

# HIV/AIDS burden in rural Africa: the people's struggle and response of the international community

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HIV/AIDS continues to be a threat for communities and countries in resource-poor settings. Despite more than 20 years of national and international efforts, countries in Africa that already faced a severe economic crisis in the early nineties are now in an even worse situation because of the macro- and microeconomic impact of the HIV/AIDS epidemic. At that time, "structural adjustment programs" were imposed by the World Bank to allow the granting of loans. These policies were applied by most of the countries implicated, thereby threatening educational, social and health systems, and preventing access to vital services by the most impoverished communities and individuals.

The joint United Nations Program on HIV/AIDS (UNAIDS) 2006 report has estimated that 39.5 million people now live with HIV infection. In the year 2006 alone, a total of 4.3 million people were newly infected and 2.9 million people died of AIDS. This overview includes an estimate that more than 15 million children under the age of 18 have lost one or both parents due to the AIDS epidemic and its consequences. The UNAIDS report has shown that sub-Saharan Africa, particularly southern Africa, continues to be the most highly affected area on the planet, with more than 12 million children orphaned by AIDS and the highest incidence rate among young adults 15-24 years old, three-quarters of whom are girls. These rising infection rates among girls and young women in countries with the highest world prevalence are clearly linked to gender-based inequities and violence in homes, schools and personal relationships<sup>1</sup>.

The impact of the disease, especially in the hardest hit countries in Africa, has led to the collapse of public health systems due to the increasing demands for health care and commodities (laboratory reagents, antiretrovirals and drugs for opportunistic infections) and for the allocation of hospital beds. The collapse has also affected economic growth at all levels, human capacity and development, demographic growth and balance by age and sex, the educational system, and national and community social networks.

The future impact of the pandemic, despite mathematical and epidemiological projections and models, is still uncertain in most of these areas because of the loss of human resources, demographic gaps, food insecurity, and socioeconomic, legal, political, cultural and gender determi-

nants, which drive the HIV epidemic and maintain, even reinforce, an environment of vulnerability and neglect<sup>2,3</sup>.

International organizations, NGOs, governments, and communities are implementing programs and investing resources in HIV prevention, treatment and care. Nevertheless, with the exception of a few successful efforts, most interventions in resource-poor settings have failed to mitigate the global impact of two decades of HIV/AIDS burden or address the critical situation of affected adults and children. Data from the WHO have shown that just 11% of HIV-positive pregnant women in need of antiretrovirals (ARVs) to prevent mother-to-child transmission of HIV in low- and middle-income countries are receiving them. Global coverage of HIV testing and counseling remains unsatisfactorily low. And, although countries committed themselves to setting targets for universal access to these resources by the end of 2006, only 90 countries have provided data on their achievements. More than 1.3 million people in sub-Saharan Africa were receiving treatment in December 2006, but this only represents coverage for approximately 28% of those in need. The number of children receiving treatment increased by 50% in the past year, but only about 15% of the total estimated to be in need of HIV treatment had access to it<sup>4</sup>.

In most AIDS-affected communities, the situation continuous to be devastating. The high death rates of parents and caregivers has increased poverty and created an environment of neglect for the new generation of orphans and other vulnerable children living in rural areas, making the HIV/AIDS epidemic the direct cause of their suffering. In some cases, single mothers or grandmothers are taking care of these children, but in families where both parents have died of AIDS and no other family members are present, the children themselves are heading households and taking care of younger siblings at the early age of 12 or 13 years. These children and their siblings are particularly vulnerable to exploitation, violence and abuse. Children left without adult care have no access to social assistance. Dropping out of school is common because of a lack of resources for fees, uniforms and transportation. The children are deprived of an education, including opportunities to learn about basic HIV prevention skills, and therefore, are at a higher risk of acquiring HIV infection.

Several studies have shown that by providing safe water, food and shelter to vulnerable women and children in the most affected areas, the impact of HIV/AIDS is mitigated at the household level and the risk of suffering sexual abuse, violence, child labor, and other forms of abuse and exploitation is reduced<sup>3,5,6</sup>.

The situation seems difficult to manage for the international community after more than 20 years of advances in

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diagnostic tests, the development of new and more effective drugs with fewer side-effects, and at a point in time when HIV/AIDS has become a chronic disease in most developed countries. But the situation in resource-poor settings is still far from being solved. We are now facing only the tip of the iceberg for forthcoming years, in which gender and socio-economic gaps continue to increase and most human rights violations are silenced, unrecorded and unpunished by governments and international organizations who should be protecting these women and children in need<sup>3,7</sup>.

