

# HIV/AIDS in Sub-Saharan Africa

## Enduring Understandings:

- Many factors affect both the spread and control of HIV/AIDS as a regional epidemic.
- The spread and the effects of HIV/AIDS have been controlled by human effort in some areas.
- In Africa, HIV/AIDS is spread largely by heterosexual activity.
- Cultural taboos and traditions, especially those having to do with sexual relations and gender roles, affect the spread of the disease.
- Poverty, war, and sexually transmitted diseases (STDs) other than AIDS also play a role in the spread of AIDS.

## Essential Questions:

- Why has AIDS affected populations of men and women differently in Africa?
- How can the spread of AIDS be slowed or stopped?
- In what ways do myths and ignorance keep people from fighting the disease?
- How have different leaders in different countries reacted? Which individuals succeeded?

## Note to the Teacher:

The UN and other organizations involved in working on HIV/AIDS in Africa often make the point that the disease is not a single epidemic; that means the disease cannot be prevented in the same way in every place or for every group. It affects populations of males differently from females; children differently from adults; the well-off and well-educated differently from the poor or uneducated; refugees differently from stable populations; urban populations differently from rural; a country at war differently from a country at peace; and a country with insightful leadership (willing to face the problem openly) differently from a country without such leaders. Thus, knowledge of these various circumstances must inform and shape any successful intervention.

This lesson first shows the student the broad picture of the historical sweep of AIDS through sub-Saharan Africa. Working in small groups, students will then narrow their focus to a particular African nation, to get beyond generalizations. The student groups will find different reactions, problems, and outcomes. When they make their report or presentation, they may be surprised at what the others found, and there should be rich ground for discussion comparing the variety of AIDS situations in Africa.

## DURATION OF LESSON:

Approximately three class periods.

## ASSESSMENT:

### HANDOUT 2

Group presentations

## HEALTH STANDARDS

Indicators addressed by this lesson:

**STANDARD 2:** Knows environmental and external factors that affect individual and community health

### LEVEL IV (9–12)

1. Knows how the health of individuals can be influenced by the community (e.g., information offered through community organizations; volunteer work at hospitals, food banks, child care centers)
2. Knows how individuals can improve or maintain community health (e.g., becoming active in environmental and economic issues that affect health, assisting in the development of public health policies and laws, exercising voting privileges)
6. Understands how cultural diversity enriches and challenges health behaviors (e.g., various food sources of nutrients available in different cultural and ethnic cuisines, influence of cultural factors on the treatment of diseases)

**STANDARD 8:** Knows essential concepts about the prevention and control of disease

### LEVEL IV (9–12)

4. Understands the social, economic, and political effects of disease on individuals, families, and communities

## HISTORICAL UNDERSTANDING STANDARDS

Indicators addressed by this lesson:

**STANDARD 2:** Understands the Historical Perspective

2. Analyzes the influences specific ideas and beliefs had on a period of history and specifies how events might have been different in the absence of those ideas and beliefs
3. Analyzes the effects that specific “chance events” had on history and specifies how things might have been different in the absence of those events
4. Analyzes the effects specific decisions had on history and studies how things might have been different in the absence of those decisions
5. Understands that the consequences of human intentions are influenced by the means of carrying them out

## Materials:

**HANDOUT 1: TIMELINE OF HIV/AIDS IN AFRICA**

**HANDOUT 2: PRESENTATION NOTES**

**HANDOUT 3: CASE STUDY ON HIV/AIDS** in an African country (sufficient copies of each page for the members of the relevant groups)

