Teacher Resource Bank

GCE Geography

Advance Information Booklet and Sample Questions: GEO4B

GEO4B – Geographical Issue Evaluation

Advance Information Booklet

Advance Information:

Item 1 HIV/AIDS Worldwide (including Figures 1 to 4).

Item 2 Extracts from UNAIDS Questions and Answers, August 2004. (UNAIDS is the United Nations Agency which collects information about HIV/AIDS and co-ordinates the campaign to deal with the world wide epidemic.)

Item 3 Report on Family Health Trust Anti-AIDS Clubs (Zambia).

Item 4 Extracts from a Report by Hannah Brown, The University of Nottingham School of Nursing, May 2003.

Item 5 Some statistics on the prevalence of HIV/AIDS in the population of Zambia and among pregnant women in Lusaka.

Item 1 HIV/AIDS Worldwide

Figure 1

Global summary of HIV/AIDS epidemic in December 2006.

	Total	Adults	Children under 15
Number of people living with HIV/AIDS infection[1] at the end of 2006	39.5m (34–47m)	37.2m (32.1m–44.5m)	2.3m (1.7–3.5m)
People newly infected with HIV in 2006	4.3m (3.6–6.6m)	3.8m (3.2–5.7m)	530k (410k–660k)
AIDS deaths in 2006	2.9m (2.5–3.5m)	2.6m (2.2–3.0m)	380k (290k–500k)

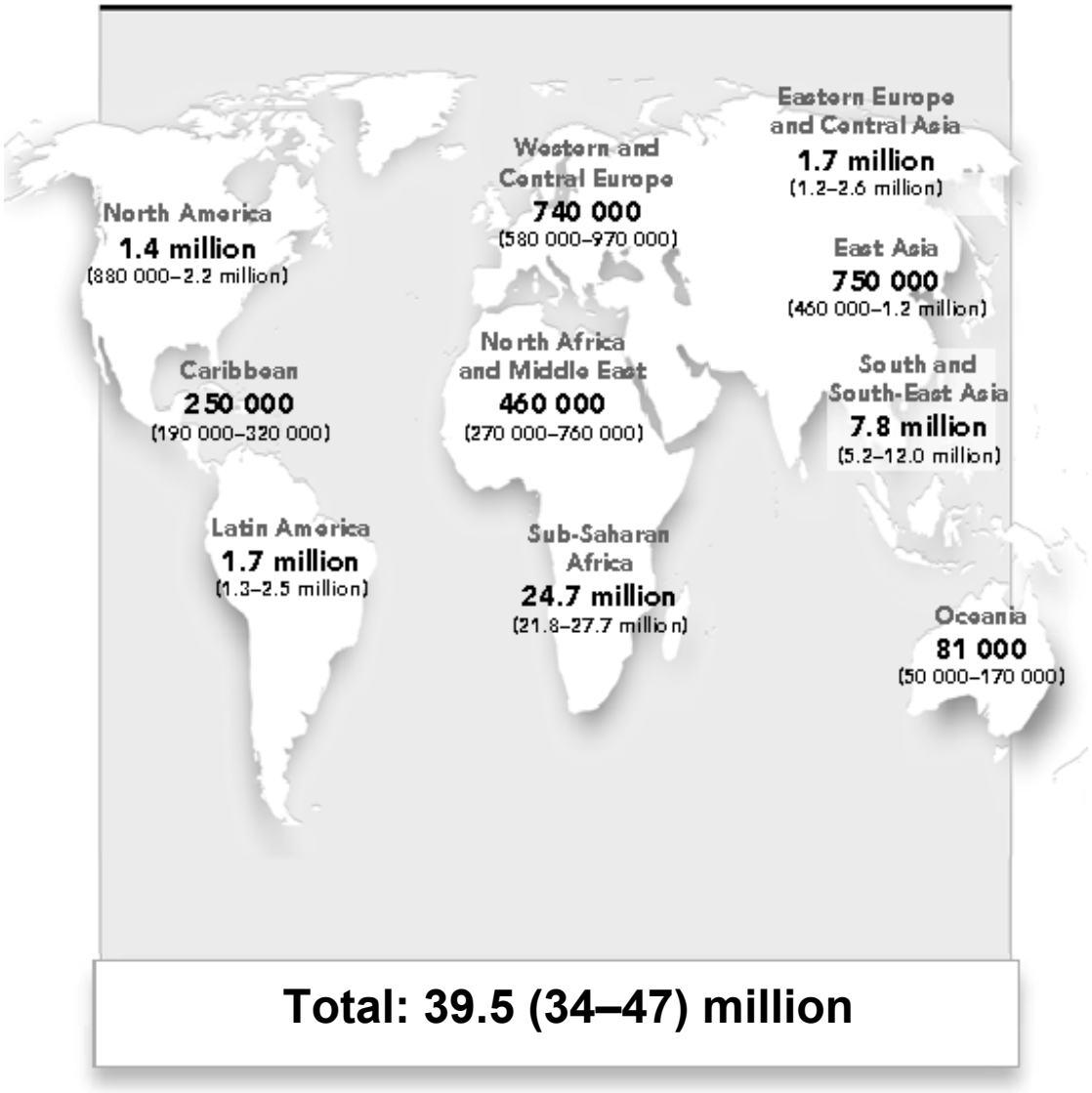
Source: UNAIDS December 2006 Epidemic Update

