HIV/AIDS

Social Science and HIV/Aids Policies in Africa

Abstract

As is well-known the HIV infection profile in sub-Saharan Africa is very different from the HIV infection profile in the developed North. This paper explores the strengths and weaknesses of the three main explanations for this difference: the cultural explanation, the dependency explanation and the rational choice explanation. I argue that all three explanations have major problems. The cultural explanation ignores the variety of African cultures and the wide variations in sexual practices of Africans in different countries and ethnic communities. It also tends to place the blame for HIV/Aids on African women. The dependency model is too concerned with the workings of the world system, puts too much emphasis on poverty and overlooks the internal dynamics of the various countries of sub-Saharan Africa. The rational choice explanation underestimates the roles of emotion and habit in human sexual behaviour. Nevertheless social science research and debate have ensured that moralism has played a minimal role in the formulation of Aids policies in sub-Saharan Africa. Social science research shows that all individuals are at risk and that the situation is going to get worse unless serious effort is committed towards the fight against Aids. Social science debate has ensured that the afflicted are seen as victims more than as vectors. Aids policies in Africa have seesawed between containment of victims and potential victims and their sympathetic treatment. I argue that policies which do not emphasise containment are preferable. However for these to work the conditions which make Africa the most Aids-affected region in the world must be addressed. Poverty, inequality and underdevelopment must be seriously tackled if real progress is to be made in the fight against HIV/Aids.

Explaining the African HIV Infection Profile

The latest figures from the United Nations and UNAIDS reveal that sub-Saharan Africa remains by far the region of the world hardest-hit by HIV/Aids. It is also well known that sub-Saharan Africa has a different pattern of HIV infections from most other regions in the world. In sub-Saharan Africa, as in parts of Latin America and the Caribbean, heterosexual intercourse is the principal mode of transmission. In addition the male-to-female case ratio is tilted against women, and overall prevalence rates are high. This is in contrast to other areas of the globe where the main modes of transmission are homosexual intercourse and intravenous drug abuse. In these areas the male-to-female case ratio heavily favours women, while overall prevalence rates are low to medium.

There are three main explanations for the differing HIV infection profile in Africa: the cultural explanation, the dependency explanation and the rational choice explanation. The cultural explanation, as proposed by should not be severely punished’ (189).

In addition they state that ‘African society recognises as a distinct phenomena longer-term girlfriends, mistresses [and] outside wives...., who partly serve in urban areas as alternatives to polygynous married wives’ (Caldwell et al. 1989: 189). Odebiyi and Vivekananda (1991) basically agree, but attribute the sub-Saharan African infection profile to such cultural factors as polygamy, which drives women to seek sexual fulfilment outside marriage, and the high value placed on children in African culture, which drives people to discriminate sexual activities.

However, in a randomised study of youth attitudes towards risky sexual behaviour, Mufune et al. (1993) found that some groups of young people in Zambia do not favour extramarital sex or multiple partners. Furthermore, in analysis of demographic and health surveys from seven African countries, Gage-Brown and Meekers (1993) reveal that the proportions of never-married adolescents who have had sex varied enormously among countries. Premarital sexual activity was virtually absent in countries such as Burundi, where only about 4 percent of never-married females have had sex, but very prevalent in Botswana, where more than 75% of never-married women aged 15-24 have had sexual experience. The evidence seems to support the argument of Le Blanc et al. (1991):

They [Caldwell and supporters] imply that sexual promiscuity, particularly among women, is the norm in Africa, and that “lack of control” of women’s sexuality is the key to the Aids epidemic in that region. It is our view that, in fact, the sexual behaviour of women is subject to a great deal of social regulation and that norms are highly variable from one African society to another (501).

It is also clear that Caldwell’s study was based on unrepresentative documentary methods. The documents written during the period of colonialism were biased and of limited reliability, since they represented stereotypical views of African sex prevailing at the time.

In the nineteenth century there were a number of highly ethnocentric, sensational, moralizing accounts of “native” sexual behaviour written by explorers, adventurers, missionaries, and amateur anthropologists whose intent was to shock and perhaps to titillate the reader, or to show that Africans were “oversexed” or lacking in moral restraints (Green 1994: 95).

The situation in the first part of the twentieth century was not that much better. The assertion that extramarital sex in Af-
Africa is very high by world standards fits these kinds of stereotypes.

In opposition to the cultural explanation of Caldwell and others, the dependency model argues that HIV/AIDS in Africa can only be understood in the wider context of national, regional and global economic inequalities. As early as 1988 Schoepf argued that the spread of HIV is determined by the international political economy and social structures as well as by the actions of individuals and groups variously situated within this historically constructed system. Using Dependency and World Systems Theory, Hunt (1989) explained the spread of HIV by starting from the premise that cities are the places where most jobs in Africa are to be found. Thus rural poverty motivates people to seek employment in the cities. The spread of HIV has likewise followed this pattern. Migrants in towns, living away from wives, turn to prostitutes and thereby promote the rapid spread of sexually transmitted infections (STIs), including HIV. Periodically migrants return to their rural homes and then spread HIV there. In line with this model Hunt found that HIV infections were most common – and appeared first – in places with high concentrations of migrant labour. It is no accident that ‘especially in large cities and along major transportation routes, Aids is so much more prevalent than in comparable settings in Europe and North America’ (Philipson and Posner 1995: 836). According to Hunt the places of origin of migrant labour are also high in HIV infections compared to places that do not serve as labour reserves.

Poverty, which inordinately affects African women, also limits choice in terms of fertility and sexual activity. Women have less access to cattle and land (the two traditional sources of wealth) as well as to education and the labour market. Thus men have more access to the few jobs available and more access to income-earning possibilities. Thus women generally have to depend on men for a living. For most women marriage and sex are the main ways to access resources. For young, single women sex may be the only way to access resources. Conversely men feel that they have a right to demand sex from wives and partners whenever they want.

The social structure of poverty relates to migration. The unemployment, poverty and underdevelopment of the populated rural districts are the “push” factors that motivate individuals and groups of people to move in search of jobs. Most migrants, however, maintain links with their place of origin. Many keep wives in their villages. Historically this has been because migrant wages have been inadequate to maintain families in the places where the men work. Moreover, during the colonial era, only males were allowed to move in search of jobs, and the housing for migrants was not built to accommodate families. Many migrants also needed (and still need) to own land and other resources in their home areas. Wives are the people who can physically secure these resources for them. This is important for migrants because their jobs have little social security attached to them. They are usually paid poorly and can be fired at any time. Migration, however, means that wives and husbands are separated from each other for considerable periods of time. Therefore extramarital sexual relationships, often casual ones, are common in the places of destination. Moreover migrants in low-paying jobs usually have little education. Many therefore have poor knowledge of reproductive health issues and little access to information to enable them to make safer-sex decisions. Furthermore the relationships of poverty, migration and power in underdeveloped Africa exist as stable, continuing patterns of behaviour involving people with others at the interpersonal level. They may not be entirely open to reflection, criticism and decisions of acceptance or rejection.

If the weakness of the cultural explanation model is its exclusive focus on internal factors to explain HIV infection patterns, the weakness of the development/underdevelopment model is its neglect of internal factors. It sees HIV infection patterns as determined by Africa’s place in the world economic system. The behaviour of individuals is overlooked. Secondly the association of HIV/AIDS with poverty is over-emphasised. For example one of the most affected countries is Botswana, yet the economy of Botswana has been among the fastest growing in the world for the last two decades. Moreover in all the southern African countries HIV/AIDS is at least as widespread among the educated and well-off as among the poor.

In an effort to avoid the weaknesses of both the cultural and dependency models, Philipson and Posner (1995) offer the rational choice model (RCM). The rational choice explanation is based on a set of assumptions about human behaviour in which social action is seen as the sum total of individuals acting to maximise their interests through the calculation of costs and benefits. Behaviour thus reflects a rational assessment of individual self-interest. For Philipson and Posner RCM is the key to understanding all human phenomena, including sex. In this view to explain the spread of HIV we need to study how rational choices made by individuals influence personal decisions regarding participation in risky sex. According to Philipson and Posner there are three factors that explain HIV prevalence patterns in sub-Saharan Africa: the nature and size of high-risk groups in the population (i.e., the high prevalence of prostitution and non-monogamous sexual activity), the resulting high prevalence of STIs and the real costs of condoms in the African context. With regard to high-risk groups, they concur with Caldwell et al. (1989) that female prostitution is higher in Africa than in America and Europe but argue for an economic rather than a cultural cause. Given the higher levels of poverty and unemployment African men cannot afford to support wives and hence rely on prostitutes. Poverty also encourages migration, which in turn increases the demand for prostitution. So polygyny and customs leading to marital abstinence.

Prostitutes are a major source of infection in Africa. The Aids epidemic has reduced the nominal price of prostitution (which is highly inelastic, since African prostitutes do not have prospects for alternative incomes), and consequently ‘the amount of potentially infectious sexual activity by prostitutes has not fallen in response to the higher risk of infection’ (Philipson and Posner 1995: 839). Similarly the services of females in casual and non-monogamous relations are inelastic, and their levels of sexual activity have also remained the same. Moreover, since infections are rampant among African prostitutes and females in non-monogamous relations, there is little incentive for safer sex: ‘The likelier one is to be infected already, the smaller the expected benefits of safe sex’ (Philipson and Posner 1995: 842). The demand for safer sex is further reduced by low levels of education and misconceptions that distort perceptions of the risks of engaging in casual sex and of the efficacy of safer sex. Lower life expectancy also reduces the perceived benefits of safer sex; the number of years of life likely to be lost through HIV infection has less value than in places where life expectancy is high. With regard to condoms Philipson and
Posner argue that their real cost is higher in Africa than elsewhere. Poor distribution infrastructure makes the supply of condoms in Africa, especially in rural areas, uncertain. More importantly condoms are very costly in terms of “foregone” expenditures. In most of Africa a month’s supply of condoms costs more than two hours of work (assuming one has work in the first place). Therefore Africans do not have what the United Nations calls ready and easy access to condoms. For many the purchase of condoms has to be calculated against the foregone consumption of other goods and services. As a result the expected demand by individuals for condoms (and therefore safer sex) is much lower in Africa.

As Philipson and Posner seem to realise, the rational choice model is a heuristic device: a simplifying mechanism aimed at enhancing understanding and explanation. However, when all human behaviour is taken as rational or as maximising self-interest, there is a serious problem. As Arrow (1987) points out, people often act unthinkingly or simply out of habit. Many of our actions are not only non-rational but may even be irrational. We act from impulse or emotions at least as much as from reason. AIDS is mostly a sexually transmitted disease in Africa, and no behaviour is more open to emotions and habit than sex. For example it seems quite unlikely that anybody takes the issue of life expectancy into account when seeking sexual encounters.

The optimisation of benefits that is implicit in the calculative model of rationality is flawed by virtue of lacking meaningful consideration of the temporal dimension that characterises everyday action. Risk of infection may be less important than the immediate and pressing relevance of sexual gratification because the apprehended risks (for example, rejection, loss of income, distrust) are more consequential than the more abstract risk of death in the future (Hughes and Malila 1996: 9).

In addition sexual practices are imbued with symbolic meaning and these rather than rationality may structure and frame individuals’ lived experiences of sex. By neglecting to integrate emotional and traditional action (à la Max Weber) in their explanation of AIDS in Africa, Philipson and Posner deal their argument a severe blow.

The rational choice model also comes with a price. Culture is judged only on the basis of whether it promotes knowledge or not, and collective action is seen simply as the sum total of individual actions. As a result RCM cannot really explain why in Zambia, Zimbabwe, Botswana, Malawi, Namibia and South Africa HIV prevalence rates are more than 20 percent but considerably less in other countries despite the fact that the same conditions (prostitution, non-monogamous relationships, high cost of condoms, high prevalence of STIs) obtain. Lastly RCM fails to explain why HIV rates in Africa are high in the first place. Proponents agree with the cultural explanation that prostitution is the norm in Africa, but why this is the case is left unanswered. Philipson’s and Posner’s analysis is incomplete since it is based on the view that sexual activity and therefore infections are voluntary. Clearly some groups in society (rape victims, minors, newborns and accident victims) cannot control their risk of infection voluntarily (Kremer 2000).

**Policy Reactions to HIV/AIDS as Antecedents of Social Science**

Inevitably many of these sociological ideas have found their way into AIDS policies in sub-Saharan Africa, albeit in an unsystematic way. Helen Jackson (1996) has pointed out that there are several reasons why AIDS policies are necessary in the region. Firstly the scale of the epidemic requires organised responses that promote effective ways to combat it. Clear-cut policy is necessary to assist behavioural changes that could make a difference to the scale of the epidemic. Secondly HIV/AIDS comes with a stigma. The infected and those perceived to be at high risk are widely discriminated against. Such discrimination violates or undermines the basic human rights of certain groups of people in society. Policy is necessary to safeguard these rights both as a matter of ethics and as part of the strategy to combat HIV. Lastly policy is also necessary to deal with the escalating costs of the disease, especially with regard to education and employment.

Usually policies towards AIDS are developed along two axes: moralism/pragmatism and coercion/compassion. These reflect the different interests and positions to be found within society. The coercion/compassion axis opposes a behavioural disposition emphasising compulsion or force to one which puts the emphasis on understanding the social needs and plight of people living with HIV/AIDS or those at risk while acknowledging that every human being is a potential victim of HIV/AIDS. The moralism/pragmatism axis opposes a disposition to judge certain types of sexual conduct as morally wrong to one that emphasises what is practicable rather than what is ideal.

Thus four general policy approaches emanate from these two axes:

1. The approach falling between coercion and pragmatism. Here policy advocates external but not necessarily punitive actions targeting those living with HIV and those defined as belonging to high-risk groups seen as dangerous to society. Policies emanating from this approach emphasise containment combined with pragmatic education and prevention.

2. The approach that falls between coercion and moralism. Here policy is punitive against those living with HIV and those seen as belonging to high-risk groups. There is a bias towards institutional controls, with the infected and members of high-risk groups seen as “them” out there who typify what is wrong with society (Vass 1989). Therefore quarantines are advocated, and the distribution of condoms is opposed as unethical. Policy emphasises punishment as an example to others. Born-again groups of the Pentecostal persuasion have been a vocal minority promoting this policy approach. Some groups even think that discussing risk factors is premature and that preventative measures are unacceptable (Osei-Hwedie and Osei-Hwedie 1996).

3. The approach that falls between moralism and compassion. Here policy rejects as inhumane mechanisms such as quarantine but also rejects practical interventions such as provision of condoms, sterile needles and sex education on the grounds that they encourage immorality. Policy therefore emphasises increased awareness through preaching what is right and wrong. Mainstream churches and traditionalist circles have argued for this policy alternative.

4. The approach that lies between compassion and pragmatism. Here HIV is recognised as a danger to society, but the rationality of external controls is questioned. Society is seen as having a responsibility to fight the spread of HIV/AIDS in the most humane way. What is envisioned is a positive interaction between society on the one hand and people living with HIV/AIDS and those at high risk on the other (Vass 1989; Osei-Hwedie and Osei-Hwedie 1996). Here policy endorses the provision of condoms, sterile
needles and sex education and resolutely opposes quarantines and compulsory testing of individuals. Policy recognises that people are not going to stop having sex and emphasises measures which are humane and practical. The idea is that HIV is a problem that subjectively and hypothetically exists in everyone.

Most Aids policies in sub-Saharan Africa have shunned moralism on pragmatic grounds. Even if it were true that HIV/AIDS is a result of “immoral” sexual activities, policy makers generally realise that widespread behavioural change will never be brought about by preaching morality (policy approach C) or by threats of punishment (policy approach B). Thus Aids policies in the region have tended to straddle approaches A and D. There have been important advocates both of HIV disease containment combined with prevention through education on one hand and of doing whatever works without infringing people’s rights on the other hand. Social science has been instrumental in promoting these two policy options. It is my contention that writings such as that of Caldwell et al. may justify policies combining containment of the HIV disease with education measures to change culture and therefore behaviour. There is an agenda in their message aiming at rolling back the tide of permissiveness. The blame for Aids is placed on sexual promiscuity. In other words African society is ultimately to blame because it has condoned promiscuity. In turn this implies that those with Aids are responsible for their situation. Although they do not say it, I believe Caldwell et al. would not be opposed to measures such as mandatory notification of an individual’s HIV infection, removal of confidentiality clauses and mandatory testing as long as these were mixed with education and other means of prevention. Zambia and Zimbabwe have in part pursued such policies, particularly in relation to women, who are seen as transmitting prostitution and drive many prostitutes must teach them bargaining skills so that they can negotiate for safer sex. In the longer term women’s empowerment has to involve increasing their education and their economic and political voice in society.

Zimbabweans may have copied these clean-up campaigns from Zambia where from the 1970s they were a regular strategy for controlling single women who showed any independence or desire to control their own sexuality. Unaccompanied women were also locked up in Zambian police cells. In Kenya, under the Public Health Act, Section 17, only women can be forcibly tested and criminally charged if they have a sexually transmitted disease (Gould 1993). In Zimbabwe Jackson and Pitts (1991) found that AIDS screening was being practiced by a significant number of firms. Thus 22 percent of the firms in their sample had some form of HIV screening in place while 40 percent thought pre-employment screening was justified despite the fact that it was not provided for in the law. Similarly in South Africa the 1987 health regulations introduced compulsory testing for foreign labour recruits and the repatriation of all HIV-positive foreign workers (Jochelson et al. 1991).

Those working from a development/underdevelopment perspective condemn such policies for, first, blaming the victims and, second, taking the simplistic view that people infected with HIV are responsible for their situation. This deflects attention from the socio-economic context that makes it very difficult for many people to escape infection. It also deflects attention from the relationship between poverty, illness, powerlessness and the colonial-induced inequalities that characterise Africa. The development perspective points to the psychological and social pressures that come into play in relation to HIV infection. Thus an effective policy has to address the power and economic relations in African society. As a short term measure it may be prudent to promote condoms, sterile needles and safe sex education, but mandatory testing, quarantines, partner notification, laws against the “wilful” transmission of HIV and other containment measures merely prop up an inequitable socio-economic order. In the medium term policy has to focus on female empowerment in limited situations. For instance those working with prostitutes must teach them bargaining skills so that they can negotiate for safer sex. In the longer term women’s empowerment has to involve increasing their education and their economic and political voice in society.

Policy measures from the RCM perspective straddle those of the others. Thus Philipson and Posner (1995) argue that public interventions are more likely to work in Africa than elsewhere. In the USA, for example, most people can afford condoms and have a high awareness of HIV, so condom subsidies and public education campaigns do not make much difference. In Africa, however, condom subsidies and public HIV/AIDS education campaigns will have a much greater impact. At the same time the RCM perspective also recognises that inequalities between men and women are a root cause of HIV infection and have to be reduced in the longer term. This would lessen prostitution and enhance the capacity of women to negotiate for safer sex, thereby reducing HIV infectivity. But among policies which will not work in Africa, say Philipson and Posner, are unionisation of prostitutes or minimum-wage laws for commercial sex work. They argue that such measures would only raise the price of prostitution and drive many prostitutes into long-term but non-monogamous relationships in order to get male support. Also unlikely to work is mandatory notification of partners of people living with HIV/AIDS. This is because such partners are transient and, given the prevalent co-factors, chances are high that such partners already have the disease.