International agencies, organizations and donors have emerged with the purpose of "making a difference" in the fight against HIV/AIDS in Africa. The first recipients of the available resources are governments and ministries, who work with organizations and NGOs compatible with their interests. Small grass-roots organizations usually have limited access to these resources. The system is limited by the fact that many governments are not the best recipients for these funds, since they do not include local, community organizations that are familiar with the true problems families are facing on a daily basis.

Nonetheless, people in rural areas are wise. They know what their needs are and how to solve their problems through social safety nets that have been successful for centuries in the face of highly critical circumstances. If they receive enough support from the international community, they will be able to cope with this devastating situation.

Communities are also aware that resources are often stalled at the central level, to be invested in programs and projects they are likely to never benefit from. These highly affected communities struggle to live with HIV/AIDS in rural areas, with limited access to HIV testing (less than 15% of the population in sub-Saharan Africa have access to voluntary counseling and testing [VCT] services) and ARV drugs (less than 10% of the total population meeting WHO criteria receive ARVs), prevention of mother-to-child transmission does not exist (only 1 in 10 pregnant women with HIV in low-income countries receives antiretroviral prophylaxis for this purpose), condom use and other prevention strategies have never been established or simply are not used, stigma and discrimination are common, and young people are at high risk of HIV infection due to gender and age inequities, and life in an environment of neglect and human rights violations<sup>2,7</sup>. What usually happens is that governments create "National AIDS Plans", but decentralization is always a pending process. The excuses that prevent decentralization of the main health and social services often include lack of a proper infrastructure, difficult access, and limited training and capacity of people working in these areas. Disparities in access to services among people living in rural and urban areas have proved to be an important factor to consider when assessing the impact of HIV/AIDS<sup>8</sup>.

HIV/AIDS is a cross-sectional issue. Affected communities need international organizations to provide true support through an "integrated approach," to protect them, to back them and work together with governments for the benefit of women and children who are struggling to survive. The effort of international agencies to prepare and revise guidelines and create a global framework and global commitments does not suffice; they must go from knowledge and commitment to real action<sup>9</sup>. Why is it that

agencies and organizations working in the same areas, with the same beneficiaries, and facing the same problems and crises, do not work together and coordinate their efforts in a way to really "make a difference"? Why is it more important for them to achieve high visibility for their logo than to reach more people in need by using an "integrated approach" for a crisis like the HIV/AIDS pandemic? When will the reality of people living in rural areas and their struggle to survive count enough for governments and international organizations to really help? Governments have to be made accountable for their activity before receiving additional funds for the HIV/AIDS battle, and they should commit to programs that will reach the most vulnerable inhabitants of remote rural areas.

The devastating situation of families and communities in resource-poor settings is a global responsibility for international organizations, UN agencies, governments, NGOs, the academic sector, communities and faith-based organizations. Resources are limited and should be used effectively, with stakeholders working together in a coordinated, cross-sectional approach. Public-private partnerships are a very good strategy to effectively combine experience, knowledge and resources<sup>9,10</sup>. Each stakeholder has a particular role to play:

- *Communities and NGOs* working at the grass roots level have knowledge and understanding of the solutions, but they need infrastructure, training and building capacity at the local level.

- *Governments* have the duty to fight the epidemic with nationwide programs, promoting decentralization to reach and strengthen the infrastructure and capacity in rural and remote areas.

- *UN agencies and international organizations* have to advocate for those in need, by making governments accountable before receiving more funds, recommending specific programs and beneficiaries, and determining where resources are most urgently needed.

- *The academic sector* has the scientific knowledge to recommend public health policies that best fit the local problems and the best strategies to implement them efficiently.

- *Pharmaceutical companies* have the social responsibility to reduce the cost of drugs, reagents and equipment and agree to declare ARVs as essential drugs to make them more available in resource-poor settings, despite the Trade-related Intellectual Property Rights (TRIPS) agreement, parallel imports, differential pricing and the capacity each government has to negotiate prices with them. A person's life is not a commodity to bargain with.

- *The private sector and donors* have to support public-private partnership as a strategic tool to bring effective care and support for HIV/AIDS.

Vulnerable women and children affected/infected by HIV/AIDS in rural and remote areas need protection and care. They need to count for international agencies and donors. This is particularly true for children left without adult care; they are our present, but above all, they are our future. They only need an opportunity to overcome the vicious cycle of poverty and neglect through establishment of a safe, nurturing environment to become citizens of a world of peace and well being.

If all the stakeholders contribute to make this happen in the global planet where we live, we will all partake of the benefits.

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