## Procedure:

1. Announce to the class that, now that they have some background knowledge of pandemics and epidemics, they are about to move to a new stage as representatives from different African nations to a UN-sponsored forum on HIV/AIDS in Africa. The purpose of the forum is for everyone involved to learn from the mistakes and successes of each other, and take back home more ideas for ways to prevent the collapse of their society and economy due to the AIDS epidemic.
  2. Then announce that before they can separate into national delegations, they all need to have basic knowledge of what is important about AIDS in Africa. Provide the following facts, giving them time to take notes:
    - HIV/AIDS in Africa is mostly transmitted heterosexually.
    - HIV/AIDS has been spread in many ways, including sex between husband and wife, sex with a person selling sex for money, and rape.
    - According to UNAIDS, nearly 60% of people living with HIV in the world are in sub-Saharan Africa, which has about 10% of the world's population.
  3. Distribute **HANDOUT 1: TIMELINE OF HIV/AIDS IN AFRICA**. Tell students that this is what has been happening in their countries for the past 20 years, and they have all come here to turn this around. Allow time to read in class or assign as homework before proceeding.
  4. Separate students into six small groups; each group will eventually get a case study for the country it represents.
  5. Give each person a copy of **HANDOUT 2: PRESENTATION NOTES**, as well as a copy of the appropriate case study from **HANDOUT 3: CASE STUDY**. Give each group sufficient time to analyze their case study, do additional research to supplement the handout, and answer the questions in order to prepare for their report. (Remind them to leave the last two questions until after all the reports have been given and the class has had a general discussion.)
- The large majority of those are between 15 and 49 years old.
  - HIV/AIDS has created millions of orphans, and school enrollment is declining.
  - HIV/AIDS is overwhelming the healthcare infrastructure.
  - HIV/AIDS is decreasing the labor force, which is slowing food production, economic growth, and development.
  - Antiretroviral drugs (ARV) have had success in allowing people to live with HIV.

6. Tell each delegation to create a visual presentation to go with their report. It could be a poster, graph, PowerPoint, or video presentation—depending on how much time you have and how sophisticated your class is. Or they could even do a skit or debate—this could work especially well for South Africa, where citizens’ groups were challenging the government to provide better care. Give them sufficient time to prepare their presentations.
7. Convene your final class as the UN Forum on AIDS in Africa. Remind the delegates that they are here not to lay blame but to learn from the past. The more honest and forthright they can be about their own country’s past, the more help they will provide. Announce the order of the reports.
8. After all the groups have reported, give them time to respond to the last two questions on **HANDOUT 2**, and give them the opportunity to talk about what they learned from hearing the other delegates.

#### EXTENSION ACTIVITIES

1. Watch the documentary film *AIDS Warriors* and compare the leadership now in Angola with the leadership in South Africa.
2. Explore further the issues of gender inequality in Africa raised by AIDS statistics.
3. Research the controversy over the use of condoms in AIDS prevention, including religious and secular positions and the position of the U.S. government. Have students take a position and write an editorial on the subject.

#### ADDITIONAL RESOURCES:

##### Internet resources:

Interview with Stephen Lewis, Special Envoy for HIV/AIDS in Africa to the Secretary-General of the United Nations.

<http://www.pbs.org/wnet/wideangle/shows/angola/transcript.html>

AVERT is “an international HIV and AIDS charity based in the UK, with the aim of AVERTing HIV and AIDS worldwide.” This site has good basic information on AIDS worldwide. <http://www.avert.org/aidsinafrica.htm>

The Joint United Nations Programme on HIV/AIDS

<http://www.unaids.org/en/>

PBS website in support of *Wide Angle’s* AIDS Warriors video; contains video clips, photo gallery, and interview with Stephen Lewis, Special Envoy for HIV/AIDS in Africa to the Secretary-General of the United Nations.

<http://www.pbs.org/wnet/wideangle/shows/angola/>

The Centers for Disease Control’s information on the connection between STDs and HIV/AIDS

<http://www.cdc.gov/std/hiv/default.htm>

## A Timeline of HIV/AIDS in Sub-Saharan Africa

**1986:** Scientists get enough information to form a picture of AIDS in Africa, realizing that the disease shows itself with infections and conditions different from those in the U.S.