Conclusion

Social science research and debate have ensured that moralism has played a minimal role in the formulation of Aids policies in the region. Social science research shows that all individuals are at risk and that the situation is going to get worse unless serious effort is committed towards the fight against Aids. Social science debate has ensured that the afflicted are seen as victims more than as vectors. Aids policies in Africa have seensawed between containment of victims and potential victims and their sympathetic treatment. Obviously policies which do not emphasise containment are preferable. However for these to work the conditions which make Africa the most Aids-affected region in the world must be addressed. Poverty, inequality and underdevelopment must be seriously tackled if real progress is to be made in the fight against HIV/AIDS. Thus Jochelson et al. (1991) have argued that HIV transmission in South Africa cannot be reduced unless the social conditions promoting it—migrant labour, vulnerable family situations, low wages for women—
- are first explained. It is difficult to disagree with them.

However all the three major explanations of the Aids epidemic from the social science perspective have major problems. The cultural explanation is not adequate. There is no one African culture, and thus there are wide variations in the sexual practices of Africans in different countries. The cultural approach is also gender-biased in its belief that sexual promiscuity among women is the key to understanding Aids in Africa. The RCM approach fails to take seriously Schutz's (1973) contention that human beings are phenomenal agents who proceed on the basis of the here and now. This may be more important to understanding Aids than the calculative model of rationality, since few human behaviours are as open to habit and emotion as sex. The dependency model is too concerned with the workings of the world system, puts too much emphasis on poverty and overlooks the internal dynamics of the various countries of sub-Saharan Africa.

References


A Life Course and Cross-Level Approach to the Study of HIV/AIDS in Africa

Abstract

The social science approach to HIV/AIDS research has been tilted excessively in favor of socio-cultural behavioural issues which can distort and mislead. Reviewing the literature on HIV/AIDS in sub-Saharan Africa reveals that much of the problem emanates from the lack of an integrated approach, one that simultaneously takes into account the different levels of social life and the timing of events in individuals’ age groups and historical periods. I argue in this paper for an approach that follows a life course perspective. This assumes that the interaction between culture and individual behaviour is mediated by historical location, social relationships, and the life stages of individuals and groups. I therefore propose a research design for the study of HIV/AIDS based on this perspective, arguing for a multilevel approach that makes use of available information from demographic and health surveys. I provide some examples of how this approach might work and conclude with suggestions for comparative research studies of HIV/AIDS in Africa.

The Current State of HIV/AIDS Research in Africa

Aids is growing at an alarming rate in sub-Saharan Africa in all sectors of society. However, we still lack a comprehensive theoretical or methodological perspective that would help us understand the transmission, distribution and impact of the disease in relation to social structures and relationships. Most studies of HIV/AIDS have been inspired mainly by bio-medical perspectives and have focused on specific high-risk groups. This has made it difficult to generalise and understand the structures and dynamics of the epidemic

Berhanhe Berhe Aria
Department of Sociology
University of North Carolina
Chapel Hill, USA
on a larger scale. In addition individual-level surveys have predominated, as they are the building blocks of many intervention programs such as safer sex campaigns. Decosas (2002) argues that individual-level reductionist analyses of the causation of HIV/Aids are still dominant in Africa because of the commercial interests of the pharmaceutical and biotechnology sectors. Other studies have tried to draw conclusions from regional-level correlations between different lifestyles and HIV prevalence. However these mostly use aggregate-level information and poorly operationalised concepts, making their conclusions unconvincing from a causal point of view.

At the early stages of the epidemic, the disease was geographically clustered in certain areas with common socio-cultural practices. This led some social scientists to draw causal arguments from the association between these socio-cultural practices and high rates of HIV prevalence. For example Caldwell and others try to explain the high HIV prevalence rates in the capital cities of the “uncircumcising belt” in southeast Africa and in East Africa on the fact that some major ethnic communities in these areas do not practise circumcision (Caldwell et al. 1998; Caldwell and Caldwell 1993). Inspired by such correlations they made culture central in the causal mechanisms of HIV/Aids. To substantiate this link, they used ethnographic studies and argued that belief systems regarding issues such as sexuality and virginity influence prevalence rates in most African societies. Their central thesis is the importance of understanding sub-Saharan African societies and the role of sexual relations within them. They acknowledge such risk factors as living in an urban environment, having a large number of sexual partners and suffering from genital lesions, but they fall short in linking socio-cultural factors with individual behaviour. Their problem has to do with both their data and their interpretation of it.

One obvious problem is the use of cultural ethnographies written decades ago to explain contemporary phenomena. The treatment of small-level cultural practices as explanatory evidence conceals the dynamics of cultural change. In a continent which has been undergoing massive social changes in terms of urbanisation and cultural diffusion, it is problematic to treat traditional practices as ready-made predictors of the relative risk of HIV/AIDS. When we note that the disease is much more prevalent in cities and along transportation routes, the arguments based on traditional cultures become even more suspect. Instead of focusing on traditional cultures, it would be more helpful to look at emerging cultural orientations and worldviews in urban areas for example. In general interest in culture has led to macro-level associations and the use of generalised descriptions of both ideas and behaviour in African societies (Lockwood 1995).

Of course socio-cultural factors influence sexual practices and make some groups more susceptible to HIV infection. Lifestyles play a dominant role in determining individual chances of infection. UNAIDS (1999) holds that socio-cultural factors must be considered because complex behaviours such as sex take place in socio-cultural contexts. Some cultural practices may directly interact with the biomedical mechanism of the disease transmission (e.g., lack of male circumcision), but most affect the individual’s chances of infection indirectly; they influence attitudes and predispositions towards safer or more dangerous behaviours. However, the mechanisms that link socio-cultural factors to HIV infection are so complex, and mediated by so many factors at different levels of social structure, that a very careful approach is required.

On the issue of circumcision, for example, the findings of Caldwell and Caldwell (1993) could simply be dismissed as inaccurate, as the disease has progressed far into the northeastern and southwestern parts of the original belt. Moreover their approach uses aggregate-level measures to predict individual behaviour. Nevertheless, in addition to the regional-level associations, the link between lack of male circumcision and HIV prevalence is consistent with clinic based case-control studies (Bongaarts, 1999) and small, comparative, individual level surveys in cities in Kenya and Zambia in the east and in Cameroon and Benin in the west (UNAIDS 1999b). However the relationship between male circumcision and HIV prevalence is neither constant nor definitive, even though circumcision is physically related to the risk of HIV infection. Research has found that the effect of male circumcision is not constant for all age groups. A study by Kelly et al. (1998) in rural Uganda found that a lower prevalence of HIV-1 was associated with pre-pubertal circumcision across all educational, ethnic and religious groups. However circumcision after age 20 was not significantly protective. The study argues that the man’s age at circumcision and the reasons for circumcision need to be considered. This shows that the timing of events is crucial in understanding the effects of any cultural event. If a practice which relates so directly to the physiology of HIV infection can be so variable with relation to age, we can expect even more variability and unpredictability concerning less direct socio-cultural factors.

Moreover the relationship between HIV/AIDS and socio-cultural structures is not one-way. The epidemic is changing socio-cultural structures. From an intervention perspective, changing the attitudes and practices that encourage high-risk behaviour is critical. Culture thus plays a central role in safe-sex behaviour, since the use of condoms, for example, is highly correlated with lower rates of infection. A UNAIDS study (1999c) in Uganda found a clear correlation between declining HIV prevalence in urban areas and behavioural data showing a growing adoption of safer sex among youths. On the other hand the use of condoms in sub-Saharan Africa is minimal both in the high and low prevalence HIV areas (Philipson and Posner 1996). Although the role of socio-cultural factors in the persistence of unsafe sex practices is salient, safe sex practices are also related to other factors. Philipson and Posner (1996: 837) argue that the long incubation period of the disease retards recognition of its dangers and how to avoid them. Lack of education results in misconceptions about the disease and lower adult life expectancy reduces the expected cost of AIDS. It can also be argued that in environments characterised by conflict and population displacements, the benefits of safe sex appear lower than in a stable population with high life expectancy. Moreover once HIV infection becomes common in a population, and in the absence of widespread testing that would enable individuals to determine their status, the average benefit of safe sex declines. In fact women who perceive themselves to be at high risk of being already infected tend to self-select to prostitution (Philipson and Posner 1996: 842). Therefore it appears that there are a great many factors that undermine the choice to practice safer sex. In short, apart from the knowledge or information about HIV/AIDS transmission or protection, an individual’s capacity to engage in con-
sistent and effective risk reduction is contingent upon a number of complex, large-scale socio-economic forces (Clatts 1995).

These forces influence the agency of individuals in terms of their risk perception, behaviour and decisions. Nevertheless such macro-structural factors have different impacts based on a person’s age, social networks and relationships, the social characteristics of the individual’s age group and the history of the society the individual is living in. To sum up, structural and cultural factors affect individuals’ perceptions and behaviour, but they do so differently based on various factors. It is the interactions between these different factors at different levels of social life that creates different results in risk behaviour. The challenge is to be able to study these factors at the same time in order to determine their interactions.

**Lessons from the Life Course Perspective**

The growing field of life course sociology offers an important lesson towards an integrative approach to the study of HIV/AIDS in Africa. It does so in two ways. First life course sociology is important in conceptualising the link between socio-cultural factors and HIV risk, as it integrates the historical and cultural location of an individual’s life, the linked nature of human lives in social relationships and the human agency of individual lives in relation to the timing of life events. Second the multilevel perspective of the life course approach recognises the location of individuals in a hierarchy of social structures and thus enables the analysis of cross-level causal relations.

The life course approach is creative in integrating different traditions of looking at the relationship between social structure and individual lives. Broadly conceived it has four principles: the principle of historical time and location, the principle of linked lives, the principle of agency and the principle of timing (Giele and Elder 1998). The first principle recognises that lives are embedded in different cultures and at different periods of world and local history. Individual behaviour is shaped by the historical times and places a person experiences over his or her lifetime (Elder 1998). Just as we cannot expect all individuals in a given group to share the same culture, we cannot expect the culture to be consistent in time and space. There is always variation according to time and location. The task therefore is to understand the effects of such variations on individual behaviour. In Africa great variations in cultural patterns exist within countries and regions. This makes it dangerous to generalise about individual behaviour without considering such variations (Zabin and Kiragu 1998). Moreover we need to take into account the historical times and experiences that countries and their citizens are living through and as people born in different birth cohorts experience them. The second principle of the life course approach, the principle of linked lives, looks at the social ties in the life course of an individual. Culture is always mediated by a person’s social relationships and networks. For example gender perceptions and expectations, which are critical factors in the HIV/AIDS pandemic, are instilled by society as a whole but reinforced – or altered – by peer pressure. Several studies, for example Billy et al. (1994), have shown that adolescent sexual behaviour is strongly shaped by the surrounding social contexts.

To return to Caldwell et al. (1989), their explanation of the role of sexual networking in HIV transmission stresses that it is not just the number of sexual partners but also the identity of the persons involved that matters. As the movement of people leads to high demands for commercial sex services and dense networks of sexual relationships, infectivity is likely to be highest when relatively few women have contacts with large numbers of men. Orubuloye, Caldwell and Caldwell (1992) call this the “female foci of infection.” However, in East Africa sexual networks tend to be focused around professional prostitutes, while in West Africa people tend to have multiple sexual partners in life, so the network is more diffuse. Similarly Van de Walle (1990) argues that when female virginity at marriage is valued and prostitution tolerated, there is a higher risk of STDs, including Aids, than in other societies where women and men are expected to have several partners in their lifetimes. Bongaarts (1996) points out that a self-sustaining epidemic can occur in a population with a given level of infectivity per contact only if a threshold rate of sexual contact with different partners has been exceeded. Lives are lived interdependently, and interactions and networks affect outcomes.

The principle of agency in the life course approach concerns individuals’ perceptions, behaviours and decisions. An individual’s agency is influenced by the two principles discussed above, but it is distinct in itself. People who are of different ages and belong to different birth cohorts can be expected to experience a cultural practice or an economic crisis differently. However different behavioural outcomes are also found among people of similar social and age groups. In addition to being influenced by historical location and time and by linked lives, agency is also related to individual characteristics such as education, temperament, intelligence and so on. For many young people in Africa agency is created and recreated in trying to break with tradition and the past in search of their future. Eventually, it is changes in the agency state that will determine the course of the epidemic. This principle concerns the timing of life events as a strategic adaptation by individuals. All the other principles come together through the funnel of timing. Whatever a person’s social location and cultural heritage, friendship and networks or personal motivations, all are experienced in time through the individual’s adaptation to concrete situations and events (Giele and Elder 1998:10). Timing refers to the intersection of the concepts of age, period and cohort. The intersection of location in time (period), agency (age) and linked lives (cohort) produces different trajectories or life patterns among different age groups. It is this integration of history, culture and biography that makes life course a better approach. From a research design viewpoint it is vital to take timing into account. This is the only way to understand the antecedents and consequences of behaviour and behavioural patterns in human lives.

Timetables and temporal expectations indicate where we are in our lives and the social expectations characterising our lives. The timing of events is the common medium for linking human agency, social relationships and geographical and historical locations to account for the shape of the individual life course (Giele 1998). For example age at first sex is a time marker but is also determined by where it happened (in or away from one’s home town), how the choice was made (through peer pressure or within marriage) and with whom (with a prostitute or a marriage partner). The timing of events can also...
tell us whether individuals follow typical sequences in getting their education, then securing employment and then getting married, for example, or if there is a different sequencing that affects the behavioural patterns individuals will have. Biological timing – the timing of maturation and aging – is another dimension. Differences in biological timing affect individual behaviours and the social expectations that follow. In historical periods the timing of events and their sequencing change through interactions with discrete historical changes or cycles of socio-economic events (Shanahan 2000). This is why the period of transition to adulthood is compressed in the USA (Modell et al., 1976), whereas in Africa, as Zabin and Kiragu (1998) argue, evidence has shown that that in some cultures age at first sexual experience has remained the same across cohorts. In the end changes in the timing of events and their sequencing results in different behavioural outcomes. Equally important are normative expectations and age identity (Neugarten and Datan 1996). How old people feel affects how they are going to behave. In Africa the “sugar daddy” phenomenon is often cited to explain why older men have sexual relationships with young girls, but this may reflect as much on how older men look and feel about their age as on social expectations. Such mismatches will always create problems. We need to study this, as the timing of sexual encounters is directly related to the risk of infection. It is estimated that controlling the HIV/AIDS epidemic depends on reducing young girls’ sexual contacts with older men (Zabin and Kiragu, 1998).

As we have seen, the life course approach takes into account the individual’s actions and decisions, relationships and social location, historical and cultural location and the timing of the individual’s life both in terms of belonging to a cohort and in terms of the actual age of the individual and how he or she feels about this. The question remains how to incorporate all these different elements and determine the relative significance of each in relation to individual behaviour. This takes us to the second point I made at the start of this section. The advantage of the life course approach is its ability to integrate structural and dynamic approaches in a comprehensive way that takes into account many levels of social structure (Giele and Elder 1998; Riley 1998). The multilevel process linked by aging, structural location and experience in historical time exposes a complex mixture of causal relations and temporal-historical contingencies (O’Rand 1998: 67). For example Elder’s seminal work, *Children of the Great Depression* (1974), pioneered a sociological approach linking large-scale social changes to the individual’s life course. Elder showed how the economic depression of the 1920s and 1930s affected individuals of different social backgrounds and age groups differently. The life course approach brings different levels of social life together in order to understand human behaviour and its interactions with structural factors. From a different approach, but with much the same analytical objective, Decosas (2002) argues for a social ecology approach that views Aids from multiple levels of analysis.

Bah (2000) categorises two variants of the models that integrate behavioural assumptions into the analysis of HIV infection. One represents behaviour aggregates instead of individuals, while the other uses micro-simulations to represent individual behaviours. As we have seen, most of the studies in Africa so far seem to follow the former pattern, while those that use individual units lack detailed behavioural data that would enable the role of socio-cultural factors to be tested. The same division also seems to be prevalent in life course studies. Riley (1998) observes that life course research tends to either: (1) use groups as research units and characterise individual members by group level properties; (2) use individuals as the research units and characterise individuals by properties of the groups to which they belong as well as by individual level properties; or (3) a combination of these two methods.

The combination of the two, which Riley calls the social system approach, uses both groups and individuals as research units and identifies which individuals belong to which groups. This method combines the advantages of the other two, enabling the researcher to explore both the independent and the interactive effects of both community and individual variables. It provides a way to link individual behaviour with larger social units. For example several studies have demonstrated that sexual behaviour is shaped not just by individual level characteristics, but also by the surrounding social context (Billy et al. 1994). A recent study by Bloom et al. (2002) found that in rural Tanzania men and women who live in villages with high levels of social and economic activity are at much higher risk of being HIV-positive. Both individual and community level characteristics provide individuals with an opportunity structure and normative environment that affect attitudes and behaviours. With the development of the statistical technique in hierarchical modelling, studying individual and community level effects at the same time is possible.

**Towards a Synthesis and Research Design**

In sub-Saharan Africa at the present time the incubation period of HIV is getting shorter, and people are developing Aids soon after infection. This results from either the modes of transmission or the degree of exposure to other diseases. Polloni (1995) holds that the changes are more closely related to patterns of geographic and social diffusion than to shifts in modes of transmission. He argues that the dynamics of the epidemic depend on its spread within high-risk groups, the degree of contact between high-risk groups and the general population, and the main modes of transmission within the general population. Therefore the study of socio-cultural issues remains important but requires an approach that places them systematically in the life course of individuals. To understand the importance of the various socio-cultural factors in affecting the biomedical mechanisms of HIV transmission and the relative risks across social and cultural groups and periods, we need individuals’ life history information. To better capture life events and their timing in the life course paradigm, longitudinal studies on cohorts are needed. A longitudinal research design would enable patterns of change in an individual to be traced so as to understand the true importance of certain explanatory variables that are often taken for granted (Rajulton and Ravenera 2000). It would also reveal the longitudinal timing of events and age-oriented goals and their affects on sexual behaviour. However longitudinal data collection may not be feasible in the study of HIV/AIDS. It is time-consuming, but the epidemic needs research to be done soon. We cannot afford to wait for data to accumulate. Thus it is more feasible to start with the analysis of available cross-sectional data.

The most important task right now is to integrate across levels of analysis rather
than follow individuals across time. The demographic and health surveys of many countries in Africa include life history data on individuals. This data could be stacked to create a longitudinal analysis, thus making possible cross national and cross community studies within a nation. Such studies should be capable of linking social structural and individual behaviour. As I argued earlier, the analysis of multilevel data is not only conceptually interesting, it is now possible as a result of advances in analysis techniques. Multilevel or hierarchical linear modeling (HLM) techniques are available for studying how hierarchical structures and interactions among covariates affect outcome variables (Bryk and Raudenbush 1992; Goldstein 1995; Gamoran 1992). For example, if we are interested in individual perceptions of the risk of HIV/AIDS, information which is available in most DHS surveys, we can determine if any variation observed in the perception is simply a result of individual differences or depends upon cultural or regional affiliations. We can also predict the differences by group level characteristics. We can also see if perceptions differ across countries by specifying country level variables of interest. For example, using data from fifteen World Fertility Survey (WFS) countries, Entwistle, Mason and Hermalin (1986) studied the contraceptive behaviour of couples as a function of socio-economic origins at the individual level, the gross national product per capita (GNP) and family planning efforts at country level. We can study cross national differences by including national differences in HIV infection rates, services available, national development levels and other important variables as predictors of risky behaviour and safe sex behaviour at the individual and the country level simultaneously. Here the main assumption we are making – and can test – is that risk perception is a social group quality even though we collect information at the individual level. Decosas (2002) offers an important concept of “community HIV competence” that is a collective attribute as indicated by the mean risk profile of communities. He means that the community’s HIV competence is an attribute in itself even though its effects are felt at the level of individuals.

