

Sexual health

communicating international development research

Is China losing the fight against AIDS?

As HIV/AIDS has spread in China, the Chinese Government has been more willing to work with international experts and civil society to fight the disease. However, China's embrace of uncontrolled capitalism, rising inequalities, reduction in state-provided welfare and the impact of decentralisation all limit the country's ability to manage the epidemic.

The Chinese Government was extremely slow to respond to HIV/AIDS in the initial stages of the epidemic. It is only since the late 1990s that there has been more openness surrounding HIV/AIDS and greater political commitment as demonstrated by sharp rises in government budget and concrete actions to combat the epidemic.

Reliable data on HIV/AIDS in China is still difficult to obtain. Disease reporting systems are underdeveloped, diagnostic facilities and trained medical personnel are in short supply, and intense stigma attaches to those living with HIV/AIDS. Local authorities also manipulate infection statistics so as not to frighten off external investors. However, the blood trade scandal of the 1980s and

1990s, which involved unsafe, unregulated collection and trade of blood, may have led to several million HIV infections amongst the most vulnerable rural groups.

A paper from University College Chester in the UK examines the AIDS situation in China and government responses to the epidemic. The Joint United Nations Programme on HIV/AIDS warns that without new policies and their effective implementation there will be 10-20 million people living with HIV in China by 2010. The impoverishing effect of HIV also means that there could be 32 million more rural poor by 2010 – wiping out all of China's recent development achievements.

The author also finds that:

- Official measures to combat HIV often focus on the HIV virus and its mechanisms, and are undermined by an approach that associates HIV infection with ideological and moral 'wrongs'.
- Fundamental problems fuelling the epidemic – widening economic disparities, worsening relative poverty, decline of state health provision and ethnic and gender inequalities – are not addressed.
- Conservatives have influenced many aspects of HIV/AIDS policies, including those directed at injecting drug use, prostitution, and safe sex.
- Local authorities often take hard-line approaches – including compulsory

'education camps' for drug addicts and sex workers – that reduce the effectiveness of strategic plans formulated by the central government.

The outbreak of severe acute respiratory syndrome and its control in 2003 has shown that the Chinese state can mobilise political power and resources to manage health crises. Whether a similar approach is used against HIV/AIDS depends on:

- a continued increase in HIV-related budgets, especially for personnel training and facilities and infrastructure building
- balancing economic growth and human development, including longer-term investment in public health and improving equitable access to health care, particularly for vulnerable groups
- overcoming local resistance to central government actions and directives
- negotiating further price reductions in anti-retroviral drugs
- enacting anti-discrimination legislation to protect those living with HIV/AIDS.

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Protecting HIV orphans' education in Zimbabwe

Before the HIV epidemic, orphans in Zimbabwe did not seem to suffer at school. But now, children orphaned by HIV are at an educational disadvantage. The breakdown of extended families' care of orphans may be to blame.

A quarter of Zimbabwean adults have HIV. Nearly 10 percent of children under the age of 15 are paternal orphans (having lost their father), 2.7 percent are maternal orphans and 2.2 percent are double orphans. Orphan levels will rise over the next ten years as HIV-positive adults succumb to AIDS.

In traditional African cultures, the care and upbringing of children involves an extensive network of relatives. However, the extended family is under a lot of pressure from work-related migration and resettlement, inter-cultural marriage, western influences, misguided non-governmental organisation run programmes, poverty, the rising cost of

living and HIV/AIDS. A study in Manicaland by the University of Zimbabwe looked at the impact of orphanhood and household arrangements on children's education.

The research included a survey of 2,402 children aged 13-15 years, in-depth interviews with children and their carers, key informant interviews and focus group discussions. It showed that:

- 18.4 percent of the children are orphans.
- Overall, more girls than boys complete primary school. Children are more likely to finish primary education if their household is of a higher socio-economic status or is headed by a parent or grandparent.
- Primary school completion rates are lowest among maternal orphans, for whom the benefits of living with more educated household heads are outweighed by the negative effect of not living with a parent or grandparent.
- Higher primary school completion rates occur among paternal and double orphans, largely because they are more likely to live in a female-headed household.

Mothers are often more willing than fathers to make sacrifices to ensure that children get the best possible education. In addition, the extended family and means-tested

government and NGO programmes play a greater role when the father has died as the mother is more likely to be in poverty. So, although maternal orphans live in more wealthy households, they need more help to complete primary education. The researchers recommend:

- relaxing selection criteria for government and NGO assistance
- setting up programmes to counter orphan stigma and to ensure fathers take financial responsibility for their children
- establishing comprehensive and sustainable care by involving extended family and the wider community
- encouraging increasing involvement of maternal relatives
- running more vocational training and community development projects to promote greater self-sufficiency.

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Pakistani women's access to health care

Women in developing countries need to travel long distances to visit health centres for treatment. In Pakistan, tradition and social convention require family members to accompany women when they visit a clinic. Does such practice affect women's use of health services and the work of women health workers?

The 'Western' notion of freedom suggests that women who can travel alone have greater independence than others who can leave home only when accompanied by a male relative. However, in Pakistan, unaccompanied travel may expose women to sexual harassment and a loss of prestige, while those who are accompanied are valued family members.

Researchers from the London School of Hygiene and Tropical Medicine analysed links between women's freedom of movement and their uptake of contraceptive and antenatal care services in Pakistan. Quantitative data was drawn from the Pakistan Fertility and Family Planning Survey of 7,848 women. In addition, an in-depth qualitative study was conducted over several months looking at life in the remote village

of Pind in Punjab. The study found that:

- Although tradition dictates that women remain secluded at home, large numbers of poor women have to leave home for work in distant isolated fields, where they are vulnerable to molestation.
- Women prefer to travel with company. However, only rich and educated women travel with company because wealthy families can afford to spare someone to accompany a woman on any trip.
- Older women, women with sons, and professional women are more likely to travel alone outside the village compared to younger women, and those who work in low-paying agricultural or non-skilled jobs.

Although 'purdah' (keeping women hidden from men outside their own family) does mean that women are less likely to travel, women's mobility may not be as restricted as it first appears. Within socially defined 'inside' space (where only family members may be present) women visit friends' houses, wash in the stream, bake bread in the communal oven, and collect water from the well.

Women who travelled in the company of another adult in the past 4 weeks were 28 percent more likely to have used antenatal care than those who had not been able to leave the home. However, the ability to travel unaccompanied had little effect on contraception use; while accompanied travel had none at all.

Making a decision to use a contraceptive was more important. Once a decision was

made (usually after negotiations involving the husband, mother-in-law and sometimes the young woman herself), older women provided the necessary company to the health centre.

The researchers recommend that:

- instead of focusing on the fact that women should be allowed to travel alone, it will be more useful to change perceptions about the need for women's reproductive health care
 - women health workers should provide the latest health information and encourage a change in attitude to health issues, in particular to antenatal care
 - health education messages should target family members, not only the young women. Husbands and mothers-in-law are likely to be the family decision-makers.
- Female health workers should be used to accompany pregnant women to the health clinic. This is an existing part of their role which is not currently used. However there are problems in recruiting women health workers because they also face restrictions on travel and may need assistance to carry out their work effectively.

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Protecting HIV infected Zambian children against infections

Evidence suggests that co-trimoxazole can help prevent bacterial infections in HIV-infected children. The drug, which is cheap and widely available, has been recommended for infants of HIV-positive mothers and for certain HIV-positive children after infancy. How effective is this drug when bacterial resistance is high?

The Children with HIV Antibiotic Prophylaxis (CHAP) trial was designed to assess how effective co-trimoxazole is in preventing opportunistic infections and death in HIV-infected children in areas where drug resistance is high. The research team conducted a trial in children aged 1 to 14 in Zambia.

Children were randomly assigned to one of two groups. Those in one group received co-trimoxazole, those in the other, the control group, were given a placebo. During the trial the children were regularly assessed. Blood tests were conducted at weeks 2, 12, 24 and every 24 weeks thereafter. The trial began in 2001 and ran until the data and safety monitoring committee recommended that it be discontinued in October 2003. By that time it was clear that the group receiving

co-trimoxazole were gaining a substantial health benefit.

The authors report the following research findings:

- Co-trimoxazole reduced mortality by 43 percent and hospital admissions by 23 percent compared with the placebo.
- The reduced mortality was seen across all age groups and regardless of the strength of a child's immune system, and was sustained for more than 12 months.
- Co-trimoxazole produced no allergic reactions.
- Use of the drug over an extended period of time does not appear to reduce its effectiveness.
- HIV-negative children in the trial had weaker immune systems than those of comparable children in industrialised countries.

The results indicate that the drug may still be effective as a preventive treatment even where high levels of resistance have been found in laboratory tests.

Policy implications of this study include:

- Immune system level thresholds for clinical care in industrialised countries are not necessarily appropriate for children in poorer countries.
- All children in Africa with clinical symptoms of HIV infection should receive co-

trimoxazole regardless of their age or level of immunity.

- Clinical care with co-trimoxazole and nutritional support should be given regardless of known levels of resistance to the drug.

The costs and benefits of the approach advocated here must be assessed through economic analyses. It is not yet known whether co-trimoxazole will also benefit children receiving anti-retroviral drugs in settings where there are high levels of bacterial infection.

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