All figures are estimates. Figures in brackets show high and low estimates.

[1] 'Living with HIV/AIDS infection' means either infected by the HIV virus but showing no symptom of AIDS, or infected and showing symptoms.

Figure 2

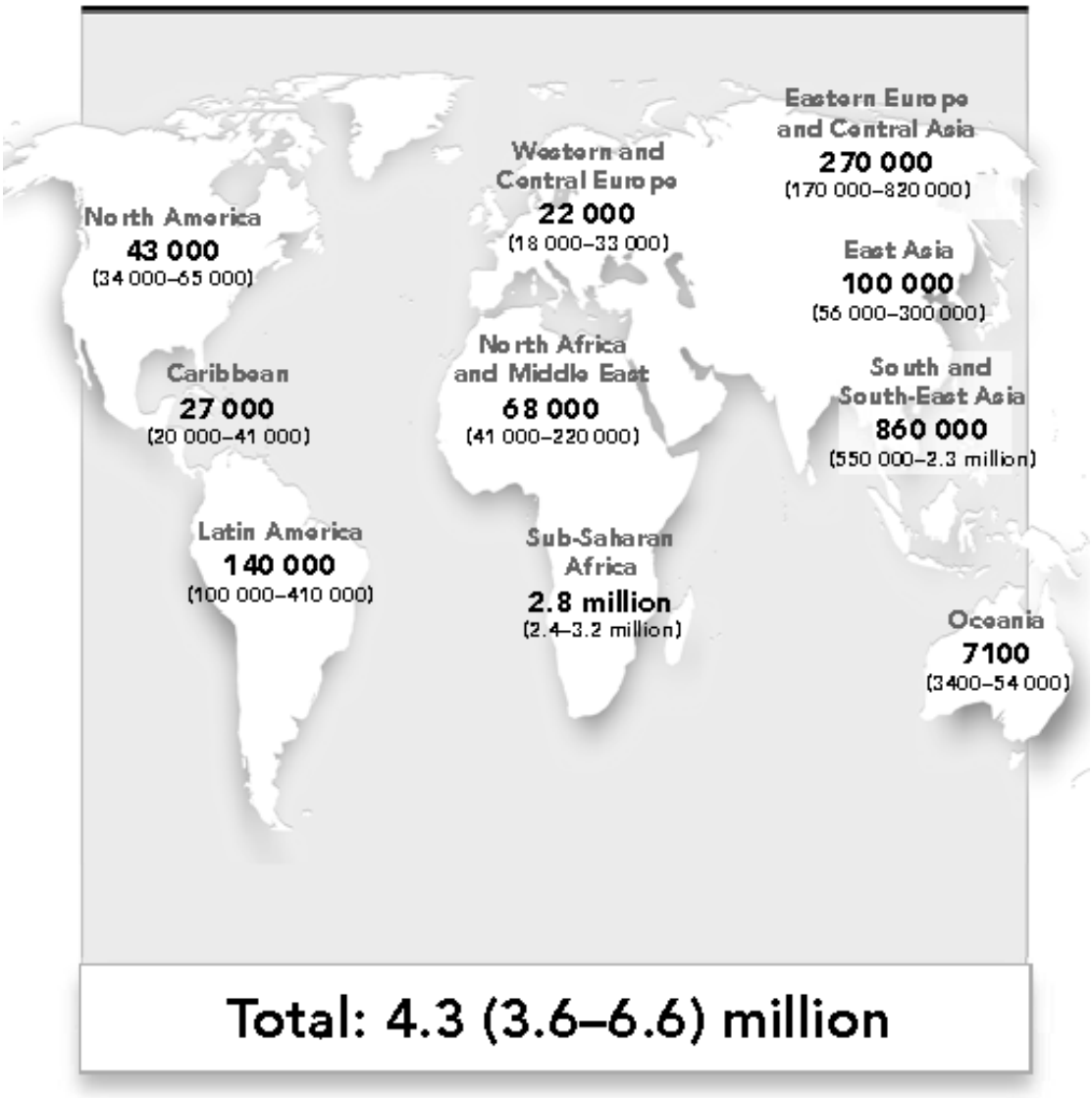
Adults and children estimated to be living with HIV/AIDS in 2006



