The Truth About AIDS

In developing countries like Uganda, Burundi, Rwanda, Nigeria, Sudan and Tanzania there are many complex issues and questions to face. It is not just a question of setting up community care programmes or reaching young people in schools.

For example, testing becomes vitally important in towns or villages where large numbers of all adults may carry HIV. When people realise how many of their friends are infected, they may have one of two reactions. They can become fatalistic, reckoning they may already be infected so not bothering to take precautions. Others may become very worried, wanting urgently to get hold of a test for themselves and their partners.

Pre-marriage testing---a social time bomb

Any church leader involved in pre-marriage counselling in such a situation will find couples wanting to be tested. In many countries, access to testing is still difficult with long travel to a testing centre, long delays, lost results and sometimes even doubt as to whether the result you have been given is really yours, or whether the result is accurate.

A church mission could order some of the newer testing kits which produce a result in a few minutes from a sample of blood or saliva without using costly laboratory equipment. Prices are falling and it is likely that soon instant saliva testing kits will be available costing less than Ã¹5 each. Testing should only be carried out after careful counselling, for reasons which will become apparent below. It is also important to know the limits of accuracy of these tests. Positive results may need confirmation to rule out a false positive result (see Chapter 5).

Some church leaders in high incidence countries are now insisting on pre-marriage testing before they will conduct a ceremony. This seems to me too drastic. It is one thing to discuss carefully the risks of entering a union without testing where one or other may have been at risk, and even to strongly encourage testing, but quite another matter to insist on tests. One hopes that all those about to embark on a lifetime of commitment to someone they dearly love will want to protect their future husband or wife and not unwittingly kill them. Testing is a very important part of pre-marriage preparation where there have been risks in the past.

Married couples want tests too

Once testing becomes available, huge problems can emerge. Married couples also want to be tested. A wife may be worried about the safety of having sex with her husband, since she is aware he has been unfaithful to her or that he had many partners before they married.

She may be even more worried when she hears that in one African country at least one in three of the women who are now dying with AIDS were virgins before they got married and have always been faithful, yet were infected by their husbands.

When testing of married couples begins, it is sometimes found that both are already infected. At least in this situation there is no risk of endangering the other person's life, although children born to the couple may turn out to be infected. The risk of babies being born with HIV can be reduced very significantly by a short course of anti-viral medication given at the right

stage of pregnancy.

For some couples it will be found that both partners are free of infection, but other couples will emerge where only one partner is infected. How are such situations going to be handled? Before you know where you are, a small testing programme involving fifty couples could have completely destroyed the marriages of ten of them, with partners walking out or being rejected or insisting on divorce.

So you can see that many churches and Christian groups in developing countries are sitting on a social time bomb which could be triggered by indiscriminate testing. Yet access to testing is vital to help contain spread.

Counselling before and after testing

Part of the answer is to provide careful counselling to people before offering a test, and afterwards irrespective of the result. Where one partner is infected, the advice will be to use condoms carefully every single time, recognising that there will be a small risk of an accident (see Chapter 6). Condom quality can vary in different countries and few people realise that latex rubber, as a naturally-occurring substance, tends to weaken with time so the expiry date on the packet is very important. In a country with a hot climate, condoms in storage can deteriorate quite rapidly.

There is some debate about appropriate advice to people where both partners are infected. It has been suggested that since the virus mutates rapidly inside each person, and since each time two people have sex there is a chance of a fresh inoculation, it is possible that those continuing to have unprotected sex may die more quickly. However, there is no real evidence to support this suggestion at present. It is certainly true that if other sex diseases are passed on, then the combined effect of these on someone whose immune system is already weakened could be great.

Engaged couples or those at the start of a relationship may be faced with very difficult and traumatic questions about their future if one tests negative and the other is infected.

Condom promotion in Africa

Africa has been targeted, as has much of the rest of the world, with the condom message, which varies in expression and emphasis from country to country. I have already challenged assumptions about condoms and safe sex in Chapter 6 .

However, even if you believe condoms to be 100% reliable, there are some serious problems to be considered in developing countries: cost, distribution and culture. It is a sobering fact to realise that, as we have seen, many African nations only have less than 2 dollars to spend on total health care for each person per year. This has to cover hospital care, clinic treatment, vaccination programmes, provision of glasses and dentistry.

Condoms can wipe out the health service

The entire health budget for a person would be used up in less than three months just in the cost of providing condoms. A couple of years ago, an international exporter faxed ACET's London offices offering us 140 million condoms at a few pence each, delivered free to any African port. The trouble was that even if we had had £11 million, *the entire consignment would have lasted the continent just one night*
---possibly two or three---and then what do you do?

