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grated farming. 'Self-reliance is the goal, integrated farming is the means, and simplicity must be the way of life.'

This refusal of the model. Is it a strategy that could inspire also the peasant associations of Senegal?

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US Aid to AIDS in Africa

Meredeth Turshen

WHO estimates that 6 million Africans have been infected with the human immunodeficiency virus (HIV) and that 1.16 million cases of AIDS had occurred among adults and children in sub-Saharan Africa by 1991. These are cumulative figures for ten years, including cases and deaths. AIDS is the only disease for which cumulative figures are published; every other disease is reported annually and new cases are separated from that year's death toll. Although I do not wish to minimize the problem of AIDS in Africa, one should note that the effect of cumulative reporting is to amplify the problem.

It is important to place AIDS in the context of other health problems in Africa when determining types and amounts of health assistance. WHO publishes no death statistics for Africa, only random data are available. Famine and malnutrition are currently the cause of most deaths in drought-stricken parts of Africa. An estimated 100,000 Somalis have died and 1.5 million are at risk of death by starvation in that one country alone. Malaria,

which like AIDS suppresses the immune system, is one of the most lethal diseases in tropical Africa; it is the most common reason for hospitalization and the most frequent cause of death of children under five years old. African governments report 80 million cases of malaria annually. There are no continent-wide estimates of deaths from malaria, but in general case fatality rates exceed 10 per cent - that means possibly 8 million Africans die from malaria each year. Like tuberculosis, another major cause of death in Africa, malaria is on the rise. An increase in the incidence of tuberculosis has been observed since 1985 in Burundi, Central African Republic, Kenya, Tanzania, Uganda, Zaire and Zimbabwe - all countries with a high prevalence of HIV; 30 - 60 per cent of the additional cases are attributable to HIV infection.

African children die of many other diseases. An estimated 250,000 infants die annually of neonatal tetanus, a disease that has been preventable since 1931 when a vaccine was developed. An estimated 1.2 million African children under the age of five die each year of diarrhoeal diseases. WHO publishes numbers of AIDS cases but not AIDS deaths. If one assumes a similar rate of deaths from AIDS in the United States and Africa (about 63% of Americans with AIDS have died), then some 94,000 African adults and children died of AIDS in 1990. AIDS is a new and growing health problem, one of the many health problems in Africa. High levels of malnutrition debilitate and make Africans susceptible to specific causes of death, a phenomenon known as generalized susceptibility or non-specific mortality. Which disease is written on the death certificate is perhaps less important for aid policy makers than the fact that high levels of

sickness and death call for public health programmes that can deliver a broad range of preventive and curative health services in Africa.

There are several problems with the response of the US Agency for International Development (USAID) to AIDS in Africa. The main problem is that USAID is setting up single-purpose programmes to prevent AIDS and AIDS alone. Yet AIDS is a syndrome of many opportunistic infections, not a single disease; and WHO has shown over the years that single-purpose programmes are wasteful of scarce resources and undermine competing health programmes. WHO has also shown that prevention and treatment need to be combined if disease control programmes are to be effective. USAID gives little assistance for treatment, even of associated infections such as tuberculosis, although African women are pleading for help in caring for the sick. Another problem is that political rather than public health criteria of need appear to guide the setting of targets for priority assistance. A fourth problem is that little of the money allocated actually goes to Africans; most of it is distributed in the US to various non-governmental and private voluntary organisations.

An Analysis of Project Aid

USAID is giving little assistance to African health services beyond the training of some health workers, and that training is single-purpose; for example, laboratory technicians are training to recognise only sexually transmitted diseases (including AIDS), despite the plethora of opportunistic infections associated with AIDS that need diagnosis and treatment. At the very least, laboratories should be able to screen for tuberculosis as well as

sexually transmitted diseases. USAID has not been integrating AIDS prevention into basic health services, favouring instead a vertical approach to AIDS control through family planning programmes and clinics for the treatment of sexually transmitted diseases. AIDS control, for example, might usefully be integrated in the Safe Motherhood Initiative. The vertical approach does not take into account that AIDS is a family disease, a disease that affects the health of several family members not seen in family planning programmes or sexually transmitted disease clinics.