The spread of AIDS in Africa came from heterosexual activity, blood transfusions, transmission from mother to infant, and exposure to unsterilized needles.

**1987:** 71,751 cases of AIDS were reported to the World Health Organization—more than half from the U.S. The World Health Organization (WHO) estimated that 5 million to 10 million people were infected with HIV worldwide.

**1990:** Africa now accounts for more than half of estimated cases, more than any other continent.

**1993:** The National Health Department of South Africa reports that HIV infections have risen 60% in the past two years, and predicts that the number of cases will double in 1993. As a region, sub-Saharan Africa now has over 9 million cases of adult HIV infection, and over 1.7 million adult AIDS cases.

**1995:** The South African Ministry of Health reports that 850,000 people in that country are HIV positive (2.1% of the population.) But some groups are higher: 8% of pregnant women are HIV positive.

On December 1, World AIDS Day, Nelson Mandela calls on all South Africans to speak out against the stigma, blame, and shame that are associated with the disease.

**1996:** Drug therapies begin to offer hope, but Nkosazana Zuma, the health minister of South Africa, says to the world that most people infected with HIV live in Africa, where expensive antiretroviral drugs are out of reach.

**1997:** UNAIDS reports that, worldwide, 30 million people are infected with HIV. They estimate that 2.3 million people died of AIDS, 50% more than in 1996.

**1998:** In South Africa, Gugu Dlamini, an AIDS activist, is beaten to death by her neighbors after revealing her HIV status on Zulu TV. Seventy percent of the new HIV infections are in sub-Saharan Africa. In Botswana, Namibia, Swaziland, and Zimbabwe, between 20% and 26% of people have HIV or AIDS. South Africa is catching up fast with its neighbors, accounting for one in seven new HIV infections in Africa.

HANDOUT 1 ► P. 2

**1999:** Rape cases involving young girls emerge in South Africa, where a popular myth suggests that having sex with a virgin can cure AIDS. Uganda starts a voluntary door-to-door HIV screening program to halt the spread of HIV. With this and other initiatives, the percent of Ugandans infected drops from 30% in 1992 to 12% in 1999.

**2000:** In Botswana, one in four adults and four of ten pregnant women are infected with HIV. UNAIDS predicts that two-thirds of the 15-year-olds in Botswana will die of AIDS before reaching age 50. President Festus Mogae announces that new donations, including 50 million dollars from the Bill and Melinda Gates Foundation, will help provide antiretroviral drug therapy to all HIV-infected pregnant women and children.

In Brazil, the number of AIDS deaths plummets by nearly 50% since the introduction of antiretroviral drug therapy in 1996. Brazil's prevention and treatment combination is looked to by other poor countries as a model to follow.

Treatment remains non-existent in South Africa, where President Mbeki says publicly that he does not think that HIV causes AIDS.

**2001:** South Africa estimates that 4.7 million people are infected with AIDS, and 25% of pregnant women are HIV positive in 2000.

Zimbabwe's government dissolves the National AIDS Council for mismanagement of funds. Zimbabwe has one of the highest rates of infection in Africa—25% of their whole population is HIV positive, and AIDS has orphaned 1 million children.

The Ugandan president, Yoweri Museveni, opens a regional center for treatment of HIV-positive patients in Kampala to train workers from all over Africa.

AIDS activists take legal action against the South African government for failing to supply antiretroviral drugs to prevent mother-to-child transmission of HIV. In December a judge orders the government to set up a nationwide program to give mothers free access to these drugs.

HANDOUT 1 ► P. 3

**2002:** Botswana is the first African government to provide antiretroviral treatment.

South Africa starts providing antiretroviral drugs to pregnant women and their babies.

**2003:** Swaziland and Botswana now have possibly the highest infection rates of any country, estimated at about 40%.

**2004:** In order to reduce the stigma of talking about AIDS, the president of Malawi, Bakili Muluzi, announces that his brother has died from AIDS. He launches the first AIDS policy in his country, where 15% of the population is HIV-positive.