The cost of rubberising all sex in Africa would be at least $250 million a year---more than the World Health programme spends on AIDS for the whole world.

Distribution can be difficult

The distribution difficulties are even greater. Let us assume for a moment that the funds are available. We still have a problem. If you give out supplies free, experience has shown with other kinds of programmes that supplies can quickly disappear. They are often bought up quickly by traders. Supplies are hard to get hold of, and as the price rises, a limited supply becomes available again in the markets.

To get over this problem, another approach has been used called social marketing. This has been tried in Congo. With this approach, condoms are not given away, but are made available to wholesalers and retail outlets at low cost for them to sell at reasonable profit.

Condoms are then always in the shops and markets, but at a low price. However, while this approach can work well in towns and cities, it is harder to make it work as well in rural areas.

A further hurdle to overcome is perhaps the most important of all. Even if condoms are available throughout a country at low cost, people may still choose not to use them. We are assuming that this is despite a comprehensive health campaign operating at every level.

Condoms are a Western `hi-tech' solution

Many African people live very simply. If you visit homes up country, you may find that the only factory-made item in the hut is a plastic petrol container being used as a water carrier, and a plastic washing-up bowl. There might be in addition one or two pots and pans and a few utensils. There may be a small battery-operated radio, but possibly not.

In comparison, a condom is real hi-tech: here is a very sophisticated item which is made to precision standard, yet is thrown away after each use. It requires great care in how it is put on and how it is removed, and requires overcoming possible cultural embarrassments or religious objections in order to talk about its use, or even to produce it. They need to be supplied regularly to places where nothing else is supplied, and where there may be a twenty-five-mile walk to the nearest clinic.

So then, condoms can provide excellent protection if used carefully every time, but can only be part of the answer to the explosive African AIDS epidemic. We have to look at other solutions as well, of which the most important in the WHO words are faithfulness and abstinence.

`Condom dumping' by the West can be resented

The perceived obsession of the West with condoms has caused some ill feeling in Africa. When I have travelled or taken part in radio phone-in programmes across Africa organised by the BBC World Service, it is clear that a number are sensitive, first to being blamed for AIDS---people say it came from Africa and it is their fault.

They are also often very sensitive to `Western imperialistic' suggestions that there are `far too many people in Africa', and that over-population is the reason for famine.

They are especially sensitive to people who seem to have population control as a hidden agenda in AIDS-control programmes. Many are deeply suspicious and angry when they find Western nations willing to pump millions into condom distribution, while their own governments are struggling to provide clean water or adequate food.

I am not saying that population-control programmes are necessarily inappropriate or a waste of time. On the contrary, anyone who has seen a graph of the world population will realise that current rates of growth cannot be sustained. Population growth is an important issue.

It is also true that the more people there are in the world, the more conditions are set for new epidemics and plagues to evolve. As we have seen, each person represents a new chance for a dangerous new mutation to emerge. The next few decades will undoubtedly see further new epidemics: we can only hope that they will turn out to be as uninfectious as HIV, and less harmful. If another lethal virus were to emerge - say - spread through sneezing, and was rapidly lethal, it would pose the greatest threat ever seen to the future of humankind.

Population control and AIDS

It is ironic perhaps that at a time when a killer plague such as AIDS is out of control, the world population should also be spiralling upwards. Perhaps that is why I have heard people dare to say that they think AIDS is a good thing to keep the population down.

When the two effects combine together, as in much of Central and Southern Africa, the end result is that population growth is slowed, while the age distribution becomes grossly distorted.

You find that the middle-age group has been decimated. The twenty- to forty-year-olds on which the future of the whole nation depends are in short supply.

People often use Uganda as an example because it is the most open in discussing AIDS. However, many other countries are at least as badly affected. Recent reports suggest similar infection rates as far south as Zimbabwe.

There is a strong link between population control politics and AIDS-prevention programmes. You must remember that African nations are largely dependent on massive foreign government handouts for AIDS programmes. In Uganda such funding has formed a major part of the economy, in the mid 1990s before a period of peaceful rapid economic growth, together with other development programmes. Any visitor to Uganda 10 years ago used to notice that many of the vehicles driving round Kampala were owned and run by relief agencies.

Rich pipers call the tune

Attending a recent meeting of the World Health Organisation in Geneva I had rather a shock. As an international AIDS agency, ACET International had official observer status and could take part in debates. Round the massive circle of desks and microphones were represented a large number of countries, each with four or five delegates. The scene was just like one of the United Nations meetings you see on the news. There was one big difference. Almost every delegate was white.