USAID's assistance to the surveillance of sexually transmitted diseases is part of the evaluation of intervention projects to reduce the spread of HIV, rather than for the treatment or cure of disease. The surveillance of sexually transmitted diseases serves as a proxy for changes in HIV incidence, since few if any projects are able to demonstrate a direct effect on HIV transmission.

Second, although contaminated blood is known as a highly efficient mode of transmitting HIV (over 90% efficiency as opposed to 0.1-1% efficiency of sexual transmission), USAID gives little assistance to protecting blood supplies other than the development of new rapid screening tests for use in emergency rooms. The main recipients of transfusions are anaemic children and women treated for spontaneous or self-induced interruption of pregnancy and complications of childbirth. Women and children, you will recall, account for more than 60% of Africans with AIDS. USAID recommends, in Cameroon and elsewhere, that blood transfusions be reduced to a minimum. Evidently there is little confidence that blood supplies can be made

safe. Nor is there support for research on sources of blood supplies in African countries.

Third, having decided that intravenous drug use plays only a minimal role in HIV transmission in Africa, USAID says little about contaminated needles and syringes in medical settings. Disposable needles, which were first introduced in Africa in the 1970s, are systematically reused in medical practice, although they cannot be sterilized. USAID's response is not, in prevailing conditions of scarcity, to supply conventional reusable syringes and autoclaves for sterilization, but rather to support research on a prefilled injection device that holds a single dose of vaccine or medication in a non-reusable syringe with an attached needle, and a device that allows only one filling of a syringe designed to be disposable. Scarce foreign exchange will be needed to import these devices.

Fourth, USAID's main preventive strategy is to persuade sexually active adults to use condoms. USAID encourages governments to target prostitutes and their clients in these efforts. This approach relies on the classic public health responses to sexually transmitted diseases - education, contact tracing and condom distribution. There are two problems with this approach in the African setting. One, these responses have little relevance to the majority of African women at risk who are school girls and married women and do not control their sexuality. They are not in a position to impose the use of condoms on their partners. Second, many of the women marked as prostitutes are not full-time commercial sex workers. In societies in which marriage is nearly universal, in which poverty is extensive and living standards are low, in which educa-

tional opportunities are restricted, especially for girls, in which there are few job opportunities for young men, and even few for uneducated women, in which couples are frequently separated when men migrate in search of work, the sale of sexual services is likely to be common, blurring the line between infidelity and prostitution.

The outcome of this strategy of targeting prostitutes is that USAID unwittingly supports the victimisation of women. Instead of receiving consolation, praise, and the assistance they need, women are being blamed for the spread of AIDS in Africa. African women are already suffering the brunt of the AIDS epidemic, both as the majority of the afflicted population and as caretakers of both sick relations and their children. Now they are being stigmatized as prostitutes, blamed for transmitting HIV to their clients, for having 'unprotected' sex, for getting pregnant, and for passing HIV to their infants.

An underlying problem is the use of target groups in planning research and intervention projects. Categories such as prostitute, intravenous drug use, and homosexual mislead health policy makers by suggesting that transmission modes differ from group to group. Recent ethnographic research reveals the collapse of all these categories in the field: not only female and male prostitutes, and child prostitutes of both sexes, use drugs and perform anal intercourse, but also female and male tourists sample drugs and sex on holidays, though they were not on sex or drug tours and may not have left home with that intention.

Fifth, USAID is channelling funds through US-based non-profit and voluntary organisations, rather than as-

sisting governments and health services directly. The disbursement of funds through US organisations may create a few jobs for Americans and markets for American products, but it does not further the original purpose of foreign aid, which as I understand it, is to help people in distress to recover their productive abilities.