To further elaborate this point, let me briefly discuss the results of an exploratory case study I did from the DHS data. I wanted to know if the variations observed in the risk perception of HIV/AIDS were a result of individual differences or cultural and regional differences and, if the latter, whether the variations could be predicted by group level characteristics. I used the Kenya DHS 1998 (women sample) and the HLM model. I tested whether there was significant random variation in risk perception among religious groups, ethnic groups and regions, and found marginal random variations for region and ethnic group but not for religion. I used the 530 clusters treated as sampling units in the survey with the assumption that norms are most likely to be generated within smaller, homogenous settings such as neighborhoods. The results showed that risk perception varied among women within their communities as well as among women of different communities. In other words there was a significant variation in the mean perception of risk among different clusters. The results indicate that there are significant differences between communities and that we need community level measures that account for these differences. As to the variation within communities, individual level variables such as age and education may explain the differences in risk perception. I am not fully reporting the results here because I am only interested in demonstrating what a multilevel approach can accomplish. With well-stated hypotheses and research problems, more advanced causal propositions can be tested.

Another possible area of research would be the prevalence of safer sex practices. Studying the process and correlates of safer sex behaviour is vital for understanding how changes get institutionalised and for designing effective interventions. The task is to determine what correlates with behavioural change in relation to such things as the severity of the epidemic, the information campaigns that have been done and the educational and economic systems of the society. By studying social change and life pattern innovations, life course researchers can clarify which innovations are likely to become the norm and then document the changes in other institutions that will be required (Giele 1998). A normative change in life course pattern is evident when the new pattern becomes institutionalised and then reproduced through socialization processes and cultural expectations. For example the emergence and sustainability of safer sexual behaviour in individuals and communities is influenced by trends in the larger society and mediated by the social experiences of birth cohorts. Studying this requires a research design that compares successive age cohorts in order to identify the start of an innovation and then trace its growth into a trend (Giele 1998). We can use inter-cohort comparisons to contrast life events across age groups and to identify the nature and extent of innovations. Intra-cohort comparisons can then be used to determine why certain individuals in an age group become pioneers of behavioural change while others do not.

On the other hand the prevalence of HIV/AIDS is changing societies in many different ways. If we want to know how social-cultural relations are changing in response to the HIV/AIDS epidemic, we could for example study birth cohorts and their relationship to specific events and experiences (Elder and Pellerin 1998). In this case the issue would be the risk of exposure to HIV/AIDS measured at the individual and community level and the differential effects on various socio-demographic and cultural outcomes. Using similar methods further cross-national research could be on differences among youth of the same age category, particularly with regard to the timing and sequencing of transitions to adulthood in different contexts either as causes or consequences of HIV/AIDS-related behaviours. Research also needs to be done into the question of the level of social aggregation at which cultural and other social explanatory factors can be conceptualised, measured and tested. For example are ethnic groups, religious groups or smaller neighborhood communities the levels at which the main behaviours pertaining to HIV/AIDS derive? What measures and indicators of the several explanatory factors can be developed? Similarly we need to disaggregate national figures of HIV prevalence to sub-national levels to use as predictors of differences in different life events among social groups at those...
levels. Thinking in terms of social aggregate characteristics would clear the way for a more empirical and methodological approach.

Conclusion
In this paper I have approached the study of HIV/AIDS in Africa from a social science perspective, arguing that life course methodology, used systematically, will help develop a better understanding of the HIV/AIDS epidemic on the continent. Understanding the social patterns of the disease is vital, and therefore an approach that can integrate all the potential factors that affect the spread of HIV/AIDS is urgent. The approach I argue for here would enable the most empirically significant factors to be isolated. I have tried to show that starting out by studying a number of research problems based on available data will help us refine the necessary conceptual, analytical and methodological tools.

References


De Boeck, F. and Honwana, A., eds. 2001, Makers and Breakers, Made and Broken: Children and Youth as Emerging Categories in Postcolonial Africa. Place?: Publisher?


UNAIDS, 1999a, Sexual Behaviour Change for HIV: Where Have Theories Taken Us?, Geneva: UNAIDS.

UNAIDS, 1999b, Differences in HIV Spread in Four Sub-Saharan Cities. Lusaka: UNAIDS.

UNAIDS, 1999c, A Measure of Success in Uganda: The Value of Success in Uganda – The Value of Monitoring Both HIV Prevalence and Sexual Behaviour, Lusaka: UNAIDS.

UNAIDS, 2001, Young Men and HIV: Culture, Poverty and Sexual Risk, Place?: UNAIDS and the Panos Institute.

Ethical and Methodological Issues in HIV/AIDS Social Science Research

Abstract

As a mainly sexually transmitted infection, HIV/AIDS basically takes advantage of how we live our sexuality. Since biomedical research has so far not been able to provide a cure or vaccine, the only option we are left with is to change the behaviours that enable HIV/AIDS to spread. To do so, however, we first need reliable data on the behavioural aspects of the HIV/AIDS pandemic. Unfortunately this has proved challenging in Africa due to the fact that sex, in many African communities, is a hidden issue and is considered taboo to discuss openly. The question then is: how can we successfully – and ethically – collect this data despite the reluctance of people to discuss sex-related issues honestly and openly? This paper explores the ethical and methodological considerations of conducting research on the sexual aspects of HIV/AIDS in the African context.

Introduction

As is well known HIV/AIDS is mainly transmitted through unprotected sexual intercourse. In the absence of a cure or vaccine, changes in sexual behaviour are therefore the only effective means of slowing the spread of the virus (Auerbach 2001; Aggleton et al. 1994; Pool 1997). Promoting such changes requires interventions that take into account the complex interplay between gender, age and cultural context on the one hand, and HIV risk on the other. To develop effective interventions it is vital to improve our understanding of how cultural beliefs and practices and institutional structures influence how people and communities utilise prevention and care services. We also need to know more about the relative effectiveness of individual, behaviour-change interventions compared to community-based interventions. These goals can only be accomplished through social science research on HIV/AIDS-related issues in society. This research should focus on how people’s ideas about HIV/AIDS affect their sexual behaviour and how the larger social, cultural and economic contexts affect both people’s ideas and their behaviour.

It is clear to social scientists which areas need their attention. However there are two key methodological issues what are not yet clear. The first is how to manage the relationship between social science research and ongoing biomedical research (NIH 2000). The second concerns the methods that are appropriate for sampling and collecting data, given that open discussion of sex is generally taboo in the African context (Bailey et al. 2002; Auerbach 2001; Tyn dall et al. 1994). These two issues are the main concerns of this short paper.

Ethical Issues and Social-Science Research on HIV/AIDS

Social science research on HIV/AIDS falls within the framework of the 1979 Belmont Report on the ethical principles and guidelines for the protection of human subjects of biomedical and behavioural research (NIH 2000). The report was a response to previous mistreatment and disrespect of human participants in research. Three famous examples will suffice to illustrate the issues. The first and most talked-about were the Nazi medical war crimes when Nazi physicians conducted harmful and degrading experiments on unwilling human participants. The experiments were performed on concentration camp prisoners and included such practices as injecting subjects with gasoline and live viruses, immersing subjects in ice water and forcing them to reject cancer cells was due to cancer or debilitation. This study involved the injection of live cancer cells into patients with various chronic debilitating diseases. Their consent had been given orally, but the injection of cancer cells was not discussed (because the researchers felt it would frighten them!) and in any case their consent was not documented. These and other cases showing serious disrespect for subjects’ dignity and human rights led the Belmont Report to develop three fundamental ethical principles for future research: respect for persons, beneficence and justice.

The principle of respect for persons directs researchers to treat individuals as autonomous agents capable of thinking for themselves and making choices. To respect their autonomy is to respect their considered choices and refrain from obstructing their actions. Accordingly prospective research participants must be given ample time and all the necessary information to decide whether or not to participate in a study. Persons with diminished autonomy, such as children, prisoners and the mentally ill or the mentally challenged, require additional protection because they cannot make informed decisions. In these cases the person must be given as much opportunity to choose as he or she is capable of before seeking a mandate from parents or legal guardians. The principle of beneficence obligates the researcher to maximise the possible benefits for research subjects while minimising the possible harm. The challenge here is to decide when it is justifiable to seek cer-
tained benefits despite the risks involved. Balancing societal risks and benefits is also an important consideration, given that the goal of any research is to benefit society. The principle of justice requires researchers to distribute risks and benefits fairly and without bias. Consequently, unless there is a clear justification, research should not involve persons who are unlikely to benefit from subsequent application of the research.

How does social science research on HIV/Aids fit into this framework? Subjects participating in HIV/Aids-related studies are likely to be people infected or affected by HIV/Aids. These people are already hurt physically or psychologically, and are often desperate for help. Therefore they may agree to anything, not because they have made a truly free and informed choice, but merely because they think or hope that the research will help them. Moreover the study will probably involve sensitive personal information on their HIV status and social networks which, if not kept confidential, could cause them discrimination or other harm. Any proposed social science research on HIV/Aids therefore should first undergo an ethical review by an independent body to ensure that research methodologies adhere to the ethical principles of respect for persons, beneficence and justice.

**Sampling and Data-Collection Methods**

Since HIV/Aids is mainly a sexually transmitted, the behavioural issues surrounding it can be very difficult for research subjects to discuss openly and honestly. Sex and sexuality are delicate and hidden issues in many African cultures, and research into sexual beliefs and practices has to be carried out in a socially acceptable manner (Pool 1997; Tyndall et al. 1994; Schoepf 1993). Highly tactful and creative methods need to be used in gathering data. No ready-made research methods can be applied to all situations and all social phenomena when studying the social and cultural aspects HIV/Aids (Auerbach 2001; Standing 1992). Therefore multiple instruments are generally used. However they still need to be adapted to the specific situation and culture under investigation. This requires creativity and innovation on the part of researchers.

In Africa people infected or affected by HIV/Aids often hide their predicament even from close friends and family members, as there is a great deal of stigma associated with the disease in most communities (Shaw et al. 1996; Aggleton et al. 1994; Hendricks et al. 1992). Consequently sampling people infected or affected by HIV/Aids is a tricky exercise, especially if they are the main subjects of study. The most viable sampling method is snowball sampling. This method is often used when the desired sample characteristics are rare, hidden or hard to reach (Nigel 2001; Faugier and Sargeant 1997; Vogt 1999). Snowball sampling relies on referrals from initial subjects to identify additional subjects. Although it poses a number of methodological problems in terms of representativeness and sampling principles, it is nonetheless the most viable method in these circumstances, especially when no rigorous statistics are required from the analysis of the data collected. Data collection on the non-biomedical aspects of HIV/Aids also needs to borrow heavily from anthropological methods designed to elicit sensitive information tactfully (Pool 1997). Although formal interviews using questionnaires can be used, these may not yield as much information as more interactive qualitative conversations (Auerbach 2001; Standing 1992). Thus social science research on HIV/Aids would benefit greatly from methods such as participant observation, narratives, life histories, ordinary conversation and focus group discussions in conjunction, if need be, with more conventional methods such as questionnaires.

Participant observation is a basic anthropological research technique (Spradley 1979; Pool 1997). In this method the researcher joins the group being studied and observes while participating in the group’s day-to-day activities. In this way the researcher gets first-hand data on the issues he or she is interested in. This method is based on the assumption that relevant and interesting information, particularly on topics that are delicate, taboo or hidden, is more likely to surface in an informal, participatory context than in a formal interview setting (Pool 1997; Spradley 1979). On the downside participant observation is time-consuming. A researcher cannot expect to gather enough data in less than six months.

Narratives are a form of interview where the informant tells a story about some relevant aspect of his or her life rather than the researcher asking question which have been pre-defined as important (Pool 1997; Boulton 1994). Narratives are particularly suitable for getting information on a specific event in the life of an informant. Thus the researcher might begin with a request such as ‘tell me the story of your marriage and how it ended up in divorce’ or ‘tell me about how your first relationship developed.’ Narrative interviews can also elicit more general information by a request such as ‘tell me how marriages typically end up in divorce.’ The narrative approach is highly suitable for studying HIV/AIDS-related topics such as sexual relations, strategies for coping with the disease, family relations and so on.

Life histories, unlike narratives, elicit the story of a person’s life or some highly significant part of it. According to Boulton (1994) life histories are particularly suitable for obtaining information on social change, especially how people perceive social change. They can therefore be an invaluable way of understanding how people’s lifestyles have changed since 1983 when the first case of HIV/AIDS was identified. Although life histories can never provide definite evidence of past behaviours and norms, they can be used to ascertain broad trends, especially if there is agreement among different people’s stories.

Ordinary conversation is also an invaluable source of information on obscure and taboo issues. In ordinary conversation information is gathered from informal discussions about a topic (Auerbach 2001; Boulton 1994). There is no clear boundary between spontaneous conversation and more informal interview settings. There are two ways of gathering information from informal conversations. Researchers may either position themselves where they can overhear people’s conversations or can intervene to provoke and steer discussion themselves or through a secretly appointed local resident.

Focus group discussion utilises a group of eight to ten selected people freely discussing a predetermined topic (Steward and Shandasani 1990; Dawson et al. 1993; Morgan 1993). A moderator is needed to ensure that the discussants keep to the subject and that each of them has a more or less equal opportunity to air his or her views. Focus group discussions are a cost-effective and rapid way to collect data and are very representative as long as age and status factors are considered when selecting participants. If a focus group discussion is well moderated, it can generate a lot of reliable
information on delicate and taboo topics such as HIV/AIDS.

**Conclusion**

There is an urgent need for more research on the social the behavioural aspects of HIV/AIDS in order to develop more meaningful and effective interventions. However it is vital that such research be carried on within the framework of accepted ethical principles guiding biomedical and behavioural research. There is no single method of data collection that can adequately be used for gathering all information needed in this kind of research. The use of multiple methods is, therefore, most appropriate. Multiple methods complement each other and therefore can be used to collect comprehensive data. Of great use in these kinds of studies are the more interactive anthropological methods such as participant observation, narratives, life histories, ordinary conservation and focus group discussions.

**References**


---

**HIV/AIDS at the Workplace: A Study of Corporate Responses to the HIV/AIDS Pandemic in Zimbabwe**

**Abstract**

Zimbabwe has one of the highest HIV infection rates in the world, and they continue to increase. About one million people (10 percent of the population) had been infected with the HIV virus by December 1995 (SAFAIDS 1997: 1). By 2005 1.2 million people will have died of AIDS, and cases of AIDS will probably only begin to decline after 2010, about eight years after HIV prevalence rates begin to decline (IDS 1999: 34). The HIV/AIDS epidemic has, perhaps inevitably, been perceived primarily as a health problem. However, as the magnitude of the problem becomes clearer, so does the recognition of how far-reaching and comprehensive the impact of HIV/AIDS will be at the workplace and in the wider community. This is largely because infection is highest among the economically most productive groups. Chitiyo (1990 quoted by Jackson 1992) states that 90 percent of people infected with HIV are employed. As the AIDS threat continues to affect the workplace, employers will increasingly require policies and mechanisms for dealing with personnel issues such as absenteeism, sick leave, ill health and early retirement.

**HIV/AIDS as a Business Issue**

It makes good business sense for companies to respond to the epidemic because of the direct impact of AIDS on business. HIV/AIDS affects people who are in their most economically productive years. The devastating effect of HIV/AIDS on the economy occurs largely through absenteeism and lowered output as infected persons become more susceptible to opportunistic infection and eventually are unable to work at all (Mbengeranwa 1997: 8). Along with the resulting loss of experience and skills that may take many years to replace, HIV/AIDS also has implications for many other aspects of employment such as training, recruitment, sickness benefits, pensions and insurance. In many developing countries there is already a shortage of...
skilled labour and a narrow, underdeveloped industrial base, exacerbated by lack of resources to overcome these problems. There is evidence that the pool of people who will make up the next generation of skilled workers is already shrinking (Panos Institute 1992: 69). The psycho-social environment of the workplace is seriously affected when some employees have a serious and, ultimately terminal, health condition, and this impacts on the morale and productivity of all workers.

For all these reasons it makes good business sense for companies to adopt HIV/AIDS policies, and to take not only reactive but also proactive measures to limit the spread of HIV and its effects in the workplace and in society at large. HIV/AIDS affects both productivity and profitability. The effects of HIV/AIDS on productivity include:

- Increased absenteeism due to workers’ own poor health or to the workers’ need to care for others who are sick or to prepare for and attend funerals.
- High staff turnover, which forces companies to spend more and more time recruiting and training new staff instead of focusing on productivity goals.
- Lower worker morale as workers see their colleagues getting sick and worry about their own health.

The impacts of HIV/AIDS on profitability include:

- Increased costs due to sick leave, funeral benefits, recruiting and training replacement staff and the higher costs of health insurance.
- Declining investment as the increasing impact of AIDS on the business climate deters new investment.
- Shrinking demand as more and more consumers die of AIDS.

These impacts are already visible in many parts of the world. However, despite the cale of the threat posed by HIV/AIDS, the business community has been slow to respond. There are various reasons for this. For one thing there is a lingering feeling in the business community that HIV/AIDS is essentially a health issue and should therefore be dealt with by health professionals. There is also a perception that HIV/AIDS programmes are not worth the expense and that HIV/AIDS activities during working hours will disrupt productivity. Many businesses also feel they lack the resources or the knowledge to develop effective HIV/AIDS programmes. Finally many proprietors and senior managers feel that HIV/AIDS is simply too sensitive an issue to raise with their workers or colleagues.

**External Regulation**

In the face of the reluctance of the business community, regional as well as national policies and laws have been developed in order to promote openness about HIV/AIDS and to end discrimination and stigma. In 1994 the Southern Africa Development Community (SADC) began formulating HIV guidelines for the employment sector. The SADC Code on AIDS and Employment, which has been adopted as a regional Code of Practice, spells out the rights and responsibilities of employers in relation to prevention and management of HIV/AIDS at the workplace. The code prohibits pre-employment testing for HIV alone and states that HIV alone cannot be a cause for termination, transfer or promotion. It asserts that people with HIV (whether workers or managers) should be treated in the same way as non-infected employees and that workers or managers with AIDS or AIDS-related illnesses should be treated like anyone else with a life-threatening illness.