Source: Reproduced by kind permission of UNAIDS *www.unaids.org*

Figure 3

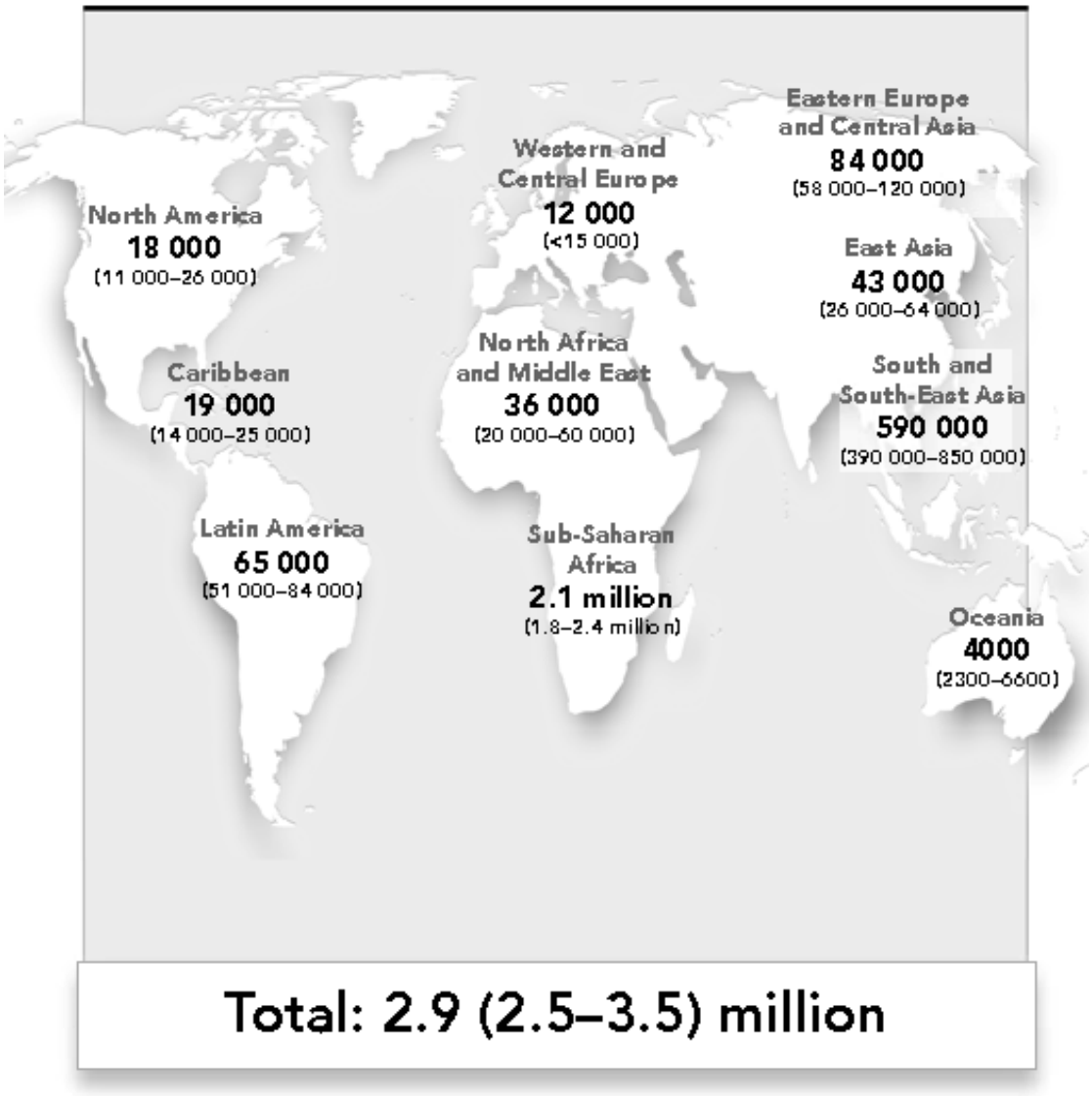
Estimated number of adults and children newly infected with HIV during 2006