USAID targets specific countries for priority assistance on criteria other than public health need. Priority recipients are political allies such as Kenya and Zaïre, or countries such as Ghana that are show-cases for the monetary policies of the International Monetary Fund or, in the case of Cameroon, which has reported fewer than 500 cases of AIDS to WHO, the country of origin of the WHO Regional Director for Africa.

Finally, USAID assistance in the category 'health care financing' revolves around financial planning, which will probably be of interest to the multinational pharmaceutical industry. Assistance is currently directed to the development of a cost model that countries can use to plan transfusion services; the object is to implement cost recovery programmes – in other words, fees for blood transfusions and for HIV testing. There is no evidence of donations to help defray the costs of treating people with AIDS or with the curable diseases of concomitant epidemics such as tuberculosis.

The Underlying Policy Objectives

The type of assistance the US government is providing to Africa seems to be determined by policy considerations as much as by science, medicine, or public health. The policy considerations concern macro-economic issues

of third world development, and the scientific issues appear to be limited to specific experiments in the control of AIDS, which may have application in the United States. The macro-economic issues are not confined to Africa; they include balance of payments deficits and the inability of third world countries to repay bank loans. In response to these problems, USAID supports IMF and World Bank structural adjustment programmes, which comprise a set of economic reforms that includes currency devaluation, export promotion, import reduction, and the curtailment of government expenditure. Their goal is the repayment of outstanding debts.

Since 1980, IMF and World Bank balance of payments loans have supported economic reform programmes in some 40 African countries; the minimum condition for these loans is the adoption of specific policies that shape the economic reforms. In addition to an auction system to determine exchange rates, the IMF and the World Bank require increased domestic currency prices for exports, price liberalization, and increased incentives to the private sector; both agencies treat the food production sector as a 'virtual "residual" in the programmes of most countries producing agricultural crops for export.'

Rising levels of unemployment and bread riots are but two indicators of the social damage these reforms have incurred. UNICEF has documented the impact of structural adjustment on health and health services. Currency devaluation reduces individual and government spending power for purchases of life-sustaining necessities (food, water, shelter), as well as health care. Export promotion increases workloads, which fall especially heavily on

Africa's women farmers, affecting their health and that of their children. Import reduction, especially in combination with currency devaluation, affects the flow of medical and pharmaceutical supplies and equipment into the many African countries that do not produce their own. The curtailment of government expenditure has more seriously affected health, education and welfare than other services. The IMF and the World Bank are encouraging several African governments – for example, Kenya and Ghana – to charge for health services, a burden that falls disproportionately on the poor. The net result is a decline in both health status and health care in Africa. In the words of an editorial in the *Lancet*, 'there is mounting evidence of deteriorating welfare conditions – e.g. as measured by infant mortality, nutritional status, and educational enrolment – throughout Africa', and 'the quality of health services overall has deteriorated ...'

Rather than use the AIDS epidemic as an opportunity to redress the underfinancing of African health services, USAID would seem to be pursuing its long-desired programme goal of population control. The agency insists on the nature of AIDS as a sexually transmitted disease, it focuses almost exclusively on the heterosexual transmission of AIDS in Africa, and it emphasizes condom use to prevent HIV transmission. Of course, condoms also prevent conception. Although USAID projects a 30 to 50 per cent increase in child mortality as a result of the epidemic, it expects the population growth rate to decline by only 1 per cent, because total fertility is so high in Africa. USAID concludes that this is not the time to diminish family planning efforts, but instead such efforts could be redoubled.

An Alternative Health Policy

The portrayal of AIDS as a sexually transmitted disease, not only exposes women to victimization, but also justifies a health assistance policy limited to health education and condom distribution, combined with HIV testing as a means of monitoring the spread of infection. The inadequacy of this approach is shown in the US where there has been a resurgence of tuberculosis linked to the spread of HIV with inner city public hospitals collapsing under the burden of caring for AIDS patients. The policy failure in Africa, where fiscal austerity programmes have cut deeply into government budgets for health, education and welfare services, is even more grave.