In Zimbabwe Statutory Instrument 202 of the Zimbabwe Labour Relations (HIV and Aids) Regulations of 1998 calls for education of employees on HIV/AIDS, prohibits testing for HIV as a precondion of employment and states that employees cannot be required to have HIV tests or to disclose their HIV status. It prohibits termination of employment on the grounds of HIV status alone, and states that no employee is to be discriminated against in relation to promotion, transfer, training, status or eligibility for occupational or other benefit schemes on account of HIV status. With regard to sick leave Statutory Instrument 202 also makes it clear that an employee with HIV/AIDS is subject to the same conditions as an employee with any other illness. Finally it makes it an offence subject to fine or imprisonment to contravene any provision of the regulations.

**Corporate Social Responsibility in the Age of HIV/AIDS**

Businesses do not operate in a social vacuum. They have an obligation to help deal with the problems affecting the society of which they are part. Thus Cushman (1978, cited in Carroll 1981: 184) argues that business ‘must . . . for its well-being be willing to give serious consideration to human needs as it does to the needs for productive profit.’ Society provides businesses with the resources and the environment to make profits. In return society expects businesses to be good corporate citizens by obeying the laws of the land and refraining from activities that have negative social consequences. In other words businesses should not just exist to make profits but should be involved in finding solutions to society’s problems and improving the quality of life of their workers and the communities in which they exist. As Cushman implies it is also in the interest of business to be socially responsible. In order to survive today’s businesses must be more attuned to social needs, especially with the Aids scourge severely affecting all facets of life. It therefore makes economic sense for industry and commerce to adopt HIV/AIDS policies which are not only reactive but also proactive. For example the costs of education programmes to limit the spread of HIV among the workforce is minimal compared to the costs of replacing scores of workers who die of the illness.

According to Sawyer (1979) the concept of corporate social responsibility evolved as the strains and frictions of the imperfect operations of industrial capitalism became more and more evident. It became necessary to define more clearly the relationship between business and society in the interest of the general welfare. This is the antithesis of the classical doctrine of profit maximization as the raison d’être of business as developed by theorists such as Adam Smith, Milton Friedman and Peter Drucker. Friedman and Drucker argue that the overriding responsibility of business is simply to achieve profitability and growth (Abt 1977: 154). They contend that since business operates in a world of scarce resources, economic efficiency is the top priority and should be the sole mission of business. Likewise, according to Adam Smith, managers are answerable to shareholders only. In contrast the proponents of corporate social responsibility argue that engagement in social issues by business is merely a recognition that economic objectives are only one part of the whole framework of business activity (Davis 1980: 22). They therefore insist that businesses must be
both economically and socially productive.

There can be no disputing that the implementation of socially oriented policies is costly for business. However there is substantial evidence that those businesses that have been most socially responsible have also achieved the greatest financial success. Although more empirical research needs to be done in this area, a preliminary review of the most socially responsible and the most financially productive corporations in the United States suggests a strong correlation. It can also be argued that business has the capacity to lead the way by enlisting the resources of an economy in solving national problems. Business must assume the responsibility of this leadership, if we are to avoid chaos (Stolk, cited in Steiner 1972: 171). According to Maphosa (1996: 11) the most important social responsibilities of businesses are to their own workers, who are the ultimate resource of any business organisation. The responsibilities of a business to its employees include fair remuneration, healthy, safe working conditions and a democratic work environment through worker participation in ownership and decision-making. As Rockfeller (1971, cited in Anshen 1980: 2) argues:

[i]t is vital that social accountability became an integral part of corporate conduct, rather than a philanthropic add-on . . . [for] only in that way will corporations assure the healthy social climate vital to their own future economic prosperity.

Businesses cannot escape from society, and society cannot exist without business (Davis 1980: 6). This leads to the argument by Carroll (1981:21) that management must be concerned with short-term as well as long-term capacity to respond to social problems.

Nevertheless there has been little research done on managing Aids at the workplace in the Southern African region. Most business managers seem to have accepted the concept of corporate social responsibility only in principle, especially regarding the issue of the HIV/AIDS menace within and outside the workplace. A UNAIDS survey in 1998 found that only a few companies had established comprehensive HIV/AIDS prevention, care and support interventions in their workplaces. It found that many small-scale and medium-scale enterprises in particular have little interest in HIV/AIDS issues. This does not mean that businesses have done nothing in response to the HIV/AIDS epidemic; it is the extent of their HIV/AIDS activities that has been inadequate, considering the scope and urgency of the problem.

However there is evidence of a growing realisation by companies throughout the world of the need to respond to the HIV/AIDS crisis. As a result increasing numbers of companies are developing and implementing workplace and community HIV/AIDS programmes aimed at mitigating the effects as well as preventing the spread of HIV/AIDS. Many business organisations are also forming national, regional and global coalitions to pool resources and help each other to better respond to the HIV/AIDS epidemic. Such coalitions now include the Global Business Council on HIV and AIDS and the Corporate Task Force on AIDS in Africa. Within Zimbabwe the National Employment Council of the Transport Operating Industry (NECTOI) is an example of a national sectoral coalition to fight HIV/AIDS, which is particularly rampant in the transport industry.

**Research Issues**

Notwithstanding the progress that has been achieved so far, there is still need for more research on how businesses can best respond to HIV/AIDS. For example more evaluative research is required to assess the true effectiveness of various types of workplace and community HIV/AIDS programmes implemented by business organisations. The extent and value of community involvement in workplace HIV/AIDS programmes also needs to be studied, and the same can be said for worker participation, especially in the formulation and implementation of workplace HIV/AIDS programmes. The issue of compliance with state or regional policies and regulations is another area that requires more research, especially in relation to discrimination on the basis of a worker’s HIV status. Anecdotal evidence suggests that discrimination remains a serious problem in many businesses. Finally the issue of networking is one that has also been neglected. More needs to be known about the extent to which individual businesses are willing to join coalitions of businesses concerned with HIV/AIDS as well as the extent to which they can or will network with national, regional and international HIV/AIDS organisations from the state and NGO sectors.

**References**


The Impact and Investment Implications of HIV/AIDS on Human Capital in Sub-Saharan Africa

Abstract
This paper addresses an aspect of the HIV/AIDS crisis which, despite its importance, has not been adequately addressed: the impact of HIV/AIDS on investment in human capital in sub-Saharan Africa. To compete in world markets African countries have to invest heavily in education and training. In the past, natural resources alone may have been sufficient, but in today’s world the most important factor is technological know-how, or human capital. HIV/AIDS makes investment in human capital both more crucial and more difficult. HIV/AIDS is undermining earlier achievements from investment in education and training and at the same time making new investment more problematic. Human capital in Africa is being heavily impacted by the HIV/AIDS epidemic. While other resources are only affected indirectly by HIV/AIDS, human capital is the entry point of the epidemic into the production system. Thus, as the International Labour Organisation (ILO) argues, Africa’s prospects for development are endangered more than anything else by the annihilation of its labour force by HIV/AIDS and the associated deterioration of education and training (Katsigeorgis 2002). This paper first discusses the effects of HIV/AIDS on human capital in sub-Saharan Africa and then argues that the current strategies to mitigate these effects are not sufficient. Finally a research agenda to address the impact of HIV/AIDS on human capital in sub-Saharan Africa is outlined.

Impact of HIV/AIDS on Human Capital

The impact that HIV/AIDS has had and continues to have on the sub-Saharan African countries is indisputable. By the beginning of the new millennium more than thirty-six million people were estimated to be living with HIV/AIDS worldwide. However 95 percent of them lived in the developing world, mostly in sub-Saharan Africa. In the year 2000 alone, there were about 5.3 million new infections worldwide. Almost four million of these were in sub-Saharan Africa. By the end of 2001 it was estimated that forty million people were living with HIV/AIDS, 71 percent of them in sub-Saharan Africa. Sub-Saharan Africa accounted for about 70 percent of all adults living with the virus, including 81 percent of women and 87 percent of children. Moreover 78 percent of the children orphaned by HIV/AIDS were in sub-Saharan Africa. With regard to AIDS deaths in 2001, 73 percent of the global total was in sub-Saharan Africa. Clearly the distribution of the HIV/AIDS epidemic in the world is highly skewed towards sub-Saharan Africa. While all the percentages of HIV/AIDS-affected sectors in sub-Saharan Africa are above 70 percent, this part of the world accounts for only 10 percent of the global population.

For those who come from sub-Saharan Africa the temptation to question or deny the HIV/AIDS figures can be immense. However, even when low-estimate scenarios are examined, the region still accounts for over 70 percent of the epidemic. What is also clear are the socio-economic impacts of HIV/AIDS in sub-Saharan Africa, which have been very well documented. At the household level families affected by the epidemic are pushed into poverty through loss of income, reduced ability of caregivers to work, medical expenses and funeral expenses (UNAIDS 2002). Households use up their savings and in many cases have to sell off their assets such as livestock and land. As less labour is available, less land cultivated and less crops grown, food insecurity has become common in households that were once secure.

At a sectoral level a lot of literature exists on the impact of the epidemic on the education, health and business sectors as well as the agricultural sector. In Zambia, for instance, 1,300 teachers died of HIV/AIDS in 1998. This was equivalent to two-thirds of the country’s annual production of teachers. Assuming the loss remains constant Zambia will have to more than treble its output of teachers every year just to replace those lost to AIDS. Even if this were possible it would still not cover the loss adequately, as it takes time for new teachers to gain the experience that has been lost through the death of their seniors. In the health sector more resources are being diverted towards HIV/AIDS care and more and more beds occupied by AIDS patients. In other words already-scarce health care resources are increasingly being diverted to the care of HIV/AIDS patients at the expense of other health-care needs. In agriculture production is declining as labour and other inputs decline, and as extension workers are also impacted by the scourge. In the business sector absenteeism has increased, as have employee turnovers, training costs and health care costs. All these have led to a decline in productivity. Barks-Ruggles et al. (2001) refer to these HIV/AIDS-related expenses as direct and indirect payroll taxes. Direct taxes consist of the direct costs for treatment of sick employees and for more expensive health and insurance benefits. Indirect taxes include the costs of absenteeism, increased recruitment and training costs and lower productivity. According to a UNAIDS (2000) assessment of one sugar company in Kenya, employee illness resulted in 8,000 days of lost labour over a period of two years, a 50 percent decline in output, a 500 percent increase in workers’ spending on funerals and a more than 1,000 percent increase in medical costs. A case study of the Debswana mining company in Botswana (Barks-Ruggles et al. 2001) revealed similar impacts.

Clearly the HIV/AIDS epidemic is devastating economic growth and development in sub-Saharan Africa. It has affected individuals and households, companies and whole economies. Research indicates that when a country has a prevalence rate of 20 percent, annual GDP growth drops by an average of 2.6 percent per year. In sub-Saharan Africa as a whole the rate of economic growth is projected to fall by over 1 percent per year, with a resulting loss of 10 percent in cumulative GDP growth over the period 2001-2010. This loss is in addition to that already incurred through lower rates of growth in recent years.

C. N. Mwikisa
Economics Department
University of Zambia
growth has dropped by an estimated two to four percent due to HIV/AIDS. According to the World Bank, countries with high prevalence rates have lost between one-half and one percent of per capita gross domestic product per year (World Bank 1993: 20). Life expectancy has declined as the HIV/AIDS death toll has increased. In Zambia, for example, average life expectancy at birth has declined to thirty-seven years. Other countries in the region have been only slightly less devastated. In Tanzania overall life expectancy has been cut by eight years, in Rwanda by seven years and in the Central African Republic by six years. In Zimbabwe, Burundi, Malawi, Kenya and Uganda the reduction has ranged from three to five years (Okonmah 2003).

However an analysis of individual countries shows some marked differences. While prevalence rates have generally been on the increase, Uganda and Zambia show some marked declines. Within sub-Saharan Africa there are also some marked differences between regions. Prevalence rates are extremely high in southern Africa, but comparatively low in West Africa. One major difference between the two regions is that one is mainly Christian while the other is mainly Muslim. Could this be an explanatory factor, or could the explanation lie in the nature and levels of response to the HIV/AIDS scourge in the two regions? Whatever the differences between countries and regions, HIV/AIDS is a national disaster across sub-Saharan Africa. The development impact of HIV/AIDS is well summarised by Nelson Mandela when he states that ‘Aids kills those on whom society relies to grow the crops, work in the mines and factories, run the schools and hospitals and govern countries.’ It seriously erodes human capacity and adversely affects what Barkes-Ruggles et al. (2001) call ‘capacity deepening’ – building on existing skills in order to increase future productivity.

**Importance of Human Capital**

Human capital is defined by Ray (1998: 100) as ‘labour that is skilled in production, labour that can operate sophisticated machinery, labour that creates new ideas and new methods in economic activity’. Broadly human capital ‘is commonly taken to include peoples’ knowledge and skills, acquired partly through education, but can also include their strength and vitality’ (Appleton and Teal 1998).

According to Lall (1990) industrial performance is explained by the interaction of some key variables. Among these are physical capital, human capital, technological strategies, policies related to trade and industry and the macroeconomic environment. Lall studied different countries in relation to their respective economic performance. One of his conclusions was that human capital development is a critical element whose importance grows as technology becomes more advanced. In order to compete efficiently in world markets, all industries need skills. But deeper industrial structures, which are inevitable in sub-Saharan Africa, require a larger complement of highly trained people in a variety of disciplines. There is also a very close relationship between educational investment and technological performance. The human capital theory (Becker 1964, 1967; Ben-Porath 1967; Mincer 1974) states that an increase in a person’s stock of knowledge raises his or her productivity both in the market sector of the economy and in the non-market or household sector (Grossman 2000: 349).

Lindauer and Velenchik (1994) also point out the existence of an extensive theoretical and empirical literature on the relationship between human capital and productivity. School enrolment rates and adult literacy rates are sometimes used as proxies for human capital. A comparison of African and Asian countries shows that African countries have accumulated less human capital. African workers therefore tend to be less productive than Asian workers. Sall (2000) calls human capital the ‘ultimate resource’ and argues that productivity gains in sub-Saharan Africa will remain illusive without an improvement in the quality of the workforce. Kane (2000) puts forward a theory of endogenous growth in which he stresses the impact of human capital on increased labour productivity via training. He further links human capital to direct foreign investment. A country with a highly educated and qualified labour force will attract more foreign direct investment. As Soludo (2000) points out there is a growing literature which identifies human capital as the key element in growth and development. The Economic Commission for Africa (ECA) makes this point very clearly:

there is a solid professional consensus that human capital plays an equal, if not a greater, role in the development process. It is almost invariably the case that countries that have achieved the fastest rates of growth are those that invested most in their people, especially in health, nutrition and education. The link between these factors and productivity, which is the basis for growth, has been sufficiently demonstrated. Human development contributes directly to the well-being of people; ensures a more equitable distribution of the benefits of growth; maximizes the linkages between various types of investment in development; and permits a more efficient exploitation of physical capital and other resources (ECA 1995: 9-10).

The biggest tragedy in sub-Saharan Africa today is the negative impact of HIV/AIDS on the development of human resources. HIV/AIDS both reduces the human capital stock and the ability to create more human capital. When the infected become ill, the value of their human capital is reduced and so is their capacity to produce more human capital by passing on knowledge and skills to others. Teachers provide the clearest example. Illness and deaths from AIDS decrease the number of teachers available and lead to a fall in the number of school graduates. Where this is avoided through larger classes, the quality of education suffers and the value of the human capital produced by the education system falls. The result is either reduced output or lower-quality products.

**Current Interventions**

In order to avert or soften some of the impacts of HIV/AIDS, governments and NGOs in the region and elsewhere have developed three main groups of interventions: prevention, treatment and care and support. However these interventions fail to adequately address the issue of declining human capital. If sub-Saharan African countries are to achieve the goals of development and poverty reduction, they have to design interventions that reduce the impact of HIV/AIDS on human capital and create more human capital. While prevention, treatment and care and support go some way to ensuring that some level of human capital is maintained, they still fall short in creating capacities that will produce enough human capital to replace the lost capital. As we have seen, for example, Zambia needs to train twice as many teachers as previously to make up for the effects of HIV/AIDS. This raises a number of questions. Has the country got enough resources
given the impact of HIV/AIDS on capacity in the education sector in particular? Are education and training systems making adequate provision to replace the loss of skills in the workforce?

As indicated earlier this paper proposes that such studies encompass both Anglophone and Francophone countries, as well as countries with both high and low HIV prevalence rates. The importance of studies along these lines is clear. Experiences can be shared between countries, and resource mobilization efforts can be embarked upon with clear targets. Different costing and spreadsheet methodologies can be utilised depending on available data. However the methodologies will have to be similar in all countries to ensure comparability of results. Both longitudinal and cross-section, qualitative and quantitative studies should be carried out. For better results study teams should be multidisciplinary even though such studies are expensive. These studies are vitally important if sub-Saharan Africa is to improve competitiveness. While the fight to convince the North to open its markets must continue, the South should also put appropriate measures in place to build the necessary capacities. While brain drain has impacted heavily on sub-Saharan Africa, the impact of HIV/AIDS is likely to be more than we can currently imagine. A research agenda such as the one proposed in this paper would be invaluable to research funding organisations, national governments and international organisations as they plan and implement programmes to address the specific needs of African countries. Studies of this nature can also lead to the development of simple methodologies to assess the impact of HIV/AIDS on human capital. They can also lead to a better analysis and understanding of the shifting burdens of human capital development.

References


Sall, S., 1989, Building Industrial Competitive in Developing Countries, Place?: Publisher?.


Abstract

This paper explores the impact of HIV/AIDS on vulnerability in the labour market, and in the labour force specifically. Research to date has concentrated on the social-behavioural and macro-economic impact of HIV/AIDS on the development agenda of the hardest-hit countries, especially in sub-Saharan Africa. Understandably, most of the analysis is geared at establishing the scale and nature of the pandemic, as well as emphasising the human tragedy that is unfolding. Most labour market analysis derives from macro-economic simulation studies as well as the few firm and sector level studies in the public domain. The focus is largely on risk assessment in relation to mortality and morbidity costs faced by governments, businesses and households. However, what is often neglected is the risk faced by the labour force in terms of increased vulnerability, the extent to which it will have to carry the AIDS burden, and how the balance of power between business and labour may be shifted in terms of collective bargaining. In this paper, I argue that there is an interdependent relationship between HIV/AIDS and social and labour market inequalities. HIV/AIDS disproportionately affects the most vulnerable and marginalised in society and in the labour force. It therefore deepens unequal relations of power, both in the structure and organisation of production and in the labour market as a whole. This paper takes South Africa as a case study and examines the challenges it faces in redressing inherited social and economic inequalities in the context of the HIV/AIDS epidemic.

Current Vulnerability in the Labour Market

The South African labour market, even in the post-apartheid period, is highly differentiated by historical cleavages of race, gender, education, skills and income. Factors internal and external to the local economy contribute towards this trend. The South African economy, like most exposed to globalisation, has shifted towards services and knowledge intensive sectors, including finance, business services and information technology. This shift has been accompanied by fundamental changes in the size and nature of labour demand. Household surveys report high levels of unemployment, between 25 and 35 percent using a narrow definition of unemployment, and between 35 and 42 percent using a broader definition (Statistics South Africa 2001). The September 2001 Labour Force Survey records an annual loss of one million jobs between February 2001 and September 2001, presumably in the informal sector and subsistence agriculture (Statistics South Africa 2001). A similar number has been lost in the non-agricultural formal sector since 1989 through restructuring in the private and public sectors (Reserve Bank 2000). There has also been a structural shift in the skills composition of the labour market. Thus the demand for highly skilled and skilled labour has increased at a higher rate than that for unskilled or semi-skilled labour (Bhorat 2000). However the education and training system is not producing enough skilled and highly skilled personnel to meet this demand.