The HIV rate in Uganda has been reduced by 70% since the early 1990s.

**2005:** Nelson Mandela announces that his oldest son, Makgatho, has died of AIDS at age 54. He wants to talk about the disease as a normal illness rather than hiding it. A report reveals that during 2000–2001 in South Africa nearly two-thirds of HIV-related deaths were misclassified as being due to other diseases. The latest survey of pregnant women shows that 30% are HIV-positive, and over 6 million people are living with the virus in South Africa—more than in any other country.

HANDOUT 2

# Presentation Notes

**HISTORY:**

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What is the history of the spread of HIV/AIDS in your country?

What was unique about that history in your country?

**RESPONSE:**

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What was the initial government response of your country to the AIDS epidemic?

What has been the reaction of the people in your country to the AIDS epidemic?

When you analyze your country's response, what was done right?

Self-Evaluation: (To be done after listening to all the reports.)

What could have been done better? Are there ideas you can take from other countries?

What is most important that your country should do now?

## HANDOUT 3 ► P. 1

## HIV/AIDS Case Study: Botswana

**Political and Economic Background:** Botswana has enjoyed peace since gaining independence in 1966. It is relatively prosperous because of diamond mines, with a gross national product almost as high as Mexico's. However, a large part of the population still lives in poverty. It has a population below 2 million.

**History of AIDS:** In 2005 an estimated 270,000 people had HIV, or 24% of the population. Life expectancy fell from 65 years in 1995 to 40 years in 2005.

**Leadership Response:** President Festus Mogae said that his people were threatened with extinction. Because of his actions, Botswana is now seen as a leader in combating the epidemic. It has a number of partners helping in the fight, notably the Bill and Melinda Gates Foundation, the Merck Company Foundation, and the Centers for Disease Control in the United States.

**Prevention:** Botswana provides the following prevention programs:

- Public education and awareness
- Education for young people
- Condom distribution
- Targeting mobile populations
- Blood safety
- Prevention of mother-to-child transmission

Counseling and testing have also been offered by the government since 2000. Officials believe the stigma associated with a sexual disease can be reduced by treating the HIV test like any other medical procedure.

**Treatment:** In 2001 Botswana was the first African nation to propose a treatment program of antiretroviral (ARV) therapy. In 2002 the goal was to provide medication to 19,000 people infected with HIV. The program was named MASA, which means "dawn." But initial problems arose: It took a long time for people to enroll; the regimen of drug therapy was hard for people to follow; and the clinics and hospitals were short of staff. People were also wary to come and receive treatment because of the stigma of AIDS. Late in 2002 only 2,200 people had enrolled; in 2003 the number climbed to 8,000; and in 2004 over 24,000 people had enrolled in MASA. By June 2005 some 43,000 people were receiving ARV treatment, and in September the number jumped to 54,000, which was 85% of the people in need of treatment. The response to the drugs was excellent, similar to the outcome in more developed countries, and mortality rates declined.

This information is adapted from AVERT at <http://avert.org/aidsbotswana.htm>.

## HANDOUT 3 ► P. 2

## HIV/AIDS Case Study: Nigeria

**Political and Economic Background:** Nigeria has been independent from Britain since 1960. It is the fifth largest oil producer in the world. With 140 million people, it is also the most populous African nation (one in six Africans lives in Nigeria.) However, because of mismanagement by military dictators from 1966 to 1999, the rest of the economy did not benefit from oil wealth, and two-thirds of the population lives on less than \$1 a day.

**History of AIDS:** The first case of AIDS in Nigeria was found in 1986. In 1988 1.8% of the population was HIV positive. In 2001 the rate was 5.8%. In 2003 the rate had dropped to 5%—or 3,300,000 Nigerians with HIV. However, only India and South Africa have a greater number of people living with HIV/AIDS. The infection rate varies in different parts of the country, suggesting that there are localized epidemics.

**Cultural Situation:** Muslims (50% of the population) and Christians (40%) both dislike talking about sex, or promoting condom use, and view AIDS as caused by immoral behavior. Girls are married off young (12 and 13), but they are then at risk of getting HIV, because it is accepted for the older men to have other sexual partners or other wives. There are more than 1 million female sex workers in Nigeria, and up to 30% of them in some areas are infected.

**Leadership Response:** No serious response was made by the government until Olusegun Obasanjo became president in 1999. He created the National AIDS Action Committee (NACA) to run prevention, treatment, and care efforts. Despite some progress, there are still large gaps in services.

**Prevention:** Nigeria provides the following prevention programs:

- Sex education for young people (because youth between 15 and 25 account for 60% of new HIV infections)
- Condom distribution, which is slow because of religious opposition
- Media campaigns, to increase knowledge and change behavior

**Treatment:** In 2002 the government started an antiretroviral program to get 10,000 adults and 5,000 children onto HIV medications. At first, \$3.5 million worth of drugs was imported from India, but in 2004 there was a shortage. Because of poor management, the program still has not reached the 2002 goals. The government itself spends little on HIV/AIDS—about 3 cents per person per year. But it received money from the U.S. (\$84 million in 2005), the UN Global Fund (\$28 million over two years), and a loan from the World Bank. However, this money has not been spent because of program delays by the government, and the rest of the loan could be forfeited.

This information is adapted from AVERT at <http://avert.org/aids-nigeria.htm>

## HANDOUT 3 ► P. 3

## HIV/AIDS Case Study: Uganda

**Political and Economic Background:** Parts of northern Uganda are still in a civil war between the Lord's Resistance Army (LRA) and government militias. Efforts to help people in the north focus on providing food and care for refugees. Also, LRA rebels have abducted children and raped women, and from tests on those who have escaped, it is thought that infection among the LRA rebel army is high.

**History of AIDS:** Although HIV was not “discovered” until 1981, we now know the disease was present on the shores of Lake Victoria in the late 1970s. In 1982 the first AIDS case was diagnosed. In 1988 the average HIV prevalence was 9%. In 1991 the national prevalence peaked at 15%–21% for pregnant women. In 2001 UNAIDS estimated the national prevalence had fallen to 5%.

**Leadership Response:** In 1986 President Museveni swiftly toured his nation, calling it a patriotic duty to abstain from sex before marriage, remain faithful once married, and use condoms. In 1990 the AIDS Information Center gave voluntary counseling and testing. In 1994 the government borrowed \$50 million from the World Bank and received \$25 million in donations to set up their Sexually Transmitted Infections Project. In 1997 Ugandans began using antiretroviral drugs to prevent mother-to-child transmission. In 1999 the Ministry of Health began a voluntary, door-to-door HIV testing program with a rapid test.

**Prevention:**

- “ABC” Program: Abstinence until marriage; Be faithful to one partner; use Condoms.
- “Zero Grazing”—avoid casual sex.
- Many grass-roots organizations educated people and reduced the stigma of AIDS. Prevention messages were spread through churches, schools, and villages.
- An open and honest discussion of the cause of AIDS and the consequences of risky behavior helped to change people’s behavior.

**Treatment:** Uganda was one of the first African nations to offer antiretroviral (ARV) medication. In 1998 it started a program with reduced prices for patients. In 2004 Uganda gave free ARV medication to people with HIV. It has received money from the Global Fund and from the U.S. PEPFAR program (President’s Emergency Plan for AIDS Relief). In 2004, over 40,000 people were receiving these drugs; in 2005 over 70,000 people received them, which is about half of those in need.

**Controversy:** Faith-based organizations supply much of the aid Uganda receives from the United States. Of the ABC program, they favor A and B but disapprove of condom use. Health officials worry that this ignores scientific evidence about the important role of condoms in reducing AIDS in Uganda.