Source: Reproduced by kind permission of UNAIDS *www.unaids.org*

Figure 4

Estimated adult and child deaths due to HIV/AIDS during 2006



Source: Reproduced by kind permission of UNAIDS *www.unaids.org*

Item 2 Extracts from UNAIDS Questions and Answers, August 2004

(●●●● means a section of the original document has been cut.)

●●●●

Drugs alone are not enough. ARV[1] and medicines to treat opportunistic infections[2] are an essential element of treatment, care and support for people living with HIV/AIDS, but they must be delivered within a continuum of care that includes: peer support; home and community care; primary, secondary and tertiary health care; as well as income-generating programmes, protection of human rights and efforts to reduce the overall stigma of HIV/AIDS.

●●●●

Comprehensive care for people living with HIV/AIDS includes, but is not limited to, the following:

- Available, accessible, voluntary counselling and testing services
- Antiretroviral therapy
- Prevention and treatment of tuberculosis and other opportunistic infections
- Prevention and treatment of sexually transmitted infections
- Palliative care to reduce the suffering of infected people
- Prevention of further HIV transmission, through existing technologies (e.g. male and female condoms, antiretrovirals for the prevention of mother-to-child transmission, clean needles and syringes) and investment in future technologies (e.g. vaccines and microbicides) as well as behaviour change
- Family planning
- Good nutrition
- Social, spiritual, psychological and peer support
- Respect for human rights
- Reduction of the stigma associated with HIV/AIDS

●●●●

The majority of people living with HIV in low and middle income countries are not aware of their HIV infection. Increased provision of treatment and care services will help motivate people to be tested. This, in turn, requires increased availability of voluntary counselling and testing (VCT) services. VCT stands at the heart of prevention and treatment. Behavioural counselling and provision of condoms, clean needles and syringes must be made available to people. After testing positive, people living with HIV can be offered care, treatment and support services, including ARV if necessary. Counselling and other services aimed at prevention of secondary transmission, as well as the provision of ARV to prevent mother-to-child transmission, are an essential component of follow-up services for individuals who test positive. Effective prevention programming and treatment, care and support services therefore go hand-in-hand.

[1] 'ARV' or antiretroviral drugs are designed to protect the immune system from the damaging effects of the HIV virus.
[2] 'opportunistic infections' are those illnesses which strike people whose immune systems have been damaged by the HIV virus. TB and pneumonia are typical examples.

●●●●

The impact of AIDS is devastating to the economies of low and middle income countries with high HIV prevalence. These countries, already suffering from heavy debt burdens, low productivity and weak infrastructures are being further impoverished by the scourge of AIDS. There is strong evidence that investment in HIV-related treatment and care can reduce hospitalisations and other direct and indirect costs of HIV/AIDS. Brazil has completed a number of economic analyses demonstrating significant cost-savings and expenditures avoided since the introduction of universal coverage of HIV-related treatments, including ARV, in 1997. Other countries that are beginning to scale up HIV treatment are also documenting savings due to avoidance of hospitalisations and lower incidence of opportunistic infections. In addition to prolonging the lives of countless teachers, health workers, farmers, students and other precious human capital, it makes sense for countries to invest in health care in general, and HIV treatment specifically, because access to care and treatment is a human right.

Different approaches are being used to help fund access to care and treatment in low and middle income countries. These include universal, free-of-charge, access to treatment programmes through the public sector (the approach used by Brazil and a number of other Latin American countries), direct government subsidies to patients (the approach used by Chile, Cote d'Ivoire, Gabon, Mali, Romania, Senegal and Trinidad and Tobago), and out-of-pocket purchasing by patients after large-volume purchases at reduced prices by governments (the approach being used by Uganda). It is clear, however, that the vast majority of people living with HIV and in need of treatment will not be able to afford to cover the costs of their care. Countries that have maximised treatment access have done so through universal access. In the Brazilian model, for example, HIV treatment is free. HIV care will need to be provided at a price that is proportionate to local purchasing power – and for many people, in many communities, in many countries, that means HIV care and treatment must be free.