This human capital deficiency is characterised by the highly differentiated nature of the labour market. Thus, large pockets of vulnerable groups, unskilled, poorly educated, poorly paid, mostly Black men and women, co-exist with smaller concentrations of well-paid, well-educated and highly skilled, mostly White man and women. Affirmative action, both in the private and public sector, has not substantively changed this profile. There have been some advances in restructuring and transforming the education and training systems in order to fast-track more equitable human resources development and supply to the labour market. However, progress and implementation have been slow, despite fundamental policy shifts.

The Main Drivers of HIV/AIDS Impacts

The main projection models in South Africa, those of Abt/Metropolitan and the Actuarial Society of South Africa (ASSA), estimate current infection levels at between four and six million (Bureau for Economic Research 2001). Prevalence for the total population in 2001 is estimated at 13 percent and is expected to peak at over 16 percent by 2006 (ASSA 2000). For the labour market the crisis of HIV/AIDS locates itself in age, sex and race distribution as shown in the prevalence and mortality patterns. Thus HIV/AIDS affects the economically active population disproportionately, with an adult (20-65 years) prevalence rate of 22.3 percent, peaking at 27 percent. There is a particular concentration amongst those aged 15-49 years (ASSA 2000). HIV/AIDS also has a differential impact on racial groups. The highest peak prevalence is for Africans (19.5 percent), compared to 3.24 percent for Whites, 4.8 percent for Asians and 6 percent for Coloureds (Bureau for Economic Research 2001:7). Women are
more vulnerable than men; more are infected and at a younger age. The most recent antenatal clinic survey shows that women aged 15-49 years constitute 56 percent of the 4.74 million people currently infected (Department of Health 2001). Women also tend to be infected earlier (15-35 years) than men (20-45 years) (Bureau for Economic Research 2001). Given the median survival time of 8-10 years, in the absence of treatment women will die sooner than men.

Aids is now regarded as the single biggest cause of death within the entire population. Mortality data trends for 1985-1999 show that more adults are dying and at younger ages as well, doubling in the 30-35 year range (Dorrington et al. 2001: 5-6). In 2000, 40 percent of adult deaths in the age range 15-49 are attributed to HIV/AIDS, as are 20 percent of all adult deaths. Mortality patterns are gendered, as young women (25-29) were dying 3.5 times faster in 1999-2000 than in 1985 (Dorrington et al 2001:6). UNAIDS (2002) projects that mortality amongst youth (15-34 years) will be seventeen times higher by 2010-2015 as a result of HIV/AIDS. A decline in average life expectancy from fifty-six years in 2000 to forty-one years in 2015 is also projected (ASSA 2000). Even more pessimistic is the Abt/Metropolitan model, which predicts a life expectancy of thirty-eight for men and thirty-seven for women by 2015 (Bureau for Economic Research 2001).

The racial and gendered pattern of prevalence and morbidity has its roots in the structural susceptibility of the historically disadvantaged groups: Africans and women. Thus, increased high-risk sexual behaviour and increased exposure may be ascribed to a continued lack of economic power, less access to education and information, a lack of social cohesion in families (as a result of the migrant system) and the relatively low social status of women compared to men. There is thus a complex combination of social and economic circumstances impacting on risk-averse behaviour and exposure to risk.

**Impact on the Size and Structure of the Labour Force**

All predictions indicate a slowdown in population growth, as opposed to an absolute reduction. Given mortality rates and the age distribution of the epidemic, projections are that by 2015 the total labour force will be at least 21 percent smaller as a result of HIV/AIDS (Bureau for Economic Research 2001). The age and gender distribution of HIV/AIDS may also contribute to deficiencies in the quantity and quality of the labour force. Thus, the morbidity and mortality effects on those aged 15-49 years, and a concentration among older people up to 65 years, may lead to the so-called funnel or chimney effect (Lisk 2002: 4). In addition, an increase in the numbers of Aids orphans and school dropouts may contribute to increased use of child labour, as children enter the workforce at even younger ages in search of financial support. ASSA (2000) predicts the number of maternal Aids orphans will increase from 190,000 in 2001 to over 1.8 million by 2015.

The dependency ratio will also increase, as fewer working-age people will take responsibility for increasing numbers of economically inactive dependents. Similarly the doubling of mortality amongst those aged 30-35 years will result in a decline in the labour participation rate of those in their peak economically active years (Dorrington 2001). The participation rate of both men and women peaks in their mid-thirties (Statistics South Africa 2001), but the effect on women may be particularly negative, as they are more likely to take responsibility for the care of sick or dying relatives or to suffer more sickness or deaths themselves. This gender disparity may translate into a gender imbalance in favour of men in the labour force.

Given the relatively high rates of unemployment amongst Africans, they have lower participation rates than all other groups, especially Whites (FAFO 2002). Thus, while increased mortality amongst Africans may not result in an absolute reduction relative to other smaller groups, it may further reduce labour force participation rates and access to productive work. However, it is the gender and skills composition of the HIV/AIDS impact that will most affect the relative status of Africans in the labour force. With a prematurely younger and older labour force and uneven levels of skills and experience, will it result in a “race to the bottom” and further “crowding in” of the historically disadvantaged at the bottom of the skills ladder?

**Skills and Occupational Segmentation**

The interplay of race, gender, education and skills contributes to occupational segmentation. Research in South Africa on the skills and occupational distribution of HIV/AIDS incidence, prevalence and mortality is very uneven and tentative. Extrapolation from the demographic models (based on antenatal clinic survey data) is contentious. There are inherent elements of bias in the antenatal clinic data, while complementary data such as the 1996 Census and the October Household Survey (OHS) are weak. Furthermore projections tend to assume that risk behaviours will remain uniform within skills categories and broad economic sectors. The risk distribution at skill levels and occupational groupings is a function of various demographic and socio-economic factors coming into play. In the absence of establishment, sector-based or even household sero-prevalence data, these projections remain very tentative and should be regarded with caution. More in-depth research is required.

Nevertheless existing data does indicate an inverse relationship between skill levels and HIV/AIDS prevalence levels. Thus lower-skilled and more poorly paid workers have higher prevalence levels than higher-skilled and better-paid workers, see study conducted by (Abt Associates 2000, 2001). The dominance of Africans, a high-risk group, may explain high prevalence levels in the semi-skilled and unskilled occupations. At the other end of the scale, Whites have lower prevalence levels and are mostly in higher-skilled occupations.

Although the data reveals unacceptably high infection levels and Aids prevalence rates at all levels (Abt Associates 2000; Quattck 2000), the prevalence rates among skilled workers are nearly as high as among semi-skilled and unskilled workers. However, the skilled level also includes large numbers of White workers, who are supposed to have lower prevalence rates. Another anomaly is that the prevalence rate among highly skilled workers is considerably lower than at other levels, yet the skilled category includes teachers and nurses, who are predominantly Black (Bureau for Economic Research 2001). The fact that the expected effect does not occur in either of these examples indicates that there must be something else at play. A more in-depth investigation of the interplay between socio-economic characteristics, including income, education and skill level, and demographic factors in risk group formation and vulnerability is clearly necessary. Nevertheless the current prevalence trends have very
negative implications for the skills shortage in the labour market. Already the decline in the economically most active sector of the population (15-49), along with increased child labour, may lower the general level of skills and experience in the workforce, even if those closer to retirement age remain in the workforce (ILO 2000). One can expect a worsening of the shortage of skilled and highly skilled employees, as the pool of eligible workers shrinks even further.

At the same time, enterprises may not wish to invest in training. The return on human capital investment is reduced or lost altogether when the life expectancy of employees is reduced. Investment in training to replace or retrain lost labour may become too costly as enterprises face declining productivity and profit levels. Thus, for skilled and highly skilled workers, companies may prefer to offload the costs of recruitment, training and replacement by reverting to poaching or even importing skills from abroad. In addition the achievement of equity in fast-tracking the flow of more Blacks and women into skilled and highly skilled occupations may be at risk. Mobility out of semi-skilled and unskilled occupations may become even more difficult for Blacks and women, further entrenching overall occupational segmentation and inequity. Anecdotal evidence suggests that despite advances under the National Skills Development Strategy (NSDS), a legislative framework geared at upgrading skills and lifelong learning through partnerships between government, business and labour, most employees receiving enterprise training at highly skilled and skilled levels are White males, whereas most employees receiving training at semi-skilled and unskilled levels are African males. The implication is that if current training continues to relegate the historically disadvantaged to low-skilled, low-paid occupations, HIV/AIDS-induced constraints on training may entrench this trend further. It will also become even more difficult for women to accumulate the skills and experience needed to break through the “glass ceiling” at the skilled and highly skilled levels of traditionally male-dominated occupations. Even now very few companies have effective managed care programmes that include succession planning in order to provide sufficiently trained people to replace those lost due to AIDS-related illnesses.

**Labour Force Substitution**

Macro-economic simulation studies point to a decline in productivity levels as a result of the projected labour force decline (Bureau for Economic Research 2001). The overall decline in skills and experience will lead to lower productivity, thus increasing the possibility of capital substitution. For skill-intensive sectors capital and skilled labour are complementary inputs. Thus technological substitution may be hampered by an inability to fast-track high skills acquisition in the system, given the costliness of replacements and retraining. As noted before, a reversal to poaching and importation of skills is likely. Less skilled and labour-intensive industries are already experiencing increased capital intensity, which may be exacerbated by the cost impact of HIV/AIDS.

Many companies regard the large pool of unemployed and unskilled Black workers as an effective option to fill the gaps left by ill or dying unskilled and semi-skilled workers. However, this may not be a sustainable option. The unemployed, Black, young and female sectors have a highly susceptible demographic profile and projected HIV prevalence rates of above 30 percent (Bureau for Economic Research 2001). In the absence of training, and with reduced replacement possibilities, capital substitution becomes even more entrenched. As a result reduced labour demand impacts negatively on both the currently employed and the unemployed.

**Impact on Wage Distribution**

Currently there is no comprehensive analysis available on the impact of HIV/AIDS on wage distribution. In the aggregate it is expected that wages will rise with the decline in labour supply (Bureau for Economic Research 2001). However, given the direct and indirect costs of HIV/AIDS, labour demand may fall, which will have a dampening effect on wages, especially at low and unskilled levels. Macro-economic studies indicate that household savings capacity is eroded as more household income is shifted towards medical, care and funeral costs (Bureau for Economic Research 2001). Given the increased dependency ratio, the labour force faces increasing income vulnerability. Very poor households rely heavily on remittances from working members, which they are now likely to lose completely or partly. This will contribute to further destitution in very poor households.

Medical and care costs related to HIV/AIDS will increase expenditure for infected individuals and their families. Medical benefits are very expensive and mostly concentrated amongst so-called white-collar workers in skilled and highly skilled occupations. Thus skilled and highly skilled workers will have relatively enhanced access to medical treatment and care in order to prolong their productive lives. However, with medical benefits either absent or unaffordable, those in lower-skilled positions are more likely to carry the cost from their own savings, or else use the overburdened public health system. The estimated cost of treatment per person per year ranges from R13,000 to R25,000, which is completely out of reach of most of the labour force (Business Day 12 September 2002). The overall impact may increase levels of debt and deepen poverty within the labour force. South Africa already has among the highest levels of income inequality. The differentiated burden on wages may worsen this trend. Collective
Abstract

There have been a number of litigations in Africa on the human rights of people living with or affected by HIV/AIDS. Issues of confidentiality, informed consent for testing, discrimination in employment and access to drugs and treatment have been subjects of serious contestation in our law courts. Nevertheless the number of cases remains small compared to the magnitude and complexity of the HIV/AIDS crisis in Africa. This paper focuses on the interconnections between law, human rights and public health in HIV/AIDS-related human rights cases in Africa. In particular it will examine how litigation can help promote and protect the rights of people living with HIV and Aids (PLWHAs) as well as fight HIV/AIDS stigma. The paper relies mainly on an analysis of judicial decisions in the context of the ethical and human rights issues raised by the cases. My experience as a human rights lawyer providing free legal aid services to PLWHAs in Nigeria is also discussed where relevant. The paper argues that while many factors constrain PLWHAs from benefiting from litigation, the critical obstacle is the non-recognition of their rights. It therefore proposes the institutionalisation of human rights education on HIV/AIDS along with legal reforms to reduce discrimination against PLWHAs.
Introduction

The 2002 UNAIDS report on HIV/AIDS indicates that the pandemic has reached unprecedented levels in sub-Saharan Africa. The report estimates that 28.5 million out of the 40 million adults and children with HIV/AIDS around the world live in sub-Saharan Africa (UNAIDS 2002: 8). These alarming figures clearly demand a multi-faceted approach toward prevention and control of the HIV/AIDS pandemic in Africa. HIV/AIDS is not just a public health problem. It has important moral, political and legal dimensions that need to be dealt with if the pandemic is to be brought under control in Africa. Some of the greatest challenges in the campaign against Aids involve stigma and discrimination. These create important barriers to prevention and treatment efforts. The stigma and discrimination faced by PLWHAs make many people afraid of being tested or of seeking assistance if they know they are infected. In fact HIV/AIDS is an epidemic of stigma and discrimination. Stigma affects not only the lives of PLWHAs but also those of their lovers, families and caregivers. It affects not only those who are stigmatised but also those in the community, on the job, in professional capacities, in public office or in the media who stigmatise them. Often the stigma of HIV/AIDS compounds old prejudices with new ones.

As a result of stigma Africa’s growing number of PLWHAs encounter many human rights problems regarding confidentiality, informed consent for HIV/AIDS testing, discrimination in employment and health services and access to drugs and treatments. One might therefore expect that there would have been a large amount of litigation in Africa on HIV/AIDS-related human rights issues. On the contrary, outside South Africa there have been very few cases. Why is this so? Is it because the human rights of PLWAs are so well-respected in Africa that there is nothing to litigate? Unfortunately the reality is that PLWAs in most parts of Africa have been forced to suffer extreme discrimination in silence. The main reason is fear of stigmatisation.

In addition litigation in general is not an easy affair in Africa. Culturally most Africans are litigation-shy and will only go to court as a last resort. Other factors also constrain litigation. The most important is legal non-recognition of rights. In discussing some of the few judicial decisions relating to the human rights of PLWHAs in Africa, I will focus mainly on cases from Nigeria and South Africa but will also refer to cases from other jurisdictions, particularly outside Africa, to show the potential of litigation to protect the rights of PLWHAs.

Human Rights and Public Health

The HIV/AIDS pandemic has raised many issues worldwide about the human rights both of people living with HIV/AIDS and of people affected by HIV/AIDS (PABA). The most prominent of these issues is the right to equality of treatment and freedom from discrimination. The discriminatory treatment meted out to many PLWHAs has been justified on the basis of separating the healthy from the infected for the protection of society according to the notion of the common good. Is a medical officer who discriminates against a patient with HIV/AIDS on this notion of public health acting legally? What amounts to protection of public health? In the bills of rights of national constitutions restrictions of fundamental human rights are often justified on grounds of public health, safety or morality. However the concept of the public good is an unruly horse, and it is often difficult to determine what should be included within the concept.

The International Guidelines on HIV/AIDS and Human Rights (WHO/USAIDS 1999) recommend that states review and reform public health laws to ensure that the laws adequately address public health issues raised by HIV/AIDS and that their provisions on easily transmitted diseases are not inappropriately applied to HIV/AIDS, which is relatively difficult to transmit. The rationale for this is that protecting HIV-related human rights will not impede the achievement of public health goals as long as appropriate steps are taken. The guidelines also advise states to strengthen their public education efforts against the stigmatisation and discrimination. Therefore public health laws are expected to empower public health authorities to provide a comprehensive range of services for the prevention and treatment of HIV/AIDS, including relevant information and education, adequate sexual and reproductive health services (including provision of condoms), access to voluntary testing and counselling and appropriate HIV/AIDS drug treatments, as well as adequate treatment for HIV/AIDS-related illnesses. In particular the public health argument should not be used to victimise PLWHAs by subjecting them to isolation, detention or quarantine on the basis of their HIV status. In fact, as previously noted, the stigmatisation of PLWHAs is actually detrimental to public health. By contrast an environment in which their human rights are respected ensures that vulnerability to the disease is reduced. By enabling PLWHAs — and PABAs — to live in dignity and equality, both the personal and societal impacts of HIV infection are alleviated.

In Africa, however, people with HIV/AIDS continue to suffer discrimination. Their rights to privacy and confidentiality are breached with impunity. They are tested for HIV without their consent and without pre-test or post-test counselling. For vulnerable groups such as pregnant women this can expose them to violence from their spouses and stigmatisation from their communities. I have discussed this issue with many medical personnel. The justification usually put forward is protection of health-care providers and other health users. But could not the same public health argument be used to test service providers for HIV? Is it not equally in the interest of public health that the status of health-care providers is known?

HIV/AIDS Litigation: A Case from Nigeria

On July 14 2000, the Social and Economic Rights Action Centre (SERAC) filed Nigeria’s first-ever HIV/AIDS discrimination lawsuit (Mrs Georgiana Ahamefule v. Imperial Medical Centre and Dr Alex K. Molokwu, Suit No: ID/1627/2000, Unreported, Lagos High Court) challenging inter alia the termination of Mrs Ahamefule’s employment at the Imperial Medical Centre because she was HIV-positive. The plaintiff had been employed as an auxiliary nurse at the centre. In 1995 she became pregnant and developed some boils on her skin, whereupon she sought medical attention from the second defendant, who was also Chief Medical Director at the centre.

Dr Molokwu carried out some tests on the plaintiff without disclosing the nature or results, then asked the plaintiff to proceed on two-week medical leave and referred her (with a note in a sealed envelope) to a Dr Okany at Lagos University Teaching Hospital (LUTH). Upon reading the note Dr Okany requested the plaintiff to come back with her husband, whereupon blood samples were taken from both without any reason being given. At Mrs Ahamefule’s next visit Dr Okany informed her that she had tested positive for HIV and that her husband had tested
negative. When Mrs Ahamefule returned to work after her medical leave, Dr Molukwu abruptly terminated her employment without adequate severance compensation and despite five years of satisfactory service at the clinic. The letter of termination gave her HIV-positive status as the grounds for termination. In lieu of severance pay Mrs Ahamefule received a letter of recommendation to assist her to get employment in another clinic. Soon after this the plaintiff had a miscarriage. Dr Molukwu refused to carry out the recommended clean-up operation to remove the remains of the dead foetus. He based his refusal Mrs Ahamefule’s HIV status, stating that he did not want to contaminate his instruments.