This information is adapted from AVERT at <http://avert.org/aidsuganda.htm>

## HANDOUT 3 ► P. 4 HIV/AIDS Case Study: South Africa

**Political and Economic Background:** In response to riots against apartheid, a state of emergency was declared in 1985. It lasted for five years, and only toward the end of the 1980s, as apartheid was abolished, was more attention paid to AIDS. South Africa is one of the wealthier African countries, with a great diversity of natural resources and a developed economy.

**History of AIDS:** The first recorded case of AIDS was in 1982. Initially, AIDS among gay male South Africans received more attention, as in Europe and the U.S., but after 1991 heterosexually transmitted cases came to dominate the epidemic. In 1990 the first national study showed that 0.8% of pregnant women were infected. The numbers grew steadily: In 1993, it was 4.3%; in 1996, 12%; in 1999, 22%; and in 2003, 28% of pregnant women had HIV. In 2005, 5.5 million people had HIV, 1,000 people died of AIDS every day, and there were 1.2 million orphans due to AIDS.

**Cultural Situation:** South Africa's diverse population and social inequalities have made it difficult to produce a single, effective AIDS prevention campaign. There are 11 official languages, and many people live in isolated rural areas.

**Leadership Response:** In 1992 the government formed the National AIDS Convention of South Africa (NACOSA) to develop a national strategy to deal with AIDS. But as HIV rates rose during the mid-'90s, the attention of the people and the media was focused on political change instead. In 1998 the Treatment Action Campaign (TAC) was founded to pressure the government to create a national HIV treatment plan. Deputy President Mbeki started the Partnership Against AIDS. But in 2000 Mbeki, by then president, publicly questioned whether HIV was even the cause of AIDS and refused to provide antiretroviral (ARV) medicines. In 2003 the government created a plan to make antiretroviral drugs available to the public, which began slowly in 2004.

**Prevention:**

- In 2001 the AIDS Communication Team (ACT) undertook a media campaign to educate people about HIV, produced in several languages.
- LoveLife began in 1999, a program targeted at people aged 15 to 24, the hardest hit group in South Africa. It promotes sexual responsibility through the media, youth centers, and outreach services that travel to rural areas.

**Treatment:** By 2005, at least one center for AIDS treatment was operating in each of the 53 districts of the country. Altogether, 85,000 people were receiving antiretroviral treatment—only about 20% of those who need the ARV medication.

This information is adapted from AVERT at <http://avert.org/aidssouthafrica.htm>

## HANDOUT 3 ► P. 5

## HIV/AIDS Case Study: Zambia

**Political and Economic Background:** In 1964 the British colony of Northern Rhodesia became the independent Republic of Zambia. The country has had 40 years of peace, but little prosperity. It is one of the poorest, least developed nations on Earth. Two-thirds of Zambians live on less than \$1 a day.

**History of AIDS:** The first AIDS diagnosis in Zambia was in 1984. By 1992 the rate of HIV among pregnant women tested was 27% in the major cities, and around 13% in the rural areas. These rates remained the same for the next decade. In 2005 one of six adults was living with HIV, and in that year 98,000 people died of AIDS. This has put the average life expectancy in Zambia at 40 years, and has left 710,000 orphans.

**Cultural Situation:** Much of Zambia's population is mobile, and infection is carried along the truck routes by the drivers who regularly pay for sex. Also, migrant or seasonal workers away from home for an extended time will find temporary sexual partners where they are working, and thus spread the virus. Many women believe that they cannot refuse their husband sex even if he is HIV positive; many girls have their first sexual experience with an older man, who may offer them gifts. This is why girls age 15–19 are six times more likely to have HIV than boys their age.

**Leadership Response:** In 1986, two years after the first report of AIDS, two committees were set up to respond to the problem, and they focused on keeping blood supplies safe. During the next few years, as HIV spread, few cases were reported and most AIDS deaths were blamed on tuberculosis. The HIV rates were kept secret, and politicians were reluctant to speak about AIDS, for fear of hurting tourism. In 1992 the minister of health said malaria killed more people than HIV, but by then it was estimated that 1 in 5 people had HIV. In 2000 the National AIDS Council (NAC) was created to apply for funding and coordinate all AIDS activity. In 2004 the new president, Levy Mwanawasa, declared HIV/AIDS a national emergency and promised to provide antiretroviral (ARV) drugs to 10,000 people by the end of the year. He passed that goal and then set a new one: 100,000 people getting ARVs in 2005. The mood had changed.

**Prevention:**

- The Health Department makes condoms available, although church leaders and some politicians oppose promoting condoms on moral grounds.
- Zambia Social Marketing Project targets teenagers and teaches the “ABCs” of prevention: Abstinence, Be faithful, and Condoms.

**Treatment:** Through funding from the UN Global Fund and from the United States, Zambia succeeded in getting ARV drug therapy to about 20,000 people in 2004, which is about 13% of those who need it, a level above the average in Africa.

This information is adapted from AVERT at <http://avert.org/aids-zambia.htm>

## HANDOUT 3 ▶ P. 6

## HIV/AIDS Case Study: Angola

**Political and Economic Background:** In 2002 a cease-fire between the Angolan government and the National Union for the Total Independence of Angola (UNITA) ended a civil war that had raged for 27 years. The critical economic situation created by the war has eased, with a booming oil industry and the resettlement of 4 million refugees. Nevertheless, USAID estimates that 68% of Angolans live in poverty, and 26% in extreme poverty.

**History of AIDS:** During the civil war, Angola was isolated from its neighboring countries with high HIV rates. The isolation prevented the spread of the epidemic, but also isolated Angolans from HIV awareness and education. AIDS was not identified as a serious problem then, but that is beginning to change. In 1998 around 4% of Angolans were living with HIV, but in 2003 that percentage had risen to 6%. Reporting systems are weak and accurate numbers are hard to obtain.

**Cultural Situation:** The new peace may hold within it the seeds of an HIV/AIDS explosion. Millions of refugees and soldiers are returning to the countryside; education has been neglected; the infrastructure has been destroyed, including healthcare; women sometimes sell sex to survive. Many Angolans, including many health workers, do not know how AIDS is transmitted and how it can be controlled. Modern healthcare outside the major cities is difficult to find.

**Leadership Response:** Angola's leaders are starting to understand the danger of AIDS. The government has started prevention efforts with the military, as infection rates of soldiers are thought to be 3–4 times higher than in the general population. They use international funds to increase the ability to test people for HIV, train healthcare workers, and do more studies of infection rates. Only a small number of people are being treated with medication so far.

**Prevention:** The government works with churches, foundations, and aid organizations to develop prevention strategies. Condom use is promoted, especially for sex workers, truck drivers, youth over 14, and the military. Four centers offer testing and counseling, and youth centers are particularly important in HIV/AIDS prevention outreach. Computers and audiovisual materials have been supplied to the military to educate them in methods of prevention.

**Treatment:** In 2004 a comprehensive AIDS law was passed to promote control of the disease and combat discrimination against those infected. It protects the jobs and privacy of infected individuals and offers them free public healthcare. There are national guidelines for care, but distribution of needed drugs has not yet been successful outside of Luanda, the capital.

This information is adapted from <http://www.pbs.org/wnet/wideangle/shows/angola/index.html>,  
<http://www.cdc.gov/nchstp/od/gap/countries/angola.htm>, [http://www.usaid.gov/our\\_work/global\\_health/aids/Countries/africa/angola\\_o4.pdf](http://www.usaid.gov/our_work/global_health/aids/Countries/africa/angola_o4.pdf), and  
<http://www.state.gov/r/pa/ei/bgn/6619.htm>