PAPER ON HIV/AIDS PREVENTION AND CARE IN CENTRAL AFRICAN REPUBLIC

Presented by:

Mr. GONDA Jean Benoît
OUTLINE OF THE PAPER

I. PRESENTATION OF CENTRAL AFRICAN REPUBLIC

1.1 Geographical location
1.2 Demographic Analysis
1.3 Development Indicators

II. SITUATION OF HIV INFECTION IN CENTRAL AFRICAN REPUBLIC (CAR)

Epidemiology and dynamics of HIV infection

2.2. Socio-economic impact
2.2.1. Impact on Public Health
2.2.2 Impact on Educational System
2.2.3 Impact on Households

III NATIONAL RESPONSES TO THE EPIDEMIC

3.1 Prevention activities
3.1.1 Cultural determinants of the spreading of HIV
3.1.2 Social and Economic Determinants
3.1.3 AIDS Control and Traditional Medicine

3.2 HIV/AIDS Medical Care or Treatment

IV CONCLUSION
I. PRESENTATION OF CENTRAL AFRICAN REPUBLIC (CAR)

1.1. Geographical location

Central African Republic is bounded in the North by CHAD, in the East by SUDAN, in the West by CAMEROON and in the South by CONGO BRAZZAVILLE and DEMOCRATIC REPUBLIC OF CONGO. It covers an area of 623,000 km². The landscape shows that the country is landlocked and Bangui, the capital city, is located at 1,000 km in a straight line from the ports of Pointe Noire in Congo and from Douala in Cameroon.

These two ports are the main outlets to the Atlantic Ocean where manufactured goods for the country pass in transit.

Administratively speaking, Central African Republic is subdivided into 16 Prefectures, 69 Sub-prefectures, 174 Communes and 8,000 Villages and Districts.

1.2. Demographic analysis

With a natural growth rate of 2.5%, the population of Central African Republic was estimated in 1999 at 3,768,000. The average population density is 6 inhabitants per km².

The youth represents 55% of the total population. Adults in the 20-59 age group constitute 40% of the country's population while the elderly represents 5%. It can therefore be concluded that the structure of the population of Central African Republic is marked by its youthfulness. According to UNAIDS, life expectancy in C.A.R. was estimated at 44.9 years in 1997 as against 48.3 years in 1995 and 54 years in 1980.

1.3. Development indicators

Despite the richness of our various natural resources (diamond, gold, uranium, wood, etc.), Central African Republic remains one of the least developed countries in Africa. It is ranked 166th in the world, according to the UNDP Sustainable Human Development Index of 1999. Its Gross National Product (GNP) deteriorated between the late 80s (480 US dollars) and the late 90s (280 US dollars).
Crude birth rate = 41.6 %
Death rate = 16.7 %
Infant mortality rate = 97 %
Child mortality rate = 157 %
Enrolment ratio = 53.8 %
Illiteracy ratio = 46.6 %

II. SITUATION OF HIV INFECTION IN CENTRAL AFRICAN REPUBLIC

2.1. Epidemiology and dynamics of HIV infection

The first cases of AIDS were identified in Central African Republic in 1984 through a randomised survey of seroprevalence that reported a 2 % ratio for the population in the 15-45 age bracket. Some health surveys conducted between 1986 and 1988 confirmed a 4 % to 8 % increase in prevalence, which suggested that the epidemic actually dawned in the late 1970s. The principal mode of HIV/AIDS contamination in Central African Republic is heterosexuality since Sexually Transmitted Diseases (STD) contribute to the development of HIV transmission. Mother-infant HIV transmission is rampant in the country, judging by the high prevalence of the phenomenon among pregnant women. It presents a linkage between in utero and perinatal transmission and post-natal transmission through breast milk. Under the circumstances, the ratio of transmission from infected mothers to infants exceeds 30 %. Transmission by infected equipment or unsafe blood is probably significant even though it is difficult to evaluate. The modes of transmission through intravenous drug addition or male homosexuality are not yet reported in the country.

The seroprevalence ratio for the general population of Bangui is 15 %, according to the projections formulated in 1994 by the World Health organisation (WHO).