Mrs Ahamefule then instituted an action against the clinic and Dr Molukwu before the High Court of Lagos. She claimed that the termination of her employment based on her HIV status constituted unlawful discrimination pursuant to Articles 2, 18 (3) and 28 of the African Charter on Human and People’s Rights (Ratification and Enforcement) Act, that subjecting her to HIV testing without her informed consent constituted unlawful battery, that the defendants’ failure to provide pre-test and post-test counselling constituted professional negligence and that the defendants’ denial of medical care on grounds of her HIV status violated her right to health pursuant to article 16 of the African Charter on Human and People’s Rights (Ratification and Enforcement) Act, Cap 10 of the laws of Nigeria and Article 12 of the International Convention on Economic, Social and Cultural Rights (ratified by Nigeria in 1993). Mrs Ahamefule asked for five million naira general damages for wrongful termination of employment, three million naira as compensation for HIV testing without her consent and for defendants’ negligence and two million naira positive damages for the defendants invidious actions.

In their defence the defendants claimed that they terminated the plaintiff’s appointment in the interest of public safety. They argued that ‘[i]t they are statutorily bound to ensure that the hospital is safe, [and] that members of the public are safe, [and] protected from contagious or infectious diseases.’ They further stated that they have an obligation ‘to protect the public at large from being infected by HIV’ and that they had ‘no regrets’ for terminating the plaintiff’s appointment, as she was ‘a danger to the community at large and to patients in particular.’ They then contended that Mrs Ahamefule should not be allowed to give evidence in court unless a medical report from an expert guaranteed that she would not infect others in the courtroom. Counsel for Mrs Ahamefule retorted that it was the plaintiff’s right to give evidence in court and that in any case there was no other option. The judge ruled in favour of the counsel for the defendants, stating that ‘life has no duplicate and must be guarded jealously.’

Mrs Ahamefule’s counsel then filed a notice of appeal in the Court of Appeal, contending that the judge had erred in law by disregarding section 36(1) of the 1999 constitution which guarantees a plaintiff’s or appellant’s unrestricted physical access to the court, and moreover that the judge’s ruling violated Mrs Ahamefule’s right to the dignity of the human person as protected by Section 34(1) (a) of the constitution. Counsel urged the Court of Appeal to order a declaration that the plaintiff was a person as defined by the constitution and was therefore entitled to the enjoyment of her fundamental human rights irrespective of her HIV status. He also asked for a declaration that restricting Mrs Ahamefule’s access to the court was unconstitutional as it violated her rights to a fair hearing, to dignity of the human person and to freedom from discrimination.

The Ahamefule case is very important because of the media attention it attracted. It put the issue of the rights of PLWHAs at the centre of national discourse, though not without difficulty. Two journalists, Gbolahan Gbadamosi of the Guardian and Jenny Ekukunbor of the Vanguard, were ordered to show cause why they should not be sent to prison for contempt of court for reporting the ruling denying Mrs Ahamefule access to the court. Ekukunbor subsequently wrote a retraction, which was published in three editions of the newspaper as ordered by the court, but Gbadamosi challenged the court’s jurisdiction. However, before his case could be heard, the contempt charges were not only struck out but so was the entire suit. The ruling cited ‘undue publicity’ and the interest of the sick.

This was done notwithstanding that a valid notice of appeal had been filed challenging the court’s previous orders and that applications for a stay of execution of the order denying the plaintiff access to court and for a stay of proceedings were also before the court. Moreover SERAC, the non-governmental organisation that acted on behalf of Mrs Ahamefule, alleged that the judge stonewalled the plaintiff’s access to official records and to certified copies of court orders. The case file was withheld by the judge and only released to the records department after SERAC petitioned the Chief Judge of Lagos State and threatened to file for an order compelling the release of the file.

The Ahamefule case has garnered global attention because of its far-reaching public interest dimensions. The case has raised some burning human rights and ethical issues regarding HIV/Aids and has also illuminated the intersection between law, human rights and public health. It points up the enormity of the tasks that must be accomplished if Nigeria is to tackle HIV/Aids. If a “learned” judge of the High Court can be so profoundly ignorant as to use coercive instruments of the state to suppress criticism of her flawed ruling, then the attitudes that must prevail at other levels of society are perhaps better left to the imagination. There are many other HIV/Aids-related causes in Nigeria deserving litigation. Many people living with HIV have suffered persecution, rejection, stigmatisation and neglect in silence and without the law coming to their aid. Often the potential litigant is too ashamed to seek legal redress either because of fear of even worse consequences or because he or she simply does not know how to seek legal redress.

HIV/Aids Litigation: South Africa’s Experience

Most HIV/Aids litigations in Africa have taken place in South Africa. The courts in South Africa have been the most proactive on the continent with respect to HIV/ Aids. A host of cases, including class actions (public interest litigations), have succeeded in establishing the human rights of PLWHAs in South Africa, in particular their right to freedom from discrimination and access to treatment. In the case of Hoffman v. South African Airways (2000 2SA 628), for example, the Constitutional Court of South Africa ruled (28 September 2000) that South African Airways (SAA) had violated the constitutional rights of Jacques Hoffman by refusing four years earlier to employ him as a cabin attendant merely because he was HIV-positive. In making its ruling the court noted:
People who are living with HIV/AIDS are one of the most vulnerable groups in our society. Discrimination against them is an assault on their dignity. The impact of discrimination on HIV-positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living.

Stating ‘there can be no doubt’ that SAA discriminated against Hoffmann because of his HIV status, the Court concluded:

Neither the purpose of the discrimination nor the objective medical evidence justifies such discrimination. The fact that some people who are HIV-positive may, under certain circumstances, be unsuitable for employment as cabin attendants does not justify the exclusion from employment as cabin attendants of all people who are living with HIV.

Of particular interest, the court ruled that SAA’s argument that employing HIV-positive flight attendants would harm its commercial interests was superseded by the individual’s right to freedom from discrimination:

Legitimate commercial requirements are, of course, an important consideration in determining whether to employ an individual. However we must guard against allowing stereotyping and prejudice to creep in under the guise of commercial interests. The greater interests of society require the recognition of the inherent dignity of every human being and the elimination of all forms of discrimination.

The court also argued for the need for special vigilance regarding the rights of members of marginalised groups:

Our Constitution protects the weak, the marginalised, the socially outcast, and the victims of prejudice and stereotyping. It is only when these groups are protected that we can be sure that our rights are protected.

It noted that the ‘devastating effects’ of HIV had combined with ‘widespread lack of knowledge’ about HIV to produce ‘deep anxiety and considerable hysteria.’ However, the court insisted, ‘[f]ear and ignorance can never justify the denial to all people who are HIV positive of the fundamental right to be judged on their merits.’ Thus it concluded that ‘[o]ur treatment of people who are HIV positive must be based on reasoned and medically sound judgments. The constitutional right of the appellant not to be unfairly discriminated against cannot be determined by ill-informed public perception.’ This very important case, and others also brought against the South African Airways, firmly established the rights of PLWHAs to freedom from discrimination in employment.

Another landmark case in South Africa was Treatment Action Campaign and 2 others v. Minister of Health and 9 Others in 2001 (Case No. 21182/2001). In this case the applicants instituted a class action against ten respondents: the Minister of Health and the MECs (Members of the Executive Council) responsible for health in the nine South African provinces. The plaintiffs asked for a declaratory order that the respondents were obliged to provide nevirapine to pregnant women with HIV whenever it was medically indicated. They also asked for an order directing the state to produce and implement an effective national programme to prevent or reduce mother-to-child transmission (MTCT) of HIV, including the provision of voluntary counselling and testing (VCT), and, where appropriate, nevirapine or other appropriate medicines as well as infant formula.

The background to this case is the stark reality that about 29 percent of pregnant women in South Africa are HIV-positive and that about 70,000 or more children are infected each year through MTCT (UNAIDS, 2002: 14). Indeed MTCT is one of the commonest forms of infection in a country where five million of the total population estimated at 40 million is infected. The Treatment Action Campaign (TAC) based their case on the South African constitution, in particular Section 27, which recognises the right of everyone to have access to health care services, including reproductive health care, and the state’s obligations to take reasonable measures to ensure the progressive realisation of that right. The TAC argued that these provisions of the constitution obligated the respondents to provide nevirapine to pregnant women.

Before this case was instituted the respondents had agreed to make nevirapine available at only a limited number of pilot sites. These sites would have served only about ten percent of the eligible population. Moreover in July 2000 the manufacturer of nevirapine, Boehringer Ingelheim, had offered to supply nevirapine to public health institutions in South Africa free of charge for five years. The respondents had not accepted this offer, although they were still discussing it. When the TAC’s case came to court the respondents argued that they were not in breach of the constitution. They contended that all reasonable steps had been taken, given available resources, to achieve the progressive realisation of the right to health care. Furthermore they charged that the applicants were ignoring important infrastructural and operational considerations, such as the need to provide voluntary counselling and testing and to monitor the progress of everyone treated with nevirapine. To make nevirapine immediately available at all public health facilities, they claimed, was impossible due to a lack of human resources. They also argued that making nevirapine available to everyone who needed it would have unsustainable cost implications which would compromise the state’s ability to provide health care for other citizens. Finally they contended that nevirapine had not been adequately tested.

Nevertheless the High Court ruled in favour of the TAC. It ordered the respondents to develop and implement an effective, comprehensive national programme to prevent or reduce mother-to-child transmission of HIV, including the provision of nevirapine or other appropriate medicine and formula milk for feeding. The state immediately appealed to the Constitutional Court, arguing that the ruling interfered unacceptably with policy-making by the executive branch of government. However on 5 July 2002 the Constitutional Court reaffirmed the High Court’s ruling.

This case has substantially advanced the general right of PLWHAs to access to treatment. Access to nevirapine and other AZT-based treatments will greatly reduce infant deaths due to MTCT, as well as the stigmatisation of HIV mothers who transmit the disease to their babies. In a cultural milieu where enormous value is placed on motherhood, it is a terrible burden for HIV-positive mothers to know that they have infected their babies. This is one of the major reasons why HIV-positive women conceal their status. The TAC case – the culmination of almost four years of intense lobbying and public mobilisation – also came to symbolise the failure of the South African government to deal decisively with the HIV/AIDS epidemic. However the case also made clear the strength of the South African legal regime.
and constitution, especially in comparison to the rest of the continent. Most other African states are yet to come to terms with the role of law and human rights in the HIV/AIDS pandemic. In Nigeria the 2001 HIV/AIDS Emergency Action Plan did not even mention respect for the human rights of PLWHAs in its sixteen guiding principles. Uganda, cited by many as an example of how an aggressive state-coordinated campaign can help combat HIV/Aids, still has no specific laws protecting the rights of PLWHAs. Not surprisingly recent research UNAIDS shows a high prevalence HIV/AIDS-related discrimination, stigmatisation and denial despite high levels of HIV/AIDS awareness (UNAIDS, 2001).

### Comparative Case Analysis

Outside Africa there have been a number of interesting and important court cases involving the rights of PLWHAs. In Costa Rica and Brazil, for example, courts have ordered state-funded health care systems to pay for antiretroviral drugs for PLWHAs.

In Canada there have been many HIV/AIDS-related cases concerning employment rights. In one, Pacific Western Airlines Ltd v. Canadian Airlines Flight Attendants Association (1987, 28 L.A.C. 3rd 291 Can. Arab, Bd.), the court held, as in the South African case described earlier, that the airline had no right to dismiss an employee solely on the basis of HIV status (Canadian HIV/AIDS Policy and Law Review, 2002). In another, Thwaites v Canada (Armed Forces), a judicial tribunal ruled that an employer may use health and safety considerations to justify employment policy only if it can ‘show that the risk is based on the most authoritative and up-to-date medical, scientific and statistical information available and not on hasty assumptions, speculative apprehensions or unfounded generalizations’ (Canadian HIV/AIDS Policy and Law Review, 2002). In R v Beaulieu (1992 RJQ 2959, Cour du Quebec, Chambre criminelle et penale) the Crown Prosecutor asked for an order to test a man for HIV who had sexually assaulted a woman, as the victim feared she might have been infected with HIV. However the judge ruled that the law does not authorise compulsory testing. The accused was convicted of sexual assault and sentenced to twelve years’ imprisonment, but the court refused a second request that he be forcibly tested for HIV. After a national campaign the victim presented the Canadian Justice Minister with a petition signed by 50,000 people calling on him to amend the law to allow judges to force persons accused or convicted of sexual assault to submit to an HIV test (Canadian HIV/AIDS Policy and Law Review, 2002).

In the United States there have been several cases in which special precautions against contagion have been requested when a PLWA is involved in a court case. At a pre-trial conference in the Florida Bankruptcy Court (B.R. 568 Banker. S.D. Fla.1986), for example, the counsel for the debtor announced that his client was HIV-positive. Because some judges in Florida had previously required a PLWA to wear a face mask during courtroom proceedings, counsel asked the bankruptcy judge whether or not he would require any special precautions to be taken during the trial when the debtor was present in the courtroom. The court held that no special precautions need be taken, arguing that HIV is not spread by casual contact. In another US case Sheriff’s deputies refused to transport a defendant to court because they believed he had AIDS. This forced his case to be adjourned and the defendant to spend unnecessary time in jail. The defendant then sued the Sheriff’s office for discrimination. To settle the case the Sheriff’s Office agreed to a mandatory Aids training program for all deputies, a new Aids policy stressing confidentiality and non-discriminatory behaviour and disciplinary action for disclosure of a defendant’s medical condition against the deputies involved (Philadelphia Aids Task Force, 1988).

In Venezuela the Ministry of Health and Social Development published a resolution on 8 August 2000 ordering all public and private health services institutions to test pregnant women in prenatal care for HIV. The resolution stated that testing could only be done with the knowledge of the woman, and after proper counselling, and that confidentiality must be preserved. The ministry also guaranteed provision of antiretroviral treatment for all HIV–positive women during pregnancy and labour, as well as their babies. By contrast in many African countries pregnant women are mandatorily tested without any intention to provide them with the necessary drugs to prevent MTCT. If the state requires pregnant women to be tested, should it not be required for its part to provide treatment to women found to be HIV-positive? Without such a policy, it could be argued, mandatory testing is effectively a form of torture or inhuman and degrading treatment.

### Lessons Learned

A number of lessons can be learned from even a brief survey of HIV/AIDS-related human rights cases. One lesson is that PLWHAs in Africa experience heavy stigmatisation, discrimination and other human rights violations with little hope of redress through the courts. This situation is a major factor driving the HIV/AIDS pandemic, as it creates powerful disincentives to disclose one’s HIV status or to seek treatment, thereby increasing the chances of further transmission of the infection. A second lesson is that the law is being underutilised to confront stigma and assert the human rights of PLWHAs. Successful cases in South Africa and non-African jurisdictions show that the human rights of PLWHAs can be legally protected. However it is also clear that many PLWHAs in Africa do not understand their rights and fail to respond appropriately when their rights are violated.

Nevertheless the law is not a panacea. It can create an enabling environment but it cannot legislate people’s behaviour. It can only try to redress the consequences of behaviour when it violates others’ rights. Furthermore litigation may create or worsen rather than alleviate stigma in individual cases. At a wider level, however, it increases people’s understanding of HIV and of the rights of PLWHAs. Thus class action suits may be preferable in many circumstances. However in Africa lack of resources makes many social and economic rights such as the right to access to treatment difficult if not impossible to enforce even through class action.

### Conclusions and Recommendations

In the end the key question is: how do we get appropriate information on AIDS prevention and care skills to the people who need it, fight HIV/Aids stigma and discrimination and create a social consensus on safer behaviour? Research has shown that any approach to preventing HIV infection that fails to take human rights into account will be ineffective and unsustainable. With this in mind I offer the following observations and recommendations.
1. From the experience of countries that have attempted it, it is clear that the criminalisation of intentional transmission of HIV impedes prevention and control. For the real protection of the public’s health, criminal and anti-discrimination legislation should prohibit mandatory HIV testing of target groups. Informed consent and counselling must always precede such testing. Participation in HIV clinical trials should be voluntary as well as confidential. The government must not shy away from its obligation to provide treatment without discrimination to infected persons as well as support services for persons affected by HIV/AIDS.

2. Efforts must be increased to create awareness at community level through human rights education that promotes understanding of HIV and the rights of PLWHAs and reduces HIV/AIDS stigma.

3. Legal reforms and legal advocacy can be effective in reducing stigma when integrated with other community interventions.

4. Health care workers should receive training in ethics and human rights before being licensed to practice and should be retrained regularly. There is no doubt that health workers take enormous risks caring for infected persons. However this does not justify discriminatory practices. A code of conduct based on human rights and covering specific HIV/AIDS-related issues should therefore be adopted and enforced in all public health facilities.

5. International regulations on HIV/AIDS should be made binding at international and domestic levels. In particular fair and equal access to treatment for PLWHAs should be guaranteed. This will enhance prevention, openness and non-discrimination. We must promote and respect individual autonomy and dignity in the provision of HIV/AIDS treatment.

6. Policies on HIV/AIDS should be translated into laws to create binding legal obligations at the national level. The law should allow PLWHAs to bring actions under pseudonyms, prohibit disclosure of identity and permit hearings in camera to protect the privacy of PLWHAs and encourage them to seek legal redress when their rights are violated.

7. Free legal aid services should be made available to PLWHAs whose rights have been violated, and cases involving the rights of PLWHAs should receive accelerated hearings. Justice delayed is justice denied.

8. Intergovernmental agencies and donors should fund programmes and projects, particularly legal outreach education at grassroots levels, focusing on the human rights dimensions of HIV/AIDS.

There have been a number of litigations in Africa on HIV/AIDS dealing with the human rights both of people living with HIV/AIDS and people affected by it. These cases have reiterated the linkages between the law, human rights and public health discussed in this paper. The few cases reviewed in Africa have shown that while litigation has promoted protection of rights, particularly the right to freedom from discrimination and the right to informed consent, it has yet to assist in destigmatisation. Stigma remains a critical issue in deciding whether to litigate or not. Consequently many PLWHAs whose rights have been violated avoid the courts, even when free legal aid is available. As a result many PLWHAs have suffered extreme discrimination in silence. Many have lost their jobs following mandatory testing imposed by employers but have not sought redress in the courts. However as long as we allow abuses of the rights of PLWHAs, our efforts at prevention of HIV infection and management of the HIV/AIDS pandemic will be seriously marred. What is most critical is education and counselling of the most vulnerable groups, such as drug abusers, sex workers and prisoners. Condoms, bleach and clean needles must be made available. Moreover in most parts of Africa the law as it stands punishes people for prostitution and homosexuality. We urgently need to review these laws, criminalise these behaviours and make new laws to protect health workers and their clients.