Most developed nations were there, but only two African nations were represented, and two from Asia. To be there and have a vote, your country needed to be a donor to the World Health Organisation AIDS budget, which of course meant that the only countries deciding world policy are likely to be industrialised nations. Because Africa and the Far East would not otherwise be represented at all, the WHO had agreed that each continent could appoint two representatives for free.

The results were striking. After a long discussion by nations like Germany, the UK and the US, there was a plea for realism by an African delegate. He was listened to respectfully, but the points he made were lost among the many others present. No wonder international aid for AIDS is so often seen as so imperialistic.

Now many Western donor nations are refusing to give via WHO or UNAIDS or UNDP or UNICEF, preferring to give handouts direct to individual countries. In many cases this means even more nation-to-nation control, which suits the donor well. We have already seen how many countries have been reduced almost to economic servitude by the crippling burden of foreign debt.

Why condom programmes look good

One big advantage of condom programmes is that Western executives thousands of miles away, with no understanding of African tribal life, can then be dazzled by graphs showing millions of condoms distributed or bought each month. They can see data showing how sales are boosted by advertising campaigns and radio broadcasts. This helps keep donor nations happy, knowing that their `prevention campaigns' have reached millions of people.

So condoms are not necessarily the easy answer you might think when it comes to Africa, although their use may be measurable and attractive to fund.

Despite all I have said, we must recognise their important role in HIV prevention directly and also indirectly by reducing other sex diseases which help transmission. Finally, at a time of great unsustainable population growth, condoms also enable families and nations to control fertility.

Testing can form part of the answer too, while encouraging people to be celibate or faithful. The treatment of other sexually-transmitted diseases is also important. Testing and encouraging no-risk lifestyles do not pose any difficulties for church missions, but treating sexually-transmitted diseases can raise a few Christian eyebrows.

We must treat other sex diseases

As we have seen, one reason why heterosexual HIV has spread so fast in some countries may be because facilities for treatment of other sexually-transmitted diseases are poor, increasing the risk of transmission.

One of the most effective ways to reduce HIV spread in developing nations is to set up a large number of clinics to treat these other infections. For many churches this is less attractive than, say, suggesting people reduce their number of partners or abstain. Yet this is something we also need to think about.

Mission hospitals have always treated sex diseases as a normal part of overall community health care, but here we are talking about rapidly expanding the number of services as a deliberate anti-HIV strategy. Are supporters in countries like the UK or the US going to be willing to fund such work? Will they see it as simply encouraging promiscuity---yet another example of helping people `sin safely'?

Sex disease clinics in Christian missions

Setting up a successful service to treat sexually-transmitted disease means providing a walk-in, friendly environment where people feel very comfortable to explain what they have been up to and with whom.

If there is the faintest whiff of moralising, then experience shows that people may stay away, defeating the purpose of the clinic which is to encourage people to come forward for treatment. This atmosphere may be difficult for many Christian agencies to provide.

Different messages for different countries?

In all our community prevention we need to take great care to find the right message for each section of our society, each tribe, each ethnic group or each country. Within each country there can be unique problems. For example, in one African nation ACET has worked with a particular tribe which had an elaborate circumcision rite using a communal knife likely to spread HIV. Radio campaigns and leaflets in tribal were useless in changing the practice.

The answer was to build a relationship of trust and respect with the village chief. When the delicate discussions were over, the chief called the village together and announced that the ritual would now be modified so that it was safe. The process took some time, but the practice

has stopped in that village at least. The person who carried out the negotiations was a national of that country.

In another area there has been concern about a tradition that the brother of a dead man should have sex with or marry his widow. If the man died of AIDS, it is likely that the wife could pass on HIV to the dead man's brother. In each locality the way of life needs to be respected, understood and incorporated into every aspect of prevention.

In some parts of Thailand it is common for teenage boys to be sent into brothels as part of an initiation ceremony into manhood. It is also socially accepted---or even expected---that adult men will have sex regularly with commercial sex workers. Even with extensive government campaigns and the efforts of many other agencies, these deeply-rooted social practices may require a generation to change completely.

In Eastern Europe, AIDS campaigns are swimming against a powerful tide of Western permissive culture, which is being sucked into former Eastern bloc countries at an alarming rate. Ever since the collapse of communism in many countries, there has been an insatiable demand for pornography and sexual freedom. While many Western nations are just beginning to question the benefits of liberated sex in the light of marital breakdown, increasing juvenile delinquency and AIDS, many East European countries are enjoying the first tastes of previously forbidden fruit.