Prevention and care efforts should not be considered as separate 'add-ons'; each reinforces the other.

●●●●

Treatment brings many wider benefits and its effects on national development are also substantial. What makes AIDS uniquely destructive is that it targets adults in the prime of their lives as workers, parents and caregivers. Treating HIV, therefore, saves children from ophanhood, keeps households and businesses intact, maintains social cohesion, enhances the return on social investments in sectors such as education and rural development, boosts economic growth, enhances national security and helps prevent the exacerbation of poverty which a mature epidemic is hypothesized to cause.

Prevention can help stave off such threats in the future, but people, societies, economies and nations are at risk today – and the risk stems primarily from the likely impact of millions of premature deaths within the next decade among those already infected. Only treatment can alter that trajectory. Moreover, those countries with the highest rates of infection are at disproportionately greater risk, which makes treatment there all the more important.

●●●●

For much of the world's population living with HIV, the need for food remains an overwhelming priority. People living with HIV and AIDS need substantial nutritional inputs (up to 50% more protein) to fortify their compromised immune systems. Those suffering from hunger, famine and/or nutritional deficits are more likely to fall ill with opportunistic infections and are less likely to be able to recover from them. Malnutrition is also one of the major clinical manifestations of HIV disease. Where drought conditions exist, access to clean water is reduced, further increasing the risk of infection for adults, children and infants, particularly those on formula feeding. Clean water supplies and adequate food must be part of an overall HIV treatment, care and support package.

Source: reproduced by kind permission of UNAIDS www.unaids.org

Item 3 Report on Family Health Trust Anti-AIDS Clubs (Zambia)

Students at the David Kaunda Secondary School in Lusaka, Zambia, set up the first Anti-AIDS Club in 1991 after hearing a talk about HIV/AIDS by a doctor. They then convinced friends in other schools to adopt the idea and the clubs started to spread around the country. The efforts of the Clubs have been helped by the Family Health Trust (FHT), a Zambian non-governmental organisation (NGO), formed in 1987 to help prevent the spread of HIV/AIDS whilst offering care and support to those already affected. The FHT assists the Clubs in their peer education, which relies on role playing, focus group discussions, games and individual discussion to prevent the spread of HIV/AIDS.

The initial approach taken to 'scaling up' the work of the Clubs was to encourage their spread of geographic coverage. This decision was based on the success of the original programme and the evident desire amongst young people to take action against the spread of HIV/AIDS. The FHT provided training for the students who led the clubs, and supervised them through adult facilitators. Its staff also developed a quarterly newsletter with basic facts about HIV/AIDS, with articles by the young people themselves. However, the organisation soon found that it did not have the resources to sustain the quality of the initiative as it expanded rapidly throughout the country. The Clubs became too numerous, support could not be provided for all of them, and the clubs themselves started dying out.

In response, the FHT realised that it had to provide support for what was an excellent example of a spontaneous initiative. The FHT developed a three-step approach:

1. Consolidate the field support to the clubs through a programme of training and supervision of regional coordinators and zonal leaders, who then trained Club members.

2. Produce new educational materials, notably a manual entitled 'Happy, Healthy and Safe', which is easy to use for peer education in HIV/AIDS.

3. Recognising the limited ability of the Clubs to reach youth who were not in school (and so more likely to be vulnerable to poverty and HIV) the FHT aimed to intensify out-reach to non-members.

To achieve these objectives, the FHT enlisted volunteers who were given a small stipend, and a bicycle to help them reach the Clubs throughout the zones.

By the year 2000 there were 2561 Clubs registered, but only 717 were highly active at that time, usually those in urban areas. However, it was noticeable that, in these active

Clubs, the young people were increasing their involvement and, usually those in urban areas, expanding into care and support for victims of HIV/AIDs. For instance, Clubs were:

- moving into income generation, creating fish farms and grocery co-operatives and using the income to help orphans with school fees;
- initiating literacy classes for their friends who were out of school;
- raising awareness of the issues involved amongst members of the wider community.

Initial evaluations of the new approach to supporting the Clubs suggest one very positive result from their work … and one worrying shortcoming. The most positive result appears to be that young people are well aware of the HIV/AIDS problem, and are much more prepared to be tested and to attend clinics than were people in the same districts a few years ago. The worry is that, although there has been some increase in condom use, the overall frequency of unprotected sex has not fallen as much as had been hoped.

Source: Jocelyn De Jong, *Making an Impact in HIV and AIDS*, ITDG, Publishing, 2003

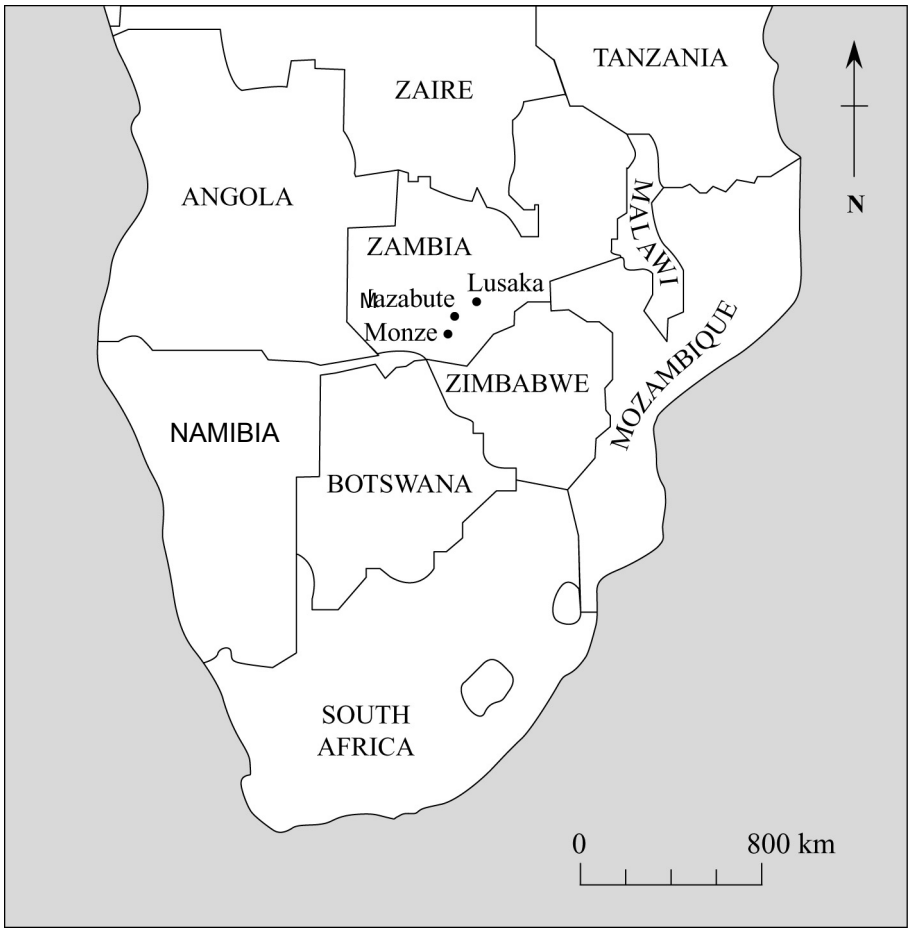
Item 4 Extracts from a Report by Hannah Brown, The University of Nottingham School of Nursing, May 2003

Introduction. This report describes my experiences whilst on a five-week placement in the Southern Province of Zambia as part of my nursing degree … The focus of my placement was to see the work of SAPEP – an HIV/AIDS project …

Aim. To observe the work of health care workers in Zambia, in a range of settings, in order to develop an understanding of the social, cultural, economic and political factors that affect the HIV/AIDS pandemic and the provision of health care and health promotion initiatives.

SAPEP is a non-governmental organisation which works in two rural districts in Zambia's Southern Province, surrounding the towns of Monze and Mazabuka. The project used to be funded by the government Family Health Trust. The project was under-funded … and has been funded by PEPAIDS, a British-based charity, since December 2002.

Figure 5



SAPEP employs two District Co-ordinators, one in Monze and one in Mazabuka. Their districts are divided into 10 Zones, each with a part-time Zone Co-ordinator (ZC). (Note that the number of ZCs was increased to 20 in early 2004.)