References


Pay or Perish? Globalisation, Pharmaceutical Multinationals and Access to HIV/AIDS Drugs in Africa

Abstract

This paper critically examines the impact of globalisation on access to drugs for the treatment of HIV/AIDS in Africa. The sad coincidence of being both the poorest continent and the one with the highest incidence of HIV/AIDS brings out in bold relief the centrality of the issue of access to drugs and health care in Africa. In particular it calls attention to the role of pharmaceutical multinationals – and their home governments – in defining issues of pricing, affordability, patents and monopoly, and how these decisions end up undermining the life chances of people living with HIV/AIDS (PLWHAs) in sub-Saharan Africa, as well as the overall health and development goals of the region. The key ethical question is why PLWHAs in Africa should be left to perish simply because they cannot afford the high prices pharmaceutical multinationals charge for HIV/AIDS drugs. Addressing these issues is urgent, as HIV infection is growing exponentially in many African countries (Becker et al. 1999: 1-29). This paper examines the ramifications — conceptual, methodological and developmental — of the impact of globalisation on attempts to contain, manage and treat HIV/AIDS in Africa. It attempts to capture the key economic, social and political conditions, and the hegemonic forces, that strengthen or weaken the “war” against HIV/AIDS in Africa.
Conceptual and Methodological Issues

In the context of HIV/Aids, globalisation can be located in the power of pharmaceutical multinationals, described as being ‘consistently among the world’s most profitable commercial enterprises’ (Foreman 2002: 9), and in the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement regime of the World Trade Organisation. Both these structures of globalisation tend to give monopoly rights over HIV/Aids drugs to the pharmaceutical multinationals, place profits before people and restrict access to life-saving medications by pricing them beyond the reach of the vast majority of the people of Africa. Africa’s place in the global HIV/AIDS picture is a dismal one. According to the Access Alert of March/April 2002, 2.4 million of the 3 million people who had died of AIDS worldwide by the year 2000 were Africans. Similarly the UN reports that of the 36.1 million people living with HIV/AIDS by the end of 2000, 75 per cent were in Africa (UN 2001: 6). At a special session of the UN General Assembly in June 2001, world leaders agreed that HIV/AIDS has created a virtual state of emergency in sub-Saharan Africa which threatens the region’s political stability, social cohesion and food security.

This situation is one of the results of the globalisation of capitalist production and trade. The defence of the monopoly powers of pharmaceutical multinationals to maximise profit from the production and marketing of drugs, including those for the treatment of HIV/AIDS, poses a threat to the lives of millions of Africans. Limiting access to drugs through pricing amounts to a death sentence on most Africans infected with HIV. Thus the expansion of access to drugs is imperative for the survival of Africa. Conceptualising the problem requires inputs from the social sciences, globalisation studies and development theory as well as an understanding of the linkages among these areas. There is also a need to grapple with their connections to the international political economy, the reproduction of global capitalism and the power of transnational corporations operating in the area of health and development in Africa.

The Social Sciences and HIV/AIDS in Africa: Survey of the Literature

A survey of the social science literature shows the near-absence of African social science input into the global debates on HIV/AIDS. Indeed social science input in general has been problematic, with far too much reliance on the myth of Africans’ sexual ‘promiscuity’ or the peculiarities of African sexual ‘networking.’ (Caldwell et al. 1989, 1991; Orubuloye et al. 1994). For this school of thought the AIDS pandemic in Africa can be explained mainly by certain cultural practices in Africa that predispose people to high-risk behaviour. The methodological flaws, as well as the conceptual weaknesses, of this approach have already been pointed out by Le Blanc et al. (1991). As they observe, ‘the evidence does not support the existence of a distinctive African pattern of sexuality’. (503). Moreover the social context of AIDS in Africa is closely connected to economic factors. Effective interventions to fight the pandemic must be hinged on improved education and living conditions. Thus there is an urgent need for an African social science perspective on HIV/AIDS that transcends the limitations of culturalist and technocratic approaches to the pandemic. This requires a multidisciplinary approach to the new policy challenges being posed by the disease. The devastating impact of HIV/AIDS on sub-Saharan Africa can only be confronted as part of a development project, including the development of tools for understanding the political economy of the HIV/AIDS pandemic.

There is a widely recognised need to deal with the marginalisation of social science approaches to HIV/AIDS (Becker et al. 1999). The disease must be approached as more than simply a health issue and the preserve of the biomedical sciences. However within the social sciences it is imperative to go beyond the dominant ‘behavioural’ approaches to develop a multidisciplinary approach. Such an approach would bring to the fore the relations of power — social, economic and political — that underpin the spread of HIV/AIDS in Africa. It would also expose the ways in which the reproduction and expansion of capital in (neoliberal) globalisation profits from HIV/AIDS, and how multinational pharmaceutical companies therefore seek to block the production and distribution of generic drugs in Africa. The HIV/AIDS pandemic in Africa makes clear the necessity for ‘increased availability and non-discriminatory access to medication’ (UN 2001:11), as well as the importance of issues of access within the overall context of social, political and economic development on the continent. The linkages between the geography of HIV/AIDS and relations of power at the national and global levels are clearly reflected in prevalence levels and death rates. The poorest and most marginalised regions of the world are the most vulnerable to the disease, and the capitalist ethos of profit maximisation implies that the infected must either be able to afford drugs to prolong their lives or perish.

Globalisation and HIV/AIDS

Before going further, it is important to examine the highly contested and ideological concept of globalisation. According to a United Nations Research Institute for Social Development report for the World Summit for Social Development (UNRISD 1995: 9), globalisation is characterised by ‘six consistent trends’: the spread of liberal democracy, the dominance of market forces, the transformation of production systems and labour markets, rapid technological change, the media revolution and consumerism, all leading to the integration of the global economy. Held et al. (1992: 2) sum up globalisation as the ‘widenings, deepening and speeding up of worldwide inter-connectedness in all aspects of contemporary social life’. Some celebrate the dissolution of state and national borders and the trans-territorialisation of production, trade and finance as a triumph of capitalism, while others argue that what we call globalisation is nothing new. Indeed they see it as merely a new term for the hegemony of strong national governments in the North (Obi 2000; Hirst and Thompson 1996).

What is clear is that multinational corporations have exploited the expansionist, integrative and capitalist market logic of globalisation to reinforce their position as dominant economic forces on a global scale. Essentially multinationals operate as monopolies, dominating and dividing the world market among themselves and manipulating prices to maximise their profits.

Cyril I. Obi
Senior Research Fellow
Nigerian Institute of International Affairs
Lagos, Nigeria
Irrespective of the economic sector in which they operate, multinationals employ broadly the same methods to “corner the market.” This phenomenon comes out in sharp relief in the practices of the major pharmaceutical multinationals that manufacture and market HIV/AIDS drugs: GlaxoSmithKline, Bristol-Myers Squibb, Roche Holdings and Abbott Laboratories. Backed by their home governments (particularly the US government) these giants use patent rights (justified by the concept of “intellectual property”) under the regime of the World Trade Organisation (WTO) to assert market exclusivity (European AIDS Treatment News 2002: 8).

The WTO TRIPS Agreement provides these companies with patent protection of a product for a period of twenty years, giving them the legal right to prevent cheap copies of patented drugs from being distributed where they are most needed.

**Pharmaceutical Multinationals and Patents: Profits versus Access**

From the foregoing it is clear that the pharmaceutical multinationals are critical players in a rapidly globalising world. In spite of the apparent expansion of total global wealth under globalisation, the distribution of this wealth (and of the good health that it makes possible) has increasingly favoured the already richest and most powerful nations, leaving countries in the developing world plagued by deepening poverty (and poor health). As Foreman (2002: 4) observes poverty and poor health go “hand in hand,” as poor countries find it increasingly difficult to pay for (capital intensive) health care and particularly to cope with endemic or epidemic diseases. By insisting on strong patent protection in all countries the pharmaceutical multinationals seek to keep prices high, protect their profit margins and control the market. Thus they also threaten countries that disregard their patent rights. In the case of HIV/AIDS drugs such threats have been issued against Brazil, Thailand and South Africa, producing a collision between the profit motives of multinationals and the right of people living with HIV/AIDS in the developing world to have access to affordable drugs. The stakes are high on both sides of this collision. Patent protections give pharmaceutical multinationals the legal power to make huge profits from monopoly prices (European AIDS Treatment News 2002). GlaxoSmithKline made a profit of 589 million dollars on a single AIDS drug in 1999 alone (European AIDS Treatment News 2002: 8). The drug companies argue that they need to recoup their huge research and development costs in order to continue developing new and better drugs, but studies show that they actually spend more on advertising than on research and development. On the other side of the equation are the thirty million or more mostly poor people living with HIV/AIDS in developing countries.

The profit logic of the pharmaceutical multinationals means that the drugs that could drastically improve the quality of life of PLWHAs in the developing world, and extend their lives for years, are simply unaffordable both to the individuals and their governments.

The irony is that the greater vulnerability to HIV/AIDS of the developing world is itself a product of the unequal relationships and wealth gap between North and South. The increasing marginalisation and pauperisation of Africa by the hegemonic forces of globalisation has created conditions which place Africa in the grip of a worsening HIV/AIDS pandemic and at the same time prevent access to the drugs that are the only hope of loosening this grip. Fortunately the production of cheaper HIV/AIDS generic drugs in India, Brazil and Thailand offers some hope to Africa. In spite of this the cost of HIV/AIDS treatment is still high, and the shadow of the WTO agreement continues to loom large over Africa’s struggles to broaden access to life-saving HIV/AIDS medication. There is clearly an urgent need for a systematic study of the implications of the access gap created by the monopoly practices of pharmaceutical multinationals on the HIV/AIDS pandemic in Africa.

**Development and HIV/AIDS**

Since the end of the Cold War, the model of development sponsored by the West, particularly the donor community, has been one of market-led growth, or what is in real terms free market capitalism. Central to this is the rolling back of the state’s involvement in the economy, as well as the promotion of “good governance” in which the state is essentially limited to purely managerial functions (Abrahamsen 2000; Olukoshi 1998). The logic of neoliberal globalisation seeks to reinforce Africa’s integration into the global capitalist market by eliminating “distortions” in African economies. By imposing the logic of the market on Africa it is said that barriers to “free trade” will be removed, growth will occur and the benefits will trickle down to the whole of society. The opposing school of thought draws on lessons from the developing states in Asia, and the clear failure of structural adjustment programmes (SAPs) and other market-led economic reforms there. This school of thought argues that because of Africa’s history, particularly the mode of its integration into global capitalism, the state needs to play a central role in development. However it also argues that until the people exercise real power and states reflect their interests, development will remain illusory (Olukoshi 1998). Unless people are placed before markets, Africa cannot overcome its developmental problems.

There are several ways in which the HIV/AIDS pandemic compounds Africa’s crisis of development. For one thing the highest prevalence rates have affected the most productive age bracket (15-49 years), thereby robbing the continent of its skilled workers and professionals. In addition the high costs of treatment, care and support for HIV/AIDS patients drains national revenues when such revenues are already inadequate to meet the basic needs and health care requirements of the populace. At the communal or family level people have to spend a great deal of time caring for PLWAs, thus limiting the amount of time they have for work or education. In the same manner the large and increasing numbers of children orphaned by HIV/AIDS place huge demands on the time and resources of their relatives or communities. Finally already inadequate public health budgets are being subjected to enormous stress as a result of the high costs of AIDS treatment and support services. Thus HIV/AIDS further impoverishes Africa, compounding the other economic and developmental problems confronting the continent. African scholars and policy makers need to focus on what can be done to overcome these broader questions relating to the impact of HIV/AIDS on Africa’s development.

The methodology for such a project will need to combine the theoretical with the analytical. It will need to be eclectic and multidisciplinary in order to develop a theoretical handle for understanding the linkage between social science issues and the HIV/AIDS pandemic in sub-Saharan Africa. Relying on a political economy approach it will seek a holistic understanding of the pandemic and explore the possibilities for social transfor-
mations to reinforce the capacity of Africans to survive and defeat HIV/AIDS. Information and data would be sourced from both primary and secondary sources, as well as specialised publications produced by HIV/AIDS activist groups and organisations based in Africa. In-depth interviews would have to be conducted with HIV/AIDS activists, NGOs working with PLWAs and state policy makers. In this manner the conceptual and theoretical perspectives would be validated with logical and empirical support.

Critical Issues

Clearly globalisation and the role of pharmaceutical multinationals are highly relevant to the social geography of the HIV/AIDS pandemic. Globalisation has far-reaching implications for the health of people in the developing world, particularly in relation to access to drugs. Thus, besides treating the HIV/AIDS pandemic in Africa as a behavioural or health issue, we must not lose sight of its underpinnings in political economy. Blutely stated the calculations of profit and market dominance central to globalisation conspire to deny PLWAs in Africa access to life-saving drugs. Moreover the critical issue of access to drugs also engages the nexus between human rights and development. It is logical that the human right to life should guarantee access to life-saving drugs. Thus it is imperative that access to drugs should be treated as a right in itself. More effort must therefore be directed towards reducing the price of such drugs through the production or importation of cheaper, generic alternatives. However it is important to avoid uncritical generalisation. This paper does not mean to blame globalisation alone for the HIV/AIDS pandemic. Instead I have tried to show how globalisation narrows the access of most Africans to HIV/AIDS drugs and thereby contributes to the worsening of the pandemic. The impact of globalisation on African countries is not uniform, hence the need to address the specificity of each country and develop tools to accurately assess the specific impacts of globalisation (as well as the impacts of local factors) on HIV/AIDS prevalence rates.

References


Anti-Aids Drugs in South Africa: An Argument for Global Community

Caroline G. Redding
University of Connecticut

Abstract

In recent years the issue of how to provide Aids drugs to developing countries has been brought to the forefront of international and domestic debate. This issue is of particular importance to sub-Saharan Africa as Aids rates spiral out of control, threatening to bust the budgets of the fragile and underdeveloped health care systems of some of the poorest countries in the world. The Aids drugs debate has drawn a great deal of attention from a variety of constituencies, including pharmaceutical multinational corporations, national governments, international organisations and non-governmental organisations. The most notable result of the debate has been the apparent creation of a new global community. Comprised of various advocacy groups and individuals this community has taken the Aids drugs debate beyond the traditional Westphalian model of nation state interaction and created a model for global participatory democracy.
The Case for a Global Community

The Aids drug debate appears to have sparked a debate hearkening back to the developing world’s call for a new international economic order. The pharmaceutical giants are depicted as neo-colonial extensions of the dominant core countries, while the developing world calls for a neo-Marxist approach to the development and distribution of Aids drugs. The existence of a global participatory democracy (or a global community) has become an increasingly common assertion in globalisation literature. Many assume that globalisation implies the formation of a global community. They argue that as the world becomes “smaller” through telecommunication and information technologies, national borders become meaningless and the nation state system wanes, while international organisations come to the fore. Others view this argument as presumptuous. Paul Hirst and Grahame Thompson (2000) argue that other theorists have often confounded the trend toward economic integration with the idea of global governance. In fact these are two distinct trends, and the latter has been overstated. Instead, according to this view, globalisation is strictly an economic phenomenon wherein multinational and transnational corporations seek to extend their markets throughout the world (p. 69, 2000).

Furthermore Hirst and Thompson suggest that globalisation is not an unprecedented occurrence. Since the beginning of the industrial period, they argue, the world has gone through periods of relative openness, most notably between 1870 and 1914 (2000: 69). They also argue that the current global economy is not truly global at all, as the international economy is still primarily characterised by exchanges among national economies (2000: 69). In the same vein Chris Brown (who avidly makes the case for a global community) states that globalisation is necessary for global community, but not sufficient (2000: 454). In other words, in order to move towards a greater global community, globalisation must be present, but just because it is present does not guarantee a robust international participation. Indeed most literature on globalisation is cautious at best about the true extent of globalisation. Assertions about a global community and a global democracy are perhaps more myth than reality.

However theorists such as Jeffrey Ayres contend that there is an increased concern, acknowledgment and activity among people, especially in the developed world, about various global issues. In particular this growing activism is often fuelled by and centred around a reaction against neo-liberal globalisation and its effects (Ayres 2002). Hence the protests which occurred in Seattle during the 2000 World Trade Organization meeting when activists from all ends of the spectrum came together to protest global expansionism. However it is important to note the distinction between those that are opposed to globalisation on the grounds that it jeopardises national interests, domestic jobs and so on, and those that are wary of the potential for unchecked exploitation by multinational corporations and the like. Ayres distinguishes two groups. The first seeks to “de-ratify” the world entirely, to rid the world of all trade regimes; the second is amenable to working within international accords but wants them to have social justice provisions “with teeth” (Ayres 2002). The former reject globalisation in any form, while the latter believe that globalisation has the potential to be an acceptable and even beneficial process.

The latter group is more interested in global community and global democracy, yet debate persists over how widespread this phenomenon actually is and the extent of its influence on global issues such as access to Aids drugs by developing countries. First, while a greater interest in international issues has been noted in terms of membership of organisations, activism and awareness, participation has mostly been by a well-educated and affluent elite in the developed world. The tendency, according to Ayres, is for the general public to have a heightened awareness at key moments such as during the WTO protests in Seattle. Most of the rest of the time these issues are difficult to discuss and frame for a mass audience (Ayres 2002). The evidence does not seem to support the contention that widespread social movement activity is on the increase, and it appears that the existence of a global community has been overstated. Instead it can be argued that a limited global community is arising with the potential for further expansion in the future. The traditional Westphalian model of nation state interaction is changing, but the ultimate outcome remains to be seen.

The Primary Actors

South Africa caused a great deal of controversy when it considered buying generic Aids drugs from Cipra, an Indian pharmaceutical company which does not adhere to international patent norms. Cipra can offer drugs for 600 dollars per patient per year compared to at least 1,000 dollars per patient per year for drugs purchased from the big pharmaceutical companies. Along with Aids activist groups such as the Aids Coalition to Unleash the Power (ACT-UP) and the Treatment Action Campaign (TAC), the South African government argued that the ability of pharmaceutical companies to control who gets Aids drugs amounts to a form of global health care apartheid in which the mostly white “haves” in the developed world can benefit from life-saving drugs while the predominantly black “have-nots” in developing countries are decimated by the epidemic (Bull 1999). It is argued that the big pharmaceutical companies profit excessively from the sale of these drugs at the expense of the human rights and lives of those who cannot afford them, including mothers and young children.

The pharmaceutical companies have replied that their profits are largely ploughed back into further research to develop and improve Aids drugs and to find a vaccine. They argue that without limitations on generic drugs, no progress will be made in the development of new drugs to save or prolong more lives. Aids drugs cost hundreds of millions of dollars to research, develop, test and gain FDA approval, not to mention the costs of marketing, and the companies argue...
that they must be able to recoup these costs or further research will be impossible. They also observe that it is unjust for generic companies to profit from research and development done by others. In response to the concerns of the developing countries, many pharmaceutical companies have offered their Aids drugs at reduced prices, while at the same time offering to donate certain allotted quantities to countries in need. The first steps in this direction were taken in 1999 when, as part of a UNAIDS initiative, six major pharmaceutical companies agreed to an accelerated access program to negotiate the sale of Aids drugs at sharply reduced prices to poor African states (Maykuth 2001). While a few countries such as Senegal and Uganda have jumped at these offers, South Africa and many other Aids-afflicted countries remain sceptical, pointing out that the reductions are still not sufficient to make Aids drugs affordable to African health care systems.

Yet it seems that the generic threat has given the developing countries some leverage to break the monopolistic price controls of the pharmaceutical companies. In March 2001 the Pharmaceutical Manufacturers Association (PMA) of South Africa (a group which represents local companies and subsidiaries of major multinationals) brought a lawsuit against the South African government to prevent the health minister from importing and/or licensing the production of generic versions of Aids drugs. The suit was dropped after a public outcry (Maykuth 2001).

For its part, the US government, under the Clinton administration, took a stand against breaking the international patent laws. Vice-President Gore even worked to place South Africa on a special watch-list of countries receiving heightened trade scrutiny. This was dropped only after a slew of protests from Aids activist groups, particularly ACT-UP (Bull 1999). The US also offered to loan African nations as much as a billion dollars each to pay for Aids drugs. However these offers were rejected, primarily because African nations did not want to accrue even more debt.