In addition, opened frontiers and mass migrations due to economic chaos and civil unrest have accelerated spread of sex diseases such as HIV. These countries have also become major corridors for illegal drugs passing from East to West. Most early AIDS cases in countries like Romania were caused through infected blood or contaminated medical treatments, but we are now seeing very rapid spread among adults. Changing medical practice as a result of intensive training of health care workers has been far easier than changing the sexual behaviour of a whole country.

Faith---the ultimate weapon against HIV?

Whether we try to prevent HIV with condom distribution, or by encouraging testing, celibacy and monogamy, we are faced with a problem. We know education encouraging these things

will have a limited effect. The reason is that most people do not want to change. Therefore the only secular motivation we can possibly provide is fear.

I have often heard AIDS educators say you must not give a negative message based on fear because it will be counter-productive (incidentally, that statement is itself a similar negative). However, the fact is that all successful health promotion works by creating anxiety about what could happen if you ignore the message.

The faith motivation is totally different and ultimately much more powerful, as social psychologists are beginning to recognise. Faith creates hope, new expectations about behaviour and gives people purpose, self-worth and meaning. Christians also believe that faith in Jesus Christ releases God's power in our lives, enabling us to change.

I will never forget meeting the Minister of Health of an African nation ravaged by AIDS, who told us that although he himself was an atheist he particularly welcomed the involvement of the church in fighting AIDS. He told us the reason was that we could give people hope so they could bear to hear a painful message, and we could also give people the power to change.

Before the communist regime fell in Hungary, secret approaches were made by the communist leaders to a friend of mine who was heading up an evangelical organisation based in the UK. His work was to smuggle Bibles and other items for persecuted Christians behind the iron curtain.

The authorities asked to meet him because they needed help in dealing with a rapidly worsening drugs problem. They knew that those finding faith often came off drugs rapidly and permanently. A wonderful, low-cost, `infectious' weapon against drugs was too good to turn down. Instead of threatening him with arrest as before, they unofficially invited him to bring others in. The gospel was proclaimed and programmes set up. They too had seen the power of faith. Likewise today in many former Eastern bloc countries there is a great openness to educators who are motivated by Christian values.

As Christians we can have confidence in who we are and what we stand for. We have an answer which we feel is the answer. We can offer sensitive, practical approaches to prevention, based on medical facts. We can also seek to influence behaviour through the rapid spread of

faith in the world today. An important part of the answer to AIDS is for the church, as the most powerful organisation in the world, to combine efforts with governments and communities to help save people from themselves.

We now need to turn to an urgent question which faces every health care worker in developing countries, especially where there is a high incidence of HIV. This issue is seen vividly in the letters missionaries send home to their supporters. How can we help prevent AIDS deaths among doctors and nurses?

Missionaries die of AIDS too

I am often asked for advice by those about to be sent overseas by missionary societies. What is the risk of occupational infection?

Why some doctors and nurses are going to die

There has been increasing concern for the health giving health care to others; not just from such hazards as multi-drug-resistant malaria, but also from HIV. The main areas of concern are from blood transfusions or contaminated equipment if the person is needing care, or from medical accidents if the person is caring for others.

So what are the risks and how can we avoid or reduce them? Fortunately, the risk of infection from a single accident such as a needle jab is known to be very small---even if the person is known to be carrying the virus. Numerous studies from different countries following up people who have jabbed themselves with needles, or otherwise injured themselves while giving care, have shown that there is around a 1 in 200 chance of transmission from a single accident. This is much lower than for hepatitis B, which carries up to a one in three chance of transmission.

However, for someone working day in, day out as a surgeon or midwife, for example, in areas of highest incidence, the cumulative risk soon begins to mount.

Exposure to HIV is common

Even assuming your hospital has enough pairs of gloves for you to operate with a good quality pair each time, the chances are that you may tear gloves during long operations several times a week. You hope you do not cut your finger at the same time, but it happens.

In many places, doctors testing patients on their wards using reliable testing methods have found that around half of their patients are HIV-infected. The percentage may be lower for surgical than for medical cases. Let us assume that a busy general surgeon tears one or two gloves each week and that once every month he cuts himself, or spray from a cut artery spurts into his eyes, or there is some other blood contamination of a wound. Let us assume that only one in four of his surgical patients are HIV-infected (it could be higher). A quarter of the time, on average, the blood could be from an infected patient.

Surgeons are working under tremendous pressures. Every time they begin an operation they know that one careless move or unexpected problem could mean HIV infection, with terrible consequences; not only for them, but also for the health of their husbands or wives, for the future of their marriages and for their families.

How big is the risk for surgeons?

The surgeon in our example will be exposed potentially to HIV around three times a year. Each time is like a pull on a fruit machine with 200 possible combinations. How long before you hit the fatal result? The average surgeon working in such an environment will be infected in sixty-six years, but it could happen in the first three months.