Anti-AIDS Clubs. Anti-AIDS Clubs had been running in Zambia since 1991. However, they were suffering from a funding and management crisis in 2002, so SAPEP took over the support of the Clubs in Southern Province. The ZCs train individuals within their zones to run Anti-AIDS clubs, which operate in local communities. The Club Leaders organise and lead activities, including running sports leagues, and competitions, and doing drama/role-plays about situations that may leave people vulnerable to HIV/AIDS transmission. Sport has proved to be a very effective way of reaching the youth and giving health education, because it attracts a large audience. The ZCs also liaise with local health clinics, hospitals and schools. 'Youth Friendly Corners' are run in rural health clinics, where young people can go for advice and discuss sex and HIV, which are usually taboo subjects in Zambian society.

Many people associated with the Clubs feel they are better able to respond to local needs since their funding was taken over by SAPEP which is based in the area.

Factors affecting the work of SAPEP

Social. There is a huge stigma surrounding HIV/AIDS in Zambia. Issues around sex are not discussed. Heterosexual intercourse is responsible for the vast majority of HIV infections in Zambia. Zambian women have an extremely low status in society. Women have no power within relationships to refuse sex, insist on condom use or demand that their partners be faithful. This is one of the most crucial reasons for the spread of AIDS in Zambia, and in Africa as a whole.

Cultural. Some practices and beliefs have a direct effect on the transmission of HIV. For instance, it is believed that men can cure sexually transmitted diseases by having sex with a virgin, and family and tribal elders are also expected to initiate young girls into womanhood, through sexual intercourse.

Poverty. Poverty plays a major role in HIV transmission. For many people each day is, literally, a struggle for survival. Many women and young girls are forced into prostitution, which obviously contributes to the spread of HIV.

Monze Mission Hospital. I worked for two days on the male ward of the hospital … There were many HIV/AIDS patients on the ward, although most had only been admitted for opportunistic infections like TB or chest infections. It seemed to me that not all patients had been tested for HIV. When I asked a nurse about this she was quite concerned. She said that HIV/AIDS was not openly talked about. Patients did not want testing, because there is no benefit to them in knowing. They cannot afford antiretroviral drugs and having a positive HIV status would bring shame on them.

Home-based care. I visited three different areas in Monze with home-based care services. The majority of the patients we visited had AIDS … they were dying without any food or pain relief. For many people, AIDS meant their family had no source of income as the sole earner was sick. There were countless orphans who had lost both parents to AIDS. One woman I met had seven grandchildren to look after, her own children having died from AIDS.

Expansion of SAPEP. In my opinion, SAPEP's work is proving effective. Statistics of sexually-transmitted infections at health clinics in the areas where SAPEP operates show that they have been reduced. SAPEP is effective because it delivers health education through local people with whom the target population can identify. Health promotion activities and information are appropriate to the community's needs. With this continued success, SAPEP is set to grow, if funding can be maintained. There are plans to expand the project to provide home-based care services in the rural communities and to provide sponsorship of orphans.

Possible follow-up work
When Hannah had finished her Report her supervisor realised that SAPEP needed more precise data on the results of their initiatives in Zambia. They felt that some field research was needed to identify:

- the young peoples' level of knowledge about HIV/AIDS in areas where sports clubs were being organised by Anti-AIDS Clubs;

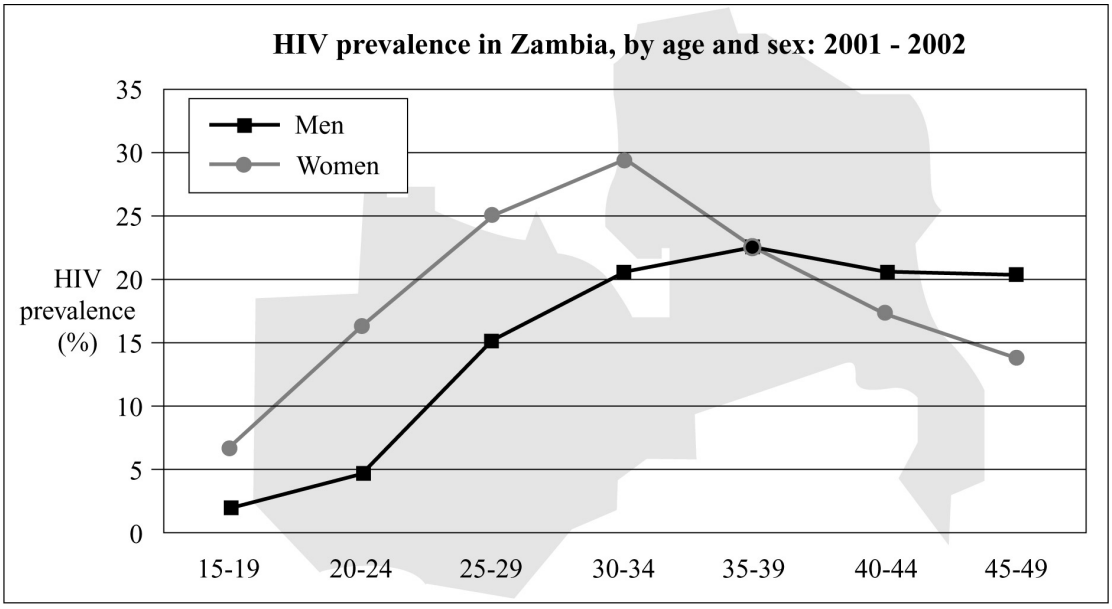
- comparable data for areas with no Anti-AIDS Clubs.

The supervisor could have considered approaching the University's Geography Department to discuss how geographers would have planned and carried out a questionnaire survey to collect this data. This could have been useful because geographers would be aware of ways of drawing up questionnaires and of sampling the population. They would also be aware of some of the problems that might be encountered in carrying out the survey.

Source: Hannah Brown/PEPAIDS Charity

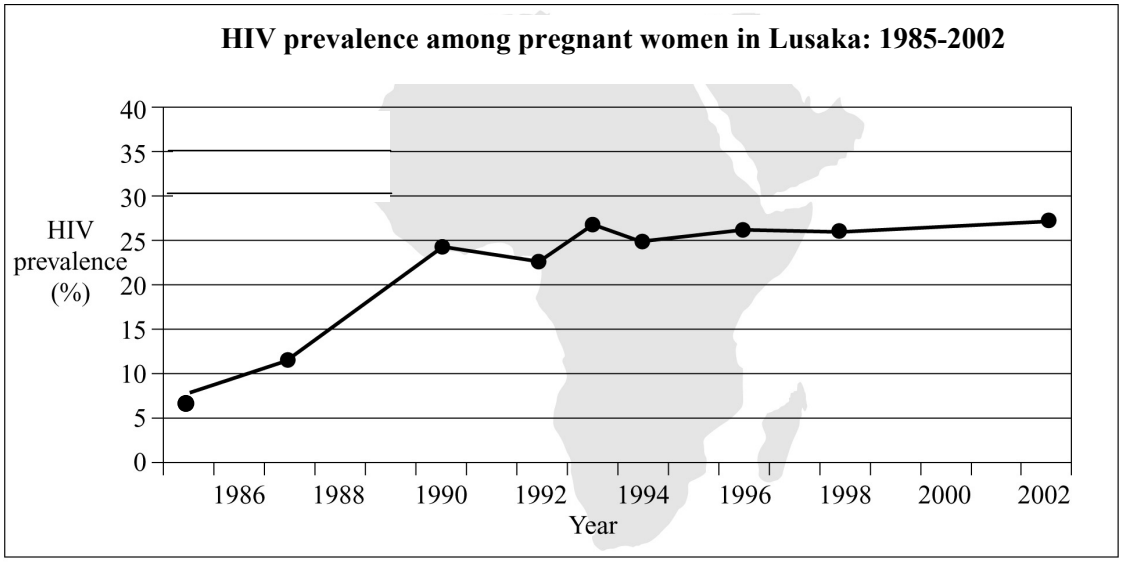
Item 5 Some statistics on the prevalence of HIV/AIDS in the population of Zambia.

Figure 6



Source: Zambia Demographic and Health Survey, 2001-2002

Figure 7



Source: National AIDS Programmes (partly compiled by the US)

ACKNOWLEDGEMENT OF COPYRIGHT-HOLDERS AND PUBLISHERS

Permission to reproduce all copyright material has been applied for. In some cases, efforts to contact copyright-holders have been unsuccessful and AQA will be happy to rectify any omissions of acknowledgements in future papers if notified.

Figure 1, 2, 3 & 4	UNAIDS: The Joint United Nations Programme on HIV/AIDS
Item 2	UNAIDS: The Joint United Nations Programme on HIV/AIDS
Item 3	ITDG Publishing, 2003
Item 4	PEPAIDS, © Hannah Brown 2003
Item 5	UNAIDS: The Joint United Nations Programme on HIV/AIDS