particularly in urban and to some extent rural areas have access to radio if not to television (Bern and Huberman, 1999).

Encouraging Testing for Infection

Educational institutions, should encourage students to get tested. Early testing for HIV/AIDS offers many benefits, especially for young people, however, in most countries, particularly in developing countries of Africa it is rare. As treatments become more available for HIV infection, early testing and counseling could lead to timely care, improve the health management of HIV-related illnesses, and provide opportunity to reduce transmission of HIV. Although debate continues whether taking HIV test leads to safer behaviour (Wolitski et al., 1997). Some researchers have shown that, once aware of their HIV-positive status, some infected people change their behaviour to avoid transmitting HIV (Lancet, 2000). In addition, starting

antiretroviral therapy as soon as possible lowers the viral load and may therefore reduce the risk of transmitting HIV (Gray et al., 2001). Nonetheless, few young people are tested. One can speculate why many young people do not go for testing: testing facilities are scarce in many countries especially in Africa; treatment for HIV –infected is often lacking, so why bother to be tested? And finally, the stigma of HIV infection can discourage many young people, as it does many adults. Regardless of age, many do not seek testing until they develop symptoms or a spouse or sex partner dies of AIDS. They may have been transmitting HIV to others for years. (Kornfield et al., 2001).

Because of high mortality from HIV/AIDS, populations in some African countries will begin to shrink in not too distant future. Researchers project that by the 2010 the average life expectancy of some countries could decline to about 30 years in those countries hard-hit, such as Botswana, Zimbabwe and South Africa. An additional effort should be made to address cultural and social norms. Many traditions and cultural practices increase risks for young people more than adults and for young women even more than young men. Efforts to involve communities and to change social norms are as crucial as efforts to reduce individual risk-taking. Certainly, no one strategy against AIDS can apply everywhere; the approach in each country should reflect the epistemological patterns of the infection. Nevertheless, because most HIV infections occur during adolescence, focusing on young people appears to be a crucial strategy and an important undertaking by educational institutions.

CONCLUSION

Certainly the UN Millennium Development Goals is laudable. Whether they would be achieved at the stated schedule will depend on lots of variables, which this brief presentation is not designed to accomplish. It must be noted that the strategy for implementing these goals are yet to be presented to the world body. The Secretary General of the UN, Kofi Annan, in 2001 commissioned a UN Millennium Project to provide him with strategies and performance measures for accomplishing these goals. The final version of the draft is scheduled for submission to the UN Secretary General in January 2005. Thereafter it will be discussed, and debated and resolutions passed. Time is of the essence when one is dealing with HIV/AIDS.

Africa needs attention now. Above all, Africa needs help. Africa seems trapped by an unfortunate synchronicity of time, place and fortune. Africans are not the mass of pathetic victims we see on television often, but lively, courageous people victimized by unscrupulous opportunists—some African, some not—who take advantage of poor governance, weak civic institutions, poor education or outright illiteracy and feeble communication to create a situation where the devastation of HIV/AIDS could have been prevented or at least controlled to a manageable degree.

In the final analysis, it is the political ambience in which activities to curb, control and ultimately eliminate HIV/AIDS, that would make it possible for educational or academic institutions or civic societies to function. If policies only remain in books and never implemented; if money allocated for fighting HIV/AIDS wind up in someone's private bank account with impunity; the incidence of HIV/AIDS would have remained a curse on humanity, including Africans.

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NOTES

1. *Since HIV/AIDS diagnosis was made in 1985, the overall prevalence rate has risen dramatically. Results of investigation show a rise from 18.1% in 1992 to 35.7% in 1998 and 37.3% in 2003 according to the 2004 Report on the global AIDS epidemic. In 2003, in more than two-third of Botswana had the prevalence of over 30%, and in the other third it exceeded 40%. The government of Botswana has put in place a strong multisectoral response through the National AIDS Council. Such political commitment has led to the integration of HIV/AIDS into national development planning.*
2. *Just like Botswana, the government of Ethiopia is actively engaged in combating the prevalence of HIV/AIDS. Antiviral therapy is accessible on payment in most of the country's regions. Individuals have been provided with guidelines for preventing mother-to-child transmission have been developed. Even the president of Ethiopia chairs the National AIDS Council. This council includes stakeholders. The HIV/AIDS Prevention and Control Office was established in 2002, both at federal and regional levels.*
3. *Nigeria has put in place necessary coordinating and decision-making bodies: the Presidential AIDS Council is chaired by President Olusegun Obasanjo. The federal coordination mechanism, the National Action Committee in AIDS, has been fully established with adequate infrastructure and capacity. Civil society participation in the fight against HIV/AIDS has been institutionalized thought the establishment of coordination mechanisms, for example the Network of People Living with HIV in Nigeria, the Civil Society Consultative Group on HIV/AIDS in Nigeria, the Faith-based Forum on HIV/AIDS, and the Nigeria Business Council on HIV/AIDS.*

4. *In 2000 the President of the United Republic of Tanzania declared HIV/AIDS a national disaster, which led to the establishment of the National AIDS Commission in mainland Tanzania and the Zanzibar AIDS Commission in Zanzibar. These multisectoral bodies are responsible for guiding national efforts to fight HIV/AIDS. Both commissions have successfully formulated a Multisectoral Strategic Framework to fight HIV/AIDS for the period 2003 – 2007.*
5. *South African government fulfils the 2001 Abuja commitment to allocated 15% of government expenditure to health. Commitment to tackling the epidemic in South Africa is backed by increased domestic financial resources. In 2003, the government allocated about $1.7 from the national treasury to fight HIV/AIDS over a three-year period. South Africa has a national strategic framework for 2000 – 2005. In 2003, the government approved a Comprehensive National Plan on HIV/AIDS Care, Management and Treatment, which aim to provide antiretroviral treatment to more than 1.4 million South Africans by 2008. The deputy president of South Africa chairs the multisectoral National AIDS Council. Civil society and private sector engagement in shaping, influencing and implementing policies and programmes have been facilitated largely by the progressive constitutional democracy of the country. There is a plethora of international bilateral organizations, foundations and Non-governmental Organisations working in South Africa on HIV/AIDS epidemic.*
6. *To lead the national response to the epidemic of HIV/AIDS Zimbabwe established the National AIDS Coordination Programme in 1987. In 1999 the National AIDS Policy and National Strategic Framework 1999-2004 were launched followed by an Act of parliament that established multisectoral National AIDS Council in 2000. In 1999, Zimbabwe became the first country in the world to introduce a 3% levy on all taxable income to finance HIV/AIDS activities. By December 2003, approximately $2 million had been raised through the AIDS levy. Civil society and private sector are playing important roles in the response to the epidemic of HIV/AIDS. In 2004, it was estimated external assistance to the Zimbabwean HIV/AIDS response amounted to $60 million, significantly less than aid provided to some neighbouring countries. The government has set aside, together with National AIDS Council, $600,000 in 2003 and $2.5 million in 2004 to procure antiretroviral drugs, while external donor funding for antiretroviral drugs remained very limited. As of 2004, only 5000 individuals have benefited from the antiretroviral drugs. Zimbabwe is ineligible for financial assistance from the International Monetary Fund and the World Bank because of debt arrears. With international isolation, land reform leading to substantial migration, impact of drought, and HIV/AIDS, have all combined to further increase the numbers and size of groups that are vulnerable.*