According to the WHO projections, the seroprevalence ratio is 8 % for the general urban population and 4 % for the general rural population of Central African Republic. All the age groups are affected, the prominent one being the 15-45 age bracket. Women are infected earlier than men: thus, young women of the 15-24 age
group are 5 times more infected than men of the same age group. From one monitoring centre to another, the prevalence ratio varies from 5.3 % to 25 % (1998). Prevalence ratios reported over the last five years varied from 16 % to 29 % among patients consulting for STD, according to the health centres; the ratio for workers stood at 15 %. The recent epidemiological data established in 1999 from documentary resources of the STD care or serological screening centres present figures confirming cases of increased contamination. Thus, 26 % of the patients consulting at the National STD reference centre, the principal STD clinic in Bangui, are infected with HIV. At this centre, the Voluntary Screening Unit or "Anonymous Screening Unit" indicated a 15.5 % seroprevalence ratio among the consulting patients; the ratio was 4 % for the screened males of the 15-24 age group and 18 % for screened women of the same age group. Among the screened patients of the 24-34 age group, the prevalence ratio stood at 17 % for males and 37 % for females. The National Blood Transfusion Centre reported that 11 % of the blood donors for 1999 were HIV positive. Since 1988, the National AIDS Control Programme has established an AIDS data collection system defined according to the criteria set by WHO/Bangui in 1985, thanks to a data sheet prepared in collaboration with clinicians of the University Hospital and counterparts from other hospitals in Bangui. The total number of cases increased from 622 in 1988 to 3,313 by December 31, 1991, thus representing factor 5 for 3 years. The total number of established AIDS cases notified by the health centres under the National AIDS Control Department between 1990 and 1997 was 10,208 (figure highly underestimated).

2.2. Impact of the HIV/AIDS epidemic

This epidemic assumes a multi-dimensional character that finds expression in its impact on the various development sectors.

2.2.1 Impact on Public Health

HIV/AIDS infection has increased morbidity and mortality among a population whose health condition is already precarious.

Thus, at the Internal Medical Department of <<Hôpital Communautaire>> (Community Hospital), one of the three reference hospitals in Bangui, 66 % of the
patients are admitted for opportunistic infections linked to AIDS, with joint infection by tuberculosis in particular (78 % of the tubercular patients are HIV positive). 95 % of the patients admitted were ignorant of their HIV serological status. The mortality rate recorded among this category of patients is very high (24 %).

In the basic health units (15 urban health centres), the rate of consultation is increasing considerably and has tripled over the last three years. However, the epidemiological surveys indicate that the screening services provided to the population by health workers are still insufficient because barely 2 % of the patients had monitoring test for pregnant women and barely 6 % of their number had tested for HIV, but the results were often not declared. On the other hand, expenses induced by disease are becoming too heavy and in most cases they are a strain on family budget.

2.2.2. Impact on the educational system (a very worrying situation)

Reducing illiteracy ratio implies making available sufficient and experienced human resources as well as consistent materials and infrastructures. The results of the UNICEF / UNDP / other partners joint survey of HIV/AIDS impact on education in Central African Republic and the level of implementation of the "primary education for all" objective constitute a matter of great concern : AIDS appeared as the first cause of death among teachers in C.A.R. particularly those in full professional activity. In the 1996 and 1997 academic years, HIV/AIDS infection accounted for 85.71 % of the cases of death among teachers in Central African Republic.

The projection for the 1997-2005 period indicated that 71,520 children of the 6-11 age group cannot benefit from normal schooling in five of the seven school inspectorates in the country.

2.2.3. Impact on households

It is at the family level that the impact of HIV/AIDS infection is mostly felt, from the outbreak of the disease up to the time of death, by virtue of :
- a gradual decrease in family income (reduction of family labour force as a result of
disability and death) ;
- a redistribution of responsibilities ;
- the transfer of a considerable portion of family income to meet medical expense
that continue increasing at the expense of other household needs. For example,
the average cost of one meningitis treatment is 30,000 CFA Francs, whereas the
Guaranteed Minimum Wage (SMIG) now stands at 18,000 CFA Francs ;
- the high cost of funerals, which also usher in additional expenses that come to
aggravate the family budget deficit ;
- the constant increase in the number of orphans estimated at nearly 70,000 in late
1999. In most cases, the orphans are left to their own devices, thereby exposing
them to delinquency : 2,640 street children were recorded in the same year.

Central African Republic ranks 10th among the 24 most infected countries in
Sub-Saharan Africa but 1st among countries of the Central African Sub-region.

Today, the number of people living with HIV/AIDS is estimated at 240,000 and
this comprises 230,000 adults (15-49 years) and 10,000 children (0-14 years),
according to UNAID/WHO sources as of June 2000.