Pharmaceutical companies are a powerful lobby in the United States. This is the main reason why the US has defended patent laws. Nevertheless, after a great deal of pressure, the Clinton administration eventually tempered its stand on patent restrictions. In April 2000 President Clinton conceded that Aids had the potential to destabilise governments and declared Aids a national and global security threat. In effect this gives responsibility for fighting Aids to the US National Security Council. In response to this proclamation Senate Majority leader Trent Lott, speaking for conservatives, declared that he did not consider Aids to be “our” national security threat, reaffirming the idea that health care is the responsibility of individual nations, not the global community (Myers 1999).

More recently, the administration of George W. Bush pledged 15 billion dollars over five years to fight Aids in fourteen of the neediest countries. This commitment came in the wake of failing diplomacy as the US struggled to gather backing to support its military intervention in Iraq. However scepticism about the pledge has been partially allayed by a bi-partisan congressional measure to increase Bush’s 2 million dollar-a-year pledge to the Global Fund to 1 billion dollars per year, after President Bush stated that the fund ‘has not proven itself’ (New York Times 2003). Furthermore the world Aids community had feared that the Bush administration’s emphasis on faith-based initiatives and abstinence-only education would pre-empt important prevention initiatives involving such measures as condom usage. In response to this fear Democrats successfully ensured that the House measure added the use of condoms to the list of the healthy lifestyle practices which the initiative seeks to promote, along with monogamy, marriage and faithfulness (New York Times 2003).

Controversy over the Bush administration’s policies on Aids came to a head when the anthrax and smallpox scares hit America. In the aftermath of the September 11th attacks on the World Trade Center, the United States was confronted with a bio-terrorism scare after letters contaminated with the virus resulted in several deaths. In the wake of this scare the Bush administration sought to ignore the very same patent laws and TRIPS agreements blocking African countries from accessing generic Aids drugs. By waiving the Bayer drug company’s patent the US would have been able to access greater and cheaper supplies of ciprofloxacin, a generic version of the drug that fights the anthrax virus (Clark 2001). According to the BBC Deepak Chatterraj, the head of the US arm of India’s Ranbaxy Laboratories, was approached by a US senator to see if the company could supply anti-anthrax drugs if necessary (Clark, 2001). India is a WTO member, but is still in a transition stage regarding the trade rules on pharmaceutical patents. This status allows it to make generic drugs regardless of patents until 2005. As fears over the prospects of bio-terrorist attacks on the US continue to mount, the push to immunise against such viruses as smallpox, among others, may lead to further pleas to break patents and use generic medicines, a major U-turn from past US policy (Clark 2001). Thus, despite the 15 billion dollar pledge, sceptics still argue that there is a double standard in what the Bush administration defines as a national emergency or other circumstances sufficient to justify waiving the TRIPS agreements.

Civil society has fought very strongly in the Aids drugs debate. TAC and ACT-UP are two organisations that have pushed very hard to ensure access to Aids drugs in Africa (IRIN 2000). The European Union, the World Health Organisation, the National Aids Council in France and Doctors without Borders have all begun raising awareness for the cause. Ralph Nader’s Citizen Action Group has also protested America’s protection of WTO clauses forbidding patent infringement (IRIN 2000). In response to Clinton’s proposal to make loans to African nations to defray the cost of Aids drugs, a coalition of concerned advocacy groups lobbied against the idea. In a letter to President Clinton the Advocacy Network for Africa (ADNA) wrote:

The US, through loans from the Export-Import Bank, is asking African governments to mortgage the future of their peoples by taking on increased debt, at commercial rates, to pay for badly needed medicines to address the HIV/Aids pandemic…. At a time when international pressure, and G-8 commitments, have focused on lifting Africa’s crushing debt, what Africa needs is grants, not new loans. (source?)

Indeed, to take this argument a step further, more debt cancellation for Africa could actually serve as another means of freeing up vitally needed funds to put towards public health campaigns.

In recognition of the need to create a centralised outlet for all NGOs and IGOs engaged in HIV/AIDS advocacy, a call to create a Global Aids Fund was first issued in July 2000 at the G8 summit in Okinawa. Due to concerns that a focus on HIV/AIDS alone neglected other related, debilitating
diseases, the fund sought to take a holistic approach to fighting HIV/AIDS by linking it with tuberculosis and malaria. The G8 leaders endorsed the international development targets for HIV/AIDS, tuberculosis and malaria (Global Fund to Fight Aids, Tuberculosis and Malaria 2003), and in April 2001, the UN Secretary-General issued a call to action for the creation of a Global Fund to fight HIV/AIDS. Also in April 2001 African leaders at a summit of the Organisation of African Unity (OAU) in Abuja, Nigeria, endorsed the need for greater efforts to fight HIV/AIDS on the continent, and committed their leadership to the cause.

Brazil: The Generic Approach Coupled with Support Services

Brazil is often cited as an example of a developing country in which the importation, production and distribution of generic Aids drugs does work. Brazil both imports and manufactures such drugs and distributes them free to its citizens living with HIV and Aids. Brazil has confronted the problems of non-adherence by training its nurses and doctors to stress adherence concerns to patients and to monitor their progress (Rosenberg 2001). Despite being put on America’s WTO violator hit list alongside South Africa, Brazil has stuck with its programme. However Brazil’s situation is often said to be too different from that of many African states to provide an example of how to tackle the Aids drug issue in Africa. Brazil has far fewer infected people in both absolute and relative terms compared to most African states, and especially South Africa. The situation in South Africa and many other African states is so overwhelming that the government has all but abandoned any Aids drug-financing scheme.

South Africa: Skepticism Towards the Treatment Approach

South Africa continues to receive mounting global criticism for its unusual approach to the Aids epidemic. In addition to flirting with dissident Aids theories President Thabo Mbeki has been reluctant to provide Aids drugs to his people at any cost, arguing that the efficacy and safety of the drugs have not yet been proved. Instead he has concentrated on providing drugs for diseases such as tuberculosis. The approach appears is to treat Aids-related illnesses as they appear rather than treating HIV, the primary cause of these illnesses. Mbeki further argues that Aids is not a disease itself, but rather a collection of poverty-related illnesses which have existed in Africa since well before the age of HIV/AIDS. His policy is: treat poverty first and that will cure Aids (Swarts 2000: 1). However the reality is likely to be the opposite. HIV/AIDS will greatly increase poverty as the productive population dies off, crippling business and leaving behind millions of destitute Aids orphans and other dependents.

However it is politically understandable why Mbeki prefers to deny Aids and blame poverty. Even if drug prices were significantly reduced the South African health budget would be stretched beyond the breaking point trying to pay for Aids drugs for the several million people now living with HIV and Aids. Moreover the drugs would only prolong the lives of these people, and arguably give them more time to spread the disease to others. President Mbeki has been attacked for his unwillingness even to provide drugs to prevent mother to child transmission (Swarts 2000: 1). Yet, when confronted with a health epidemic of this magnitude, perhaps the bigger picture must be viewed if the epidemic and ensuing increase in poverty rates is to be staved off in the future.

Aids Drugs to South Africa and the Global Community

As the preceding discussion makes clear the issue of Aids drugs has attracted a great deal of international attention. A broad spectrum of national and international players have pushed the issue to the top of the world agenda. In terms of the global community the Aids drugs debate thus illuminates some of the important difficulties in assessing the nature of this community. On the one hand it can be argued that neo-liberal globalisation, in the form of the global expansion of multinational pharmaceutical corporations, has been allowed to expand free from any regulatory frameworks, and with the support of powerful national governments. The United States, for example, has until recently supported the pharmaceutical companies. This support could be viewed as a loss of national control over imperialistic economic expansionism. On the other hand it could be argued that the US has made this support their particular policy preference and that without their backing the multinational pharmaceutical corporations would be forced into concessions. More recently, however, America’s admission that Aids is an international security issue and its pledge of 15 billion dollars to fight HIV/AIDS are evidence of a reconceptualisation of the epidemic as an international issue and a recognition of the common identity and common interests of the US and Africa. As problems within national borders continue to spill over, particularly moving from peripheral to core countries, it is clear that international issues can only be ignored for a time, as the American policy revamps illustrate. However Bush’s wavering on the TRIPS agreement when his own country’s health was threatened elucidates one of the dangers that undermine international regulations and the idea of global participatory democracy. States are likely to follow international law only when it serves their interests and ignore it, if they have the power, when it does not. The more a powerful a state is, the more likely it will succeed in serving its own interests.

Brazil and India add an interesting dimension to the debate. These two cases represent alternative voices from marginalised but powerful developing countries. Brazil and India have chosen to challenge the existing global structures of the WTO through the production and distribution of generic drugs. In essence, they are demanding that teeth be added to the TRIPS agreements to give genuine merit to the escape clause in the agreement allowing for exceptions to be made in a time of crisis. South Africa has chosen “the road less travelled” in its Aids drugs policy, risking international criticism not only from the pharmaceutical companies and WTO states, but also from civil society groups who normally support the positions of developing countries. It appears that South Africa has succeeded in alienating every venue of advocacy, save for its own people. South Africa in this instance represents to some degree the struggle between the desire to claim universal values of human rights while at the same time wishing to protect group rights and avoid Western domination. South Africa’s position on generic drugs is to a large degree a call for recognition of human rights, as well as for the special rights of developing countries. Yet at the same time the South African government has asserted that it should be able to handle the situation from an African perspective without fear of criticism for this stance. Furthermore influential NGOs such as ACT-UP have visibly brought the Aids
drug issue to the fore, openly challenging American policy and American officials. These groups serve as actors working outside the interest of national governments. On the other hand the PMA, operating in the US and South Africa, illustrates the problems of Halliday’s concept of GONGOs (government controlled NGOs). He argues that GONGOs ‘use the appearance of independence to promote the goals of the state’ (2000: 438). However in this situation the PMA is not representing the goals of the state, but rather the goals of the pharmaceutical companies. Thus the claim that increasing levels of civil society activity will lead to some form of global governance or global participatory democracy are called into question by groups such as the PMA which are basically only fronts for special interests. On the other hand each interest deserves equal access to and representation within the system of global governance. As Halliday puts it, ‘not all that is “non-governmental” is civil’ (2000: 438).

Intergovernmental organisations such as the UN probably make the best case for a global community or global governance. They have sought to address the Aids drug issue through the creation of a Global Aids Fund as an impartial arbiter. The question remains, is it still nation states that control international policy, or can a case be made for the existence of a global community? The answer appears to lie somewhere in the middle. Nation states still play a powerful role, but with much pressure and guidance from NGOs, IGOs and MNCs. The situation is at best a case of McGrew’s liberal-democratic internationalism in which the primary actors remain nation states, but are joined together in a world community and held to certain predetermined standards.

In summary, through the Aids drugs debate, a definite case can be made for the existence of a global community and the prospects for a global participatory democracy. While the existence of a collective global will to address the crisis is readily apparent, the issue is still dominated by traditional nation state diplomacy, with a few extra players coming to the fore. The issue is a rapidly evolving one that will not disappear soon, as death tolls continue to rise in sub-Saharan Africa. It does appear that the collective efforts of a wide array of actors has contributed to numerous efforts to address the Aids drugs issue head-on. The US government has repeatedly reformed its original platform, ultimately debunking claims that the US has contributed little to help the developing world. Furthermore the large pharmaceutical MNCs have been railroaded into submission and have slashed the costs of their drugs in the developing world in response to threats to “go generic”. Thus the presence of such a wide array of actors could be viewed as the beginnings of a global community recognising common interests and a common identity.

The Role of Civil Society/IGOs

Britain’s stance fits well with this model. Britain does not support breaking patents. Instead, the British government has urged African nations to cooperate with the pharmaceutical companies and lobby for reductions in the cost of Aids drugs. In general, however, British media appear to have a slightly more liberal slant towards siding with African nations in their media reporting. Particularly, the article entitled “Evil triumphs in a sick society,” printed in The Guardian, February 12, 2001, the author Larry Elliot takes the developed world and the US especially to task for siding with the pharmaceutical companies. He points out that the US is trying to close the loophole allowing patents to be broken during national emergencies, stating that “If the HIV/Aids pandemic does not constitute an emergency it is hard to know what would.” The British media appear to use more of the world systems approach in reporting the Aids drug debacle.

all working together offers a unique case study in which, despite the disparate interests of these groups, there appears to be at the very least a dialogue and some positive outcome on the difficult task of providing Aids drugs to South Africa.

The role of the individual actors follows.

The Role of National Governments

A diverse group of actors with disparate interests has been brought together over this issue.

References


Production and International Marketing of Generic Drugs and the Fight Against AIDS in Africa

Abstract

The fight against the AIDS pandemic is one of the New Millennium’s major challenges, particularly in Africa which has a large number of HIV-carriers. The measure of success to be achieved in this fight will depend on innovations that will be done in the manufacture and marketing of drugs capable of treating the disease. However, manufacturing and selling such drugs are in themselves not enough; the drugs must be accessible to the people who need them most of whom are poor. The aim of this study is to explore possibilities of manufacturing and marketing generic AIDS drugs at affordable costs. Studying the production and marketing of AIDS drugs on the international market is important for two reasons. First, AIDS is spreading, with disastrous social and economic consequences for countries in search of growth and development opportunities. In Congo-Brazzaville, for instance, statistics show a sharp increase in the number of AIDS cases. In fact, from 1986 to 1999, the number of infected persons increased from 3,000 to 13,798, that is, an increase of 359.9 percent in 13 years. According to WHO (2002), only 5 percent of AIDS patients in developing countries have access to anti-retroviral drugs, that is, about 230,000 people. Half of those people live in Brazil. Africa stands out as the continent most affected by the pandemic. Indeed, Sub-Saharan Africa accounts for 70 percent of the world’s 40 million infected persons and only 50,000 patients can afford treatment, that is, less than 2 percent of the cases (Marchés Tropicaux et Méditerranéens – MTM, 2002). The second reason is that AIDS has been little researched and analyzed by social scientists, in spite of the magnitude of the pandemic and its catastrophic consequences (UNAIDS, 2002). Indeed, adequate multi-dimensional research should be carried out with a view to understanding the socio-economic dimensions of AIDS and identifying not only medical, but also social, economic and cultural solutions, among others, that could contribute to the eradication of the pandemic. This study focuses on two issues: the characteristics of the manufacture and international marketing of AIDS drugs, on the one hand, and innovative possibilities of reducing prices to make the drugs more accessible to poor countries, on the other.

1. Characteristics of the International Drugs Manufacturing and Marketing System

The international system is characterized by the concentration of production in a small group of corporations, and the weakness of the African pharmaceutical industry and market.

Global Supply of AIDS Drugs

The global supply of AIDS drugs is concentrated in the developed countries which have a quasi monopoly on production. In fact, almost ¾ of all AIDS drugs are produced in developed countries, particularly the US, France and the UK. India is one of the few developing countries competing with producers in the developed world. Its pharmaceutical industry supplies almost 24.39 percent of the anti-HIV products selected by World Bank experts. The table below illustrates the domination of corporations based in developed countries and highlights the strong dependence of developing countries, including African countries, in the manufacturing and marketing system put in place by a few major industrial groups in developed countries.

<table>
<thead>
<tr>
<th>Jean-Christophe Bougou Bazika</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty of Economic Science</td>
</tr>
<tr>
<td>Marien Ngouabi University</td>
</tr>
</tbody>
</table>

AIDS drugs supply on the international market is concentrated in developed countries where the major pharmaceutical production facilities are located. Hence, 75.61 percent of anti-HIV/AIDS drugs are produced by multi-national corporations based in industrialized countries. American pharmaceutical firms alone, located in the US, the UK and France, manufacture 31.7 percent of the drugs. This situation has an impact on drugs prices which are influenced by the industrialized countries’ monopoly on production and market outlets. The industrialized countries therefore have a clear edge over the developing countries.

Another characteristic of the world pharmaceutical industry is its tendency, since the mid 1990s, to pool production and research activities. Alliances and mergers between the major groups are occurring at both national and international level (Oppenchaïm, 2001). Such alliances and mergers are designed to strengthen the monopoly that increasingly fewer and fewer industrial consortiums have on patented drugs, and their financial acumen. This puts them in a position to release the enormous financial resources required for research and development.

Drugs Prices

Prices of AIDS drugs are generally high and therefore unaffordable to most patients in African countries, given their low levels of incomes. The estimated cost of treating an AIDS patient is 300,000 FCFA. In Senegal, the Government subsidized the purchase of generic AIDS drugs to the tune of 200 million FCFA. The cost dropped to 60,000 FCFA, thanks to state subsidies (UNAIDS, 2002). This is still quite high for poor households. Hence public health services should of necessity provide health care to AIDS patients in Africa and the cost of such care ought to be covered by the State budget. This would help guarantee a steady supply of essential drugs to health centres so as to alleviate the suffering of patients. However, African countries’ capacity to procure essential drugs on a regular basis is limited by budgetary constraints. There are glaring disparities in the distribution of funds between the North and the South. It is obvious that 90 percent of the overall AIDS funding is used to treat only 10 percent of the world’s AIDS patients.
living in the developed countries (MTM, 2002).

**The African Essential Drugs Market**

In the mid-1980s, WHO conducted a survey on the general availability of essential drugs in 104 developing countries. The results of the survey are relevant as they shed light on the current difficulties encountered by African countries in procuring AIDS drugs. About 70 percent of the population of 17 countries (including Nigeria) with a total population of about 200 million inhabitants did not have regular access to essential drugs. The World Bank’s estimates show that 60 percent of the population of Sub-Saharan Africa does not have regular access to the drugs they need. (World Bank, 1994).

In Angola, only 48 percent of health facilities are provided with the essential drugs required for treating patients. In Tanzania, difficulties faced by the Ministry of Health in financing drugs orders have resulted in significant shortages of drugs in hospitals, forcing the Government to resort to foreign aid to meet drugs supply needs in urban and rural areas.

The lack of a national pharmaceutical industry in most African countries leaves the latter with no choice but to import large quantities of pharmaceutical products at very high cost. In 1998, Congo-Brazzaville imported drugs worth 17.5 billion FCFA (UNDP, 2002). Even generic drugs are sold at prices which the majority of the people cannot afford. A recent survey revealed that the high drugs prices compelled approximately 33 percent of poor households to buy their drugs not from pharmacies, but from street vendors selling products of very doubtful quality (J.C. Boungou Bazika and R. Samba, 2002). About 3,000 generic drugs specimens are sold on the Congolese market. Public and private health facilities spend an estimated 30 percent of their operating budget on pharmaceutical products (UNDP, 2002).

Profit-making private health facilities encounter less difficulties in procuring drugs. They have the necessary resources for purchasing at high cost, drugs needed by their limited clientele which comprises well-to-do households living in urban areas. Multi-national pharmaceutical corporations prefer to work with private operators who have a higher purchasing power. In Niger, for instance, drugs sales increased to 46 percent in Niamey, and to 35 percent in the chief regional towns, whereas 80 percent of the people live in rural areas (World Bank, 1994).

**The African Pharmaceutical Industry**

The African pharmaceutical industry is still teething, compared to that of Western countries. Similarly, the marketing of drugs is still very limