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A Regional Perspective towards Managing HIV/AIDS in Northeast Africa

Lemma Merid

Abstract

Several African countries, including those in Northeastern Africa, have declared HIV/AIDS a national emergency and have defined national strategies. To carry the strategies through, they have set up institutions. These strategies however are confined to national boundaries and fail to take into account the cross-border implications of the epidemic. The paper identifies several avenues through which cross-infections take place in the Northeast African context. It then suggests that supranational (or regional) organizations such as the Inter-Governmental Agency for Development (IGAD) or the Common Market for Eastern and Southern Africa (COMESA) gear themselves to address such issues that require the involvement of more than one country. It provides a list of issues with which such regional organizations could start.

Key Words**:** IGAD, COMESA, conflict, refugees, pastoralists, cross-border traders

Address for correspondence: Lemma Merid, 206 Lynnwood Close, 4 East fort Park St, Lynnwood, PTA 0081, South Africa. Phone: 27-12-369-9929/ Fax: 27-12-348-7688. Email:lemma.merid@undp.org

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Introduction and Background

HIV/AIDS does not recognize national boundaries. To the extent that there are existing or potential interactions among people living across national boundaries, a dynamics will be unleashed for infecting one another. Thus, regardless of how effective national programs are, movements of people and intimate interactions would reverse any gains that a particular country may achieve. This paper argues that Northeast African countries, as well as others, would need to initiate a collaborative effort with their neighbors to promote cross-border prevention programs. The approach proposed here calls for a supra-national organization to initiate cross-border prevention programs and co-ordinate national ones to minimize cross-infection[2]. Barring a supra-national organization, each country would benefit through investing in cross-border prevention programs as much as it does from purely national ones. The paper identifies the current hotspots requiring such intervention, and provides the nature and content of a regional intervention.

It is understood that HIV/AIDS is both a humanitarian and development issue. It is a humanitarian issue because every year many people die in Northeastern Africa needlessly without AIDS as a result of perpetual wars and political strife within and across the borders, famine and other infections diseases. One more death resulting from AIDS is one too many. It is a development issue because HIV/AIDS depletes the productive labor force, leaves too many dependents, and erodes the opportunities for saving and investment. In countries where household budget surveys have been conducted and focused on the impact of HIV/AIDS, about 10 percent of expenditures are used up in medical and funeral expenses in infected/affected households – a proportion much higher than the expenditure by un-infected/un-affected households (World Bank, 1999).

State of HIV/AIDS in North East Africa

The seven Northeast African countries, forming IGAD or a subset of the members of COMESA, have diverse HIV/AIDS-related experience. The prevalence in some countries is very low, while there are adjacent countries with double-digit prevalence figures. The sub-region also houses Uganda, a country commended internationally for its successful HIV/AIDS management and approaches, and others neither with the institutional framework nor strategies to address the problem. This diversity accords unique opportunities for countries, particularly the late starters in the sub-region to draw lessons from and start from a higher plat-form.

The epidemic has reached an alarming level in some countries. But to put data on HIV/AIDS in the sub-region in broader perspective, it is important to provide a comparator against which such data may be gauged. In 2001, the Northeast African countries were inhabited by 60.6 million adults (ages 15-49). Essentially about 21 percent of all adults in Sub-Saharan Africa (SSA) lived in Northeast Africa. In terms of HIV/AIDS however data indicate that these countries suffered disproportionately more in some respects.

Of the about 28.5 million people (children and adults) in SSA estimated to have been infected, about 5.3 million people or 18.7 percent resided in NEA countries. Likewise, of the 11 million orphans, about a quarter (or 25.3 percent) was Northeast Africans; and of the 2.2 million people who died of AIDS, a fifth (19.7 percent) was a loss of NEA countries. These data show while NEA is home for slightly over a fifth of adults in SSA, it accounted for substantial portion of the HIV/AIDS damage (UNAIDS, 2002). The proportions show a high loss in and of them and exacerbate the loss of life and dislocation resulting from frequent famines and political strife.

The diversity in HIV prevalence rate and in the management of the epidemic at the national level provides great opportunities and poses major challenges for the management of the epidemic in the region at large in the future. Before delving into why and how this is true, it would be useful to examine some of the country-specific data for those countries for which such data are reported. Data are generally lacking for Somalia and The Sudan, but anecdotal evidence shows that the problem in those countries, particularly in some pockets of their population, could be equally serious, as will be discussed below.

Data from UNAIDS indicate that the prevalence rate for four of the seven countries is higher than or equal to 5 percent – a level at which the epidemic is characterized as generalized and going out of control. Among the countries for which there are some data, only Eritrea and Somalia reported prevalence of less than 5 percent. In terms of prevalence rate, Kenya with 15 percent is the most affected country. But, due to its large population size and the high prevalence rate, Ethiopia, until the latest data was issued, had the largest number of infected people (about 3 million people). Overall about 8 percent (or one out of every 12 people) of Northeast Africa is HIV-positive. NEA also inhabits about 2.8 million orphans. These are entirely in Ethiopia, Kenya and Uganda. In the early 1990s, it was the shock wave of deaths and the escalating number of orphans that caused massive governmental and popular intervention to reverse some of the trends in Uganda. Overall, close to half a million people die of AIDS every year in the sub-region.

Since the mode of transmission is the same, the gravity of STD is an indicator of the susceptibility to HIV. Many of the countries in NEA experience major STD prevalence. Even in Eritrea, which otherwise experiences low HIV, STD prevalence is a serious concern, raising question on the validity of the HIV prevalence data.

The data and knowledge about the epidemic and its socio-economic impact in the region are limited. For some countries, such as The Sudan, there are hardly any comprehensive and consistent data on prevalence. Data reported at some Conferences show prevalence rate of less than 1 percent for Somalia and less than 2 percent for The Sudan (UNDP, 2002). Anecdotal evidence however portrays much more serious nation-wide problems and/or in pockets of these two countries. For instance, IRIN indicates, "At present, the prevalence of HIV/AIDS is believed to be less than one percent (IRIN, 2001). But, Somalia is surrounded by high-risk countries, like Kenya, Djibouti and Ethiopia, and has a huge Diaspora outside of Africa. … reports condom use as "extremely low" and the rate of STD in the general population "unacceptably high" … It also noted that Somalia has a very high prevalence of TB closely associated with HIV/AIDS, …" Likewise, the American Refugee Committee reported that "If there is not an intervention soon, HIV/AIDS could eclipse the war to become the worst tragedy to hit Southern Sudan. Southern Sudan has recently experienced an increase in the traffic of military personnel, commercial transporters, commercial sex workers, and other at-risk groups" (ARC, 2001).These statements indicate that despite the lack of data, these countries suffer seriously from the epidemic. In fact, the neighboring areas of Uganda, Kenya, The Sudan and Ethiopia (Gambella) may be experiencing prevalence levels in upper teens or lower twenties to put them in league with countries in Southern Africa.

Special Circumstance of North East African Countries

The Northeast African countries share several socio-political and economic characteristics that have a bearing on the rapid transmission of HIV/AIDS and that warrant for a sub-regional approach to the management of HIV/AIDS, in addition to the national programs.

Northeast Africa is prone to perpetual conflicts among and within countries; there are a large number of people under arms (formal or informal militaries); a large number of refugees, internally displaced people (IDPs) and returnees; there is also a considerable amount of voluntary cross-country movement of people (e.g. cross-border trade and pastoralists). These factors unleash the dynamics for faster HIV transmission and pose a major challenge for the management of the epidemic within individual countries themselves.

Conflict Prone: Conflict is not good for development, but it is disastrous for HIV transmission and management[3]. During a conflict, the social and economic infrastructure (such as clinics and schools) is destroyed by one or the other party deliberately. If and when peace comes providing basic services, including for HIV/AIDS, would be delayed by several months or years until the infrastructure is put in place again.

The military all over the world are known to be carriers of STD, as well as HIV/AIDS. A study on the military and HIV reports that "In peace time, STD infection rates among armed forces are generally 2-5 times higher than civilian populations; in time of conflict the difference can be 50 times or higher". Likewise, "Comparative studies of sexual behavior in France, the UK, and the USA showed that military personnel (both career and conscripted personnel) have a much higher risk of HIV infection than groups of equivalent age/sex in the civilian population" (UNAIDS, 1998). Closer to the sub-region, "A 1995 estimate of HIV in Zimbabwe places infection rate for armed forces at 3-4 times higher than the level in the civilian population" (UNAIDS 1998). Similar experiences exist from other African countries. In Nigeria, HIV prevalence among peacekeepers returning from Sierra Leone and Liberia was 11 percent compared to 5 percent in the adult population (Nigeria AIDS Bulletin, 2000). In South Africa, prevalence rates of 60-70 percent have been recorded among the military compared to 20 percent in the adult population (Mail and Guardian, 2000). Among the Northeast African countries, only Eritrea reported prevalence rates among the military at the Kampala Workshop. Compared to the 2.8 percent prevalence for adults reported above in 2001, the prevalence among the military in 2001 was 4.6 percent – a little less than twice (UNDP, 2002).

There are several factors why the prevalence rate among the military is higher, and these factors hold among the military in Northeast African countries. However, prevalence would still be more pronounced among the informal military (i.e. "technical") than the formal since there is some control mechanism with the latter. Since personnel are often posted at locations far away from the areas they were originally recruited, opportunities for risky behavior are rampant. Combined with the risk taking behavior and the age-profile of the military, the exposure to risk is exacerbated.

Post-Conflict and Demobilization: Ethiopia and Eritrea have demobilized soldiers in the early 1990s and following the recent conflict of late 1990s. The demobilization of both countries included a program of awareness raising to HIV/AIDS and its transmission mechanism to the combatants who would be demobilized. Demobilized soldiers were then incorporated into the communities from which they were withdrawn. To our knowledge, no tracer studies have been done on the impact of these reintegration programs on the surrounding communities from the point of HIV transmission. Undocumented report shows that it may have been the first wave of demobilization in the early 1990s that spread the epidemic to the interiors of Ethiopia, to places that were otherwise unaffected

Equally disturbing, the combatants return with new behaviors and experience, which they spread in the communities they return to. In addition, there is the grave effect of post-conflict trauma. In some areas, this had created household violence (i.e. husband/wife and husband/wife/children) and community-level conflict, which could have serious ramification for HIV transmission in the short to medium term.

Refugees, IDPs and Returnees: The perpetual conflicts, together with drought and other adverse movements in weather condition, have resulted in a large number of refugees and IDPs in NEA.

According to UNHCR, of the about 6 million refugees and IDPs in Sub-Saharan Africa in the early 2000, 2.4 million (or 40 percent) lived in NEA. While about 1.5 million were refugees, the remaining 1 million were IDPs in Eritrea[7].

Refugees and IDPs, particularly female refugees and IDPs, are highly vulnerable to forced high-risk sexual contact and sexual abuse, heightened violence (including rape), multiple partners, unprotected sex and offering sex for cash and in-kind gifts (e.g. food, sugar, oil, etc.). These factors make them more vulnerable than other members of society.

As conflicts subside, refugees would like to return to their communities voluntarily or as part of government or international organization programs, such as those of UNHCR and Red Cross programs. Based on a few cases, it has been found that HIV prevention services are provided on the side of the sending country, but

these services are not continued on the side of the recipient country. Since programs on both side of the border are not coordinated, the returnees would be exposed to risk in their new environment.

Peace and Reconciliation: If and when peace reigns in the region, the movement of people and trade will start to rise. This has positive aspects in many respects, but could be of great concern from the point of HIV transmission. Since Eritrea is a low prevalence country and Ethiopia is a higher prevalence country, the situation could create conditions for higher HIV transmission in the former country. A similar situation would emerge in The Sudan as Southerners start to move to the north. It would therefore be sensible to include the management of cross-border HIV transmission as one of the issues to be discussed, at least at the technical level, in peace negotiations and reconciliation efforts. Similar rationale would encourage the inclusion of HIV in the peace and reconciliation negotiation among the Somalia parties.

Voluntary Cross-border movements: Like in other parts of SSA, there is much cross-border temporary or permanent migration among the people of NEA. In fact, the same ethnic group may live on different sides of the same border. The three groups of people that warrant attention are pastoralists, cross-border traders and transporters, people living in the high infection axis of Southern Sudan-North-West Uganda, Western Ethiopia (Gambella) and South West Kenya.

Pastoralists: There are no data or studies on HIV prevalence and transmission in the pastoralist population. There is reason to think however that prevalence rate among the pastoralist could be lower than the surrounding urban or sedentary farming population. The pastoralist population, often nomadic, moves from place to place together with their cattle, in search of water and pasture. Often, this population group does not mix well with the surrounding urban or semi-urban population. As a result, it is expected not to be exposed much. The relevant point here is that since these people move across national boundaries, prevention programs should be designed jointly by two or more countries to cater to these people in a continuous manner. Their mode of economy and culture pose additional design problems since these people is not fixed geographically. Water points are the most likely sites where they could be reached in large number.

Cross-border Trade and Transportation: Transportation facilitates trade and the movement of people. But at the same time, it promotes the transmission of diseases, such as HIV/AIDS. Of immediate concern, for the purpose here, is the Ethiopia-Djibouti corridor. Since both Djibouti and Ethiopia experience high levels of prevalence (the first in rate and the other in number of people infected), prevention and mitigation programs would need to be designed jointly. Otherwise, any success in one country could be eroded or reversed unless the neighboring country has similar and synergic ally coordinated programs.

It is to be noted that about a fifth to a quarter of Djibouti's population is of Ethiopian origin. Most of these people are engaged in the high-risk sector of Djibouti's economy. These people are in Djibouti for part of the year and migrate to Ethiopia when the temperature in Djibouti becomes unbearable. It is crudely estimated that about 20,000 people make the one-way trek from Addis to Djibouti on Ethiopian Airlines. When the numbers of Ethiopian and Djiboutian truck drivers, who traverse the road to the port on regular bases, are added, the number could reach about 200,000. As a result, the towns on the road from Addis to Djibouti are among the highly affected places in the country. The impact on Ethiopia could be further compounded by Ethiopians in Diaspora, who return home from other neighboring countries.

Another transport corridor that poses a similar challenge for HIV prevention is the Great Northern corridor[9]. The Great Northern Corridor connects the port of Mombassa with Entebbe, and with countries further south. Surveillance data from Mombassa usually put the prevalence rate at 16-17 percent (MOH, 2001). Lake Victoria provides transportation means for the people of Kenya, Uganda, Tanzania, Rwanda, and Burundi. The prevalence in Kisumu, one of the major urban centers on the Lake on the Kenyan side, recorded 35 percent in 2000. The prevalence in the rural areas of Nyanza Province, in which Kisumu is also located, reached close to 30 percent – almost double the national average.

Ethiopia-Sudan-Kenya-Uganda Axis: As indicated above, the prevalence of HIV in Southern Sudan has reached alarming proportions. Prevalence is believed to be high in Northeastern Uganda and Northwestern Kenya. The prevalence rate in Gambella (Southwestern Ethiopia) in 1999/00 had reached 19 percent – the highest in the

country. It therefore looks that an axis of high epidemic, spanning four countries, is emerging in that region. Addressing the epidemic would therefore require a multi-national intervention.

Justification for a Regional Approach

NEA countries have very close relationship among and between themselves. The economic, social, political and historical relationships between these countries overwhelm their relationship with SADC or countries in the Greater Lakes region. This however does not mean that these countries are closed-off from the rest of the continent. There is, for instance, a similar close relationship between Uganda and Rwanda, and then with the rest of the Greater Lakes region and Central Africa. There is, in fact, a need for an interlocking chain of sub-regional organizations to develop and manage cross-border and sub-regional economic, social and health matters, including HIV/AIDS.

NEA countries have long and porous borders. The same ethnic groups live along both sides of artificially drawn national boundaries. People move from one country to the adjacent country on a daily (or seasonal) bases on foot or horse (camel) back. Due to the transhumance economic livelihood of pastoralists that inhabit the border areas, movement of people, together with their cattle, is a regular phenomenon. This uncontrolled (or uncontrollable) movement has existed for several centuries. Cross-border movement is reinforced by the fact that several countries are land-locked, thus trucks and buses traverse across one or two other countries to reach the ports.

Conflict in the sub-region is recurrent giving rise to the maintenance of large military, post-conflict demobilization, refugees, IDPs, and other dislocated population groups. If the cross-border and national conflicts subside, there would not be a need for a large military and the fall-out would have been avoided.

Would countries be better off focusing more on implementing effective national programs, and controlling the spill over effects from neighboring countries through screening? Barring entry into one country are impractical and costly due to the porosity of the boundaries and the sheer size of the movement. It is however important and necessary for each country to design and implement strong prevention and impact mitigation programs addressing people within its border and along areas of population confluence. The sub-regional programs will reinforce the national efforts and make it possible, in the long-term, to eradicate the epidemic. The absence of such sub-regional programs however would cause adverse effects on the success of national programs or would leave pockets of high infection that would eventually engulf the rest of the country otherwise. For instance, while the national average prevalence of HIV in Uganda has been declining and now hovers around five percent, the prevalence in Northwestern Uganda has followed the opposite trend due to conflict and large cross-border movement. Likewise, the towns along the transport route from Mombassa inwards experience higher prevalence rates despite the lower and declining national averages (GOU, 2001). Uganda, together with Sudan, Kenya and Ethiopia, would gain significant pay-off if they manage their HIV situation in their common border or contiguous areas.

Two or more countries could join their efforts to address the cross-border problem on an ad hoc and bilateral manner. But there are too many problems and host spots. Such ad hoc and bilateral arrangement would be ideal for a one-of unique temporary problem. HIV however is likely to spread and its impacts to be felt for the next several decades. Creating an institutional home that would address the cross-border aspects of the epidemic would generate economies of scale and scope. An institutional home such as IGAD could mobilize resources for the same and maintain a multi-disciplinary team that would be required to design and implement sub-regional program. Moreover, unless IGAD takes up HIV/AIDS as an integral part of its programs in conflict resolution, agriculture and food security and transportation, it would generate additional unintended problems or fail to take advantage of situations as and when they arise. For instance, the management of HIV could have been taken up in The Sudanese peace negotiation to avert the spread of the epidemic from one part of the country to the other when peace comes and people start to move freely.

NEA countries, or their regional organization IGAD, will not be the first to initiate such an arrangement to address the negative cross-border externalities of HIV/AIDS. SADC, the Southern Africa Development Community, IGAD's counterpart for Southern Africa, has several years of experience in this area. SADC has implemented programs to address HIV prevention among cross-country truck drivers and commercial sex workers along the route, among migrant workers, and several economic and social sectors. It has mobilized resources from within the region and abroad for the purpose. Moreover, it has held a summit meeting to urge the Head of State to take more aggressive leadership in guiding the national agenda and obtain endorsement of its Strategic Framework (SADC, 2003). Equally important, unlike IGAD, it has a core team of staff to monitor progress.

A regional approach would facilitate bulk procurement of drugs and other supplies, thus according significant economies, in addition to forging a common stand in international trade negotiations with respect to health supplies.

Members of IGAD are poorer than their counterpart in the Southern part. IGAD and the member countries understand that HIV will make them even poorer and further erode the gains they have made in terms of education and life expectancy. But due to the fact that IGAD has not yet articulated a regional strategy and fundable programs this has militated against the regions capacity to mobilize resources. Already, the World Bank and other UN agencies are urging the organization to take action. The members of IGAD itself have also recognized the need for such collective action but the implementation has been rather slow (IGAD, 1999; IGAD 2002).

Proposals for Northeastern Africa Regional Strategy

The starting point would be to encourage IGAD and COMESA Secretariats, the sub-regional organizations of the Northeast African countries, to establish an institutional framework and a focal point to address HIV/AIDS from the sub-regional perspective. The Southern Africa Development Committee, SADC, IGAD's and COMESA's counterpart for Southern Africa has such a focal unit and has issued its sub-regional policies and strategies. SADC mobilizes resources for multinational programs and carries out projects and programs to address the cross-border aspects of the epidemic.

It should be borne in mind that even if new infections were curtained henceforth, AIDS would still remain a major development issues in Northeast Africa for many years to come. It would therefore be necessary to start addressing the impacts of the epidemic in a systematic manner and managing it from the sub-regional perspective starting now.

In parallel or subsequent to establishing a focal unit, the regional organizations would need to undertake a situation and response analyses and define policies and strategies to address the sub-regional issues. This would respond to damages the epidemic is inflicting on several member countries as partly reported in IGAD's policy statements and would be in line with the decision of the Council of Ministers of IGAD (IGAD, 1999; IGAD 2002). These would need to be followed by defining and designing a critical number of actions by the regional organizations individually or in collaboration with other bilateral or multilateral agencies. The following issues could be considered among the elements of a sub-regional strategy and plan of action.

- Launching studies on the inter-relationship between conflict and post conflict measures (e.g. demobilization) and HIV/AIDS and advising countries on the design of policies and strategies to respond to such circumstances;

- Ensuring that the management of HIV/AIDS is dealt with upfront in peace negotiations and conflict resolutions. This aspect is often neglected until much damage is done. Reaching agreement on the

establishment of a technical committee to address HIV management immediately upon cessation of hostilities would be an appropriate measure. This issue could, for instance, taken up immediately in the peace negotiation between the two parties in The Sudan, and several warring parties in Somalia as part of the negotiation being held in Kenya.

- Mainstreaming HIV/AIDS in all the programs of IGAD and building its capacity to support member countries to mainstream HIV/AIDS in their economic, social and political programs;

- Negotiating with major donors for the infrastructure sector so that the support to the various cross-border corridors includes components for HIV prevention. At present, some of the major donors for the sector forget the HIV dimension on the grounds that they do not have programs to support the health sector (World Bank, 2002).