To put it another way: if a medical organisation or missionary society is supporting fifty surgeons in high-incidence countries, then it is possible that every two or three years perhaps one or two more of the team might become infected. This has colossal implications for those concerned, their families, for churches supporting them and for the organisations.

We may debate about exact percentages, but the risk must be acknowledged. So much will

depend on local infection levels, the quality of gloves, operating lights and other equipment, the skill of the surgeon and the nature of his work. Some operations are far more likely to expose a surgeon to injury than others. Some surgeons in Rwanda did their own calculations based on their own practice. They estimated that one in four of them would become infected after thirty years' operating in their town which had a seroprevalence of more than 20%.

Unless those going out are tested regularly, we could have a situation arising where a significant number have become infected before anyone realises, because of the delay between the time of the accidents and the development of symptoms.

A medical organisation may miss an increasing number of future tragedies by just hoping for the best. However, people might argue that once you have taken reasonable precautions, all you can do is trust God for protection and there is therefore little point in regular monitoring of infection. Even if that is so, we need to think now about our responsibility to care for those with occupational infection who may be unable to carry on working as surgeons in low incidence wealthy countries where the risks of cross-infection are considered unnaceptable. These are big issues.

Reducing the risks to surgeons

There are a number of simple steps that can be taken to reduce risks in surgery. For example, always sew away from your other hand rather than towards it, use blunt needles for sewing fascia or skin, consider eye goggles in operations where your experience is that you often get sprayed, double check gloves before reusing them, and be extra careful about being jabbed by splinters of bone or other sharp objects. Cover minor skin abrasions on the hands or arms with a waterproof plaster for further protection. Following all the above, may reduce exposure by three or four times.

Perhaps if careful measures are taken, our group of fifty surgeons would only see one colleague infected every three to five years on average. These are all guesses and will depend on local factors, including the stage of illness of the patients, the nature of the operations and the skill of the surgeon. As we have seen, infectiousness increases as AIDS develops.

Testing all patients before surgery may not be helpful since the test will miss those infected

less than twelve weeks ago (a lot of people in countries where HIV is spreading fast). If funds are scarce, many surgeons may prefer the luxury of a new pair of gloves for each operation.

Midwives are in the frontline too

Nurses are also very much at risk in certain situations, particularly midwifery. Some time ago I visited a hospital in one African country where a number of midwives had died from AIDS. The death toll seemed to be far higher than in nurses from other parts of the hospital, suggesting that many had been infected through delivering babies. We will never be certain, since there were no testing facilities.

The difficulty for midwives is that their exposure to blood can be even greater than in the operating theatre. If labour is difficult, or if a piece of the placenta is left inside the womb, the midwife may need to have not only her hand and wrist inside the mother, but also much of her forearm. No glove covers that much, although waterproof arms , sleeves and gloves have been described. Midwives can finish a delivery with arms completely soaked in blood. Unfortunately, in many hospitals across Africa and Asia there are not enough gloves for midwives, so many deliveries are being assisted without glove protection. Although HIV cannot cross intact skin, there may be slight cuts or abrasions on the hands, or less commonly on the arms, which can be an entry point for the virus.

Therefore if you have friends working as doctors or nurses in high-incidence countries, pray for their protection. There have always been risks to the health of those serving in the neediest situations. Countless Christian doctors and nurses have willingly laid down their lives to bring the gospel to places where Jesus has never been known. Many have died in service, often of the very diseases they spent most of their lives treating.

Ten ways to reduce risks in medical and nursing practice with limited resources

1. Sterilise cleaned equipment after each treatment. Use autoclaves, boiling, 70% alcohol or a freshly prepared one in ten bleach solution in water.

2. Use undamaged latex gloves for operating or midwifery.

3. Use eye shields if spray is likely in theatre.

4. Use blood transfusions sparingly.

5. Get hold of instant HIV testing kits if you have no laboratory equipment---and use sparingly when needed to help save lives.

6. Cover cuts on hands with waterproof plasters.

7. Sew away from, not towards, your other hand, using blunt needles where practicable.

8. NEVER resheath needles, and dispose of used needles carefully---or keep in secure safe container until washed and sterilised.

9. Use gloves for any procedure where (extensive) contact of skin with secretions is likely, including handling laboratory specimens. The threshold for using gloves will depend on availability.

10. Ensure good standards of general hygiene, with spillages carefully cleaned up.

and pray.

Before drawing the different parts of this book together by looking at a global Christian response to what we have seen, we need to ask one thing. What should governments be

doing?

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