AIDS could usefully be conceived of as an environmental disease in Africa. A broad environmental approach would address the underlying determinants of the spread of HIV – the economic structures that create the need to migrate in search of work and in the process destroy the social and familial networks that protect people from some types of disease experience. Although African women do not advocate a return to traditional institutions of patriarchal domination, they do recognise the failure of alternative networks in urban areas to protect young girls, in particular, from the sexual exploitation that is the stigma of AIDS.

The formulation of AIDS as an environmental disease would entail a different health policy, one that calls for an investment in the prevention and treatment of common infections, including tuberculosis, sexually transmitted diseases, and malaria. Because women and children account for more than 60% of people with AIDS in

Africa, priority should be accorded to caring for them, taking their social as well as their physical health needs into consideration. Treatment implies an investment in African health services, along the lines advocated by WHO and UNICEF in the primary health care programme.

Recognition that AIDS is an environmental disease would also call for new solutions to malnutrition that address the entire food system, beginning with issues of landlessness, and not limited to improved distribution and increased consumption of food.

Because AIDS is still primarily an urban disease, an environmental approach would entail plans to accommodate rural-urban migration, which has increased under the pressure of austerity measures and structural adjustment programmes and caused African cities to grow at the rapid rate of 6% per year. Good urban planning encompasses housing, water supply, sanitation and transportation needs, as well as health care.

An environmentally oriented AIDS policy would re-examine certain development strategies that are proving detrimental to women's health. For example, the tourist industry, sponsored by national governments and encouraged by international agencies as a solution to slow economic development, has (in some cases, intentionally) promoted prostitution.

USAID needs to turn away from the search for a quick technological fix to the AIDS problem in Africa. Putting foreign aid dollars into the development of a vaccine is not likely to help Africans, who still suffer from diseases such as neonatal tetanus and tuberculosis for which vaccines were devel-

oped more than 50 years ago. Aid dollars are needed to rebuild African health services that deteriorated during a decade of neglect and are now being called upon more than ever to cope with the myriad infections associated with AIDS.

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Angola: Free and Fair Elections!

Patrick Smith

Instead of a national celebration to mark the significant achievement of the 29 and 30 September 1992 multi-party elections, Angola has been plunged into a new period of armed confrontation. Once the *Uniao Nacional para Independencia Total de Angola* (UNITA) had refused to accept the election result and its key leadership left Luanda for Huambo (its base in the Central Highlands) the stage was set for a resumption of the civil war. All that was absent in the hostilities following the polls was a formal declaration of war. In the confused pattern of events following the elections, any attempt to apportion blame for the breakdown of the political process is far from an exact science; but some key developments elucidate the issues around the resumption of major hostilities:

1. The *Movimento Popular de Libertação de Angola* (MPLA) won the elections for the National Assembly and narrowly missed winning the Presidency. They had nothing to gain and much to lose from a return to war. There is evidence to suggest that the resumption of hostilities took MPLA off-guard allowing UNITA to make rapid gains. Western military observers confirmed that of the two forces, the MPLA's *Forças Armadas Populares de Libertação de Angola* (FAPLA) appeared less prepared for hostilities and generally more eager for demobilisation. This too appeared to be the verdict of the Angolan people; they voted for the MPLA not because of their record of economic management (which is generally regarded as weak even taking the disruptions of war into account) but for their promise to deliver a consensual government of reconciliation.

2. Interviews with officials indicate there was genuine incredulity in the UNITA camp that they had lost the elections: they had been told themselves and they had been told by their erstwhile foreign backers in Washington and Pretoria that they would win. Even Savimbi appeared to believe his own propaganda. Rather than attempt to reconcile their membership to electoral defeat, the bulk of information emanating from the UNITA radio station was highly inflammatory. There had been little attempt to reconcile UNITA's *Forças Armadas de Libertação de Angola* (FALA) to demobilisation given the poor state of the economy. The reaction of the FALA troops, put in context, is also understandable; from all the information they received from their leadership, there was little economic future for them under a MPLA-dominated government.