- Supporting surveys and studies on the prevalence of HIV/AIDS in the pastoralist people and designing appropriate (i.e. culturally sensitive) policies, strategies and programs to address the epidemic as these people crisscross international boundaries;

- Establishing a research and documentation center and facilitating the exchange of information on strategies, programs and projects that have proved effective in countries of the sub-region and other countries in SSA and elsewhere;

- Assisting countries to define and implement common anti-AIDS practices and regulations (e.g. adopting similar regulation in both side of a common border, and trucking industry so that similar services and awareness messages would be provided on both sides of the border);

- Introducing similar HIV/AIDS programs by both sending and receiving countries during repatriation of refugees;

- Negotiating and facilitating bulk purchase of drugs and supplies for HIV/AIDS; and facilitating local manufacture of patented medicines through licensing agreement jointly with the patent-holder or separately through a regional multinational company (UNAIDS 2002).

- Etc.

The regional organizations will have to gear up their preparedness to support their member countries, and the member countries, in turn, will have to make the necessary resources available to establish the institutional infrastructure in place. Once this happens, development partners would provide technical support to prepare projects and programs to allow the organization get access to resources for programmatic interventions. But, first and foremost, the commitment of the member countries will have to be expressed in creating the contact point.

Notes

[1]The author is Policy Advisor, Regional Project for HIV and Development in Sub-Saharan Africa (UNDP/UNOPS), Pretoria, South Africa. A slightly different version with more focus on Ethiopia was presented at the International Conference on the Ethiopian Economy organized by the Ethiopian Economic Association, January 3-5, 2003, Addis Ababa, Ethiopia. The paper is a based on the author's opinion presented at a Regional Workshop for IGAD Countries held between February 25 and March 1, 2002 in Kampala, Uganda. The views and opinions are those of the author, and do not necessarily represent those of UNDP or UNOPS. Please send your comments to lemma.merid@undp.org.

[2]The Northeast African countries are essentially members of the Intergovernmental Agency for Development (IGAD) based in Djibouti, and form a subset of the members of the Common Market for Eastern and Southern Africa (COMESA). IGAD constitutes Djibouti, Eritrea, Ethiopia, Kenya, Somalia, The Sudan, and Uganda. Neither IGAD nor COMESA have not been dealing with HIV so far.

[3]The relationship between conflict and HIV transmission is complex. For instance, in Angola and Congo that have gone through several years of conflict, the prevalence of HIV has been very small. With the emergence of peace and reconciliation, development experts are concerned that the free movement of people would spread the epidemic over the entire population. (Cauvin, 2002).

[4]UNAIDS AIDS and the Military, UNAIDS Point of View, May 1998.

[5]Nigeria AIDS Bulletin, No. 15, May 20, 2000.

[6]The Mail and Guardian, Pretoria, March 31, 2000

[7]UNHCR recognizes as refugees those that have been registered with it. As long as there are refuges not registered, which is indeed true, the figures are an underestimate. Neither does the data provide the complete origin of refugees.

[8]The seriousness of the problem arising from Ethiopians returning from other countries, particularly from those countries where the prevalence is relatively higher, is not known. One of the tasks for a regional organization would be to understand the sexual behavior of such migrant workers.

[9]Efforts elsewhere to understand the cross-border aspects of the epidemic could be instructive (Anonymous Author, No Date) The paper addresses the implication to Hong Kong of the rapid increase in the movement of people between Mainland China and Hong Kong itself, given that the number of people infected in Mainland China is much higher and increasing faster than in the latter country.

[10]IGAD, Report of the 21st Ordinary Session of the IGAD Council of Ministers held in Khartoum, Sudan, 8-9 January 2002, p.23, Decision 27. The Decision states "that the Secretariat considers[s] other cross-cutting issues such as HIV/AIDS pandemic, girl child discrimination and women in business."

[11]The World Bank, for instance, has started to consider "sub-regional and cross-border HIV/AIDS initiatives such as targeting transport routes …" Under the Second MAP for which the Bank has

committed US$500 million, it has financed HIV programs along the Abidjan-Lagos Routes which passes through Cote d'Ivoire, Ghana, Togo, Benin and Nigeria. (WorldBank,2002).

[12]These suggestions are reflected in UNAIDS' most recent Annual Report. (UNAIDS, 2002)

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