III. NATIONAL RESPONSES TO THE EPIDEMIC

In response to this changing and worrying situation of AIDS, the Government
of Central African Republic developed three national plans for the control of the
epidemic -- the Short-term Plan or Emergency Plan (PCT),
1987-1998; the 1st Generation Medium-term Plan (PMT1), 1989-1993 and the 2nd

The objective of the Short-term Plan (PTC) was to establish operational
structures and evaluate the level of awareness of people living in the capital city
(Bangui) as well as their attitudes and practices vis-à-vis the epidemic.

Some mobilisation and sensitisation activities were also developed as part of
this emergency plan and these found expression in the production of learning
materials, training of agents and awareness campaigns (mass campaigns and targeted activities).

The 1st Generation Medium-term Plan (PMT1) laid particular emphasis on intensification of prevention activities while PMTII developed strategies to reduce the psychological, medical and socio-economic impact of HIV/AIDS infection.

### 3.1. HIV/AIDS prevention activities

In the case of prevention activities, the areas of intervention concentrated on the promotion of safe sexual behaviour (including social marketing of condoms), early diagnosis and treatment of Sexually Transmitted Diseases (STD), safe blood transfusion and development of the "Information-Education-Communication" sector.

However, the cultural and societal approach has not been adequately focussed among the different strategies established for AIDS control.

**a) At the cultural level**

In fact, it should be recognised that although cultural and social factors largely contributed to the spread of HIV/AIDS in Central African Republic, they have long been ignored or left out.

The analysis of the HIV/AIDS situation in Central African Republic revealed that certain traditional socio-cultural values associated with Central African culture, which are still upheld in some parts of the country, do contribute to the spread of the epidemic. These include marriage-related practices such as levirate (marriage to the widow of a dead brother), circumcision or blood pact, etc.

**Marriage** : This is often a family affair so parents often held consultations without the knowledge of the future couple and decided on their union. Whereas this practice has the advantage of strengthening relations between two clans/families and enhancing pride and honour within the different family units, the fact remains that it constitutes an encroachment on individual freedom or may concern two persons belonging to
different generations, in addition to promoting polygamy, which concerned 12 % of the Central African families (RGPH, 1994-1995).

**Levirate and Sororate**

This practice is widespread in Central African Republic for reasons such as dowry paid and the necessity to relieve widow or widower of the responsibility for the orphans’ education. However, most of the widowers and widows who remarry do not know of their serological status and even that of the deceased spouse. They could therefore be individuals likely to transmit the AIDS virus. At any rate, this phenomenon is seldom advanced as the cause of death, the favourite causes cited being sorcery, fetishism, jealousy, etc.

**Circumcision** : This practice is compulsory in Central African Republic. It is noticed, however, that most of the ethnic groups still practice female genital mutilation (excision). Although the ceremonies are effective means of initiating youths into adulthood, there is cause to deplore their methods and practices (use of the same tool, no sterilisation, etc.), which expose the young girls and boys to the risk of contracting AIDS.

**Blood pact** : In certain ethnic groups of Central African Republic, to seal an alliance or show love or friendship, couples of people conclude a blood pact as a sign of <<faithfulness>>. The perpetuation of this practice reflects another risk factor in a context marked by the spreading of AIDS.

Finally, there are cultural taboos on sex education, despite the proliferation of video arcades that present harmful and sometimes obscene pictures.

b) **At the social level**

As we have stated earlier, the population of Central African Republic, marked by its youthfulness, is composed of 40 % adults in the 20-59 age group with a ratio of 91 males to 100 females.
Men occupy 84 % of the Civil Service employment and are therefore the major breadwinners in the households. They are the ruling authorities in 64 % of households with an average income of 44,224 CFA Francs and they freely engage in extramarital sexual intercourse. On the other hand, women have little access to socio-economic and cultural decision-making centres and have difficulties in negotiating sexual affairs.

In summary, the Central African Republic society tolerates extramarital sexual intercourse by men, bequeaths as heritage to surviving relations the widow or the sister of a deceased wife; the female population exceeds the male population but the majority of C.A.R. women are poor. Such a social organisation presents a multiple impact that finds expression in the following trends:

- Gender inequality at socio-economic and cultural levels that deprives women of decision-making powers in matters concerning what is good or bad for them and for their entourage, while men have the power to do as they like, regardless of social norms. The consequence is sexual immorality (breeding many sexual partners, sexual violence, paedophilia, unsafe and/or forced sexual intercourse at workplaces or on learning premises) and lack of autonomy for women, who are forced to occasionally or professionally invest in the sex industry, which is encouraged in many ways by the migration of certain categories of the population (servicemen, transport agents, migrant workers and miners, etc.) and/or maintained by some wealthy men.

- A leeway that could perpetuate HIV transmission in the context of sororate or levirate.

Polygamy and extramarital relations are therefore tolerated by both men and women even though there is a crack-down on female adultery.

3.2 AIDS Control and Traditional Medicine

Aware of the important role traditional healers play in administering first aid, and considering especially the context in which medical fees charged by health
centres are recovered, the Government of Central African Republic has initiated a Research - Action Project aimed at mobilising and training traditional healers and involving them in AIDS control activities with the support of World AIDS Foundation, Health Alliance International and Seattle University in Washington.

Initially, 14 traditional healers in Bangui were identified and trained to use AIDS prevention and control methods in the context of wholesale training. They were subsequently involved in the production of a training guide for another three hundred traditional healers from Bangui and the provinces.

An evaluation conducted six months after their training in the different localities revealed that 70 % of the untrained traditional healers had acquired a low-risk practice whereby they transmitted HIV/AIDS.

This action for traditional healers has almost been the unique far-reaching initiative that took account of the cultural and societal approach to AIDS control. It must be recognised that the healing process adopted by majority of AIDS patients in Central African Republic in a context of sorcery, fetishism, etc., always ended on the traditional healer's premises. That explains why this action has been highly successful. However, scarcity of financial resources at the end of the project prevented the Health Department from carrying on with this experience.

3.3 HIV/AIDS medical care or treatment

Medical care for HIV infection is still a very fragmented service. Access to medical care is increasingly rendered difficult because most of the infected people do not know their serological status. Often, the infected patients enter the care and treatment systems at an advanced stage of their disease or through the influence of a frequent opportunistic infection such as tuberculosis. If available at all, the medical care is generally limited to counselling on nutritional practices and modes of prevention and treatment of opportunistic infections such as tuberculosis, pneumocystis carinil pneumonia (PCP) and toxoplasmosis (by cotrimoxazole) or even certain bacterial infections indicative of immuno-depressive diseases such as pneumococcus pneumopathy.
In contrast with this general scenario in Central African Republic, certain health organisations ensure proper care for HIV-infected patients in all stages of the disease, with particular regard to prevention and treatment of opportunistic infections. This service is provided by two principal hospitals in Bangui - *Hôpital Communautaire* and *Hôpital de l’Amitié* and also by Amis d’Afrique, a Non-governmental Organisation. The control of tuberculosis, one of the most common opportunistic infections, is managed as part of a National Programme for the Control of Tuberculosis, which is placed under the Ministry of Health and Population Affairs.

As regards access to anti-retroviral drugs, a pilot project for preventing mother-child transmission with Névirapine, financed by UNAIDS and UNICEF, is currently being jointly executed by the National AIDS Control Department and the Mother and Child Health Division.

The Government, UNAIDS and experts of the International Therapeutic Solidarity Fund (ITSF) have jointly designed a programme aimed at promoting access to anti-retroviral treatment (triple therapy). However, the programme has not taken off because the requisite financial resources have not yet been made available. Nevertheless, this programme is expected to take off soon even if it has to be started with national resources.

Having said that, the cultural and societal approach to HIV/AIDS care has not been adequately developed especially since Central African Republic is at the starting point, with regard to care and support for HIV-infected people.

**IV CONCLUSION**

If the two Medium-term Plans (PMT 1 and 2) produced mitigated results, it is because the cultural and societal approach, which largely contributes to the spreading of HIV/AIDS in Central African Republic, has not been taken into account, if not ignored.
It is in this context that, as part of the Strategic Planning Process (PPS/SPP), emphasis is laid on the cultural approach in the first two stages covering situational analysis and response, in order to come up with a planning that takes account of all the aspects concerning AIDS Control, especially the social and cultural aspects.

Contact:
African Itinerant College for Culture and Development
P.O.Box : 3186
Dakar, Senegal
Tel. : (00 221) 823 10 20
Fax : (00 221) 822 29 64
E.mail : idep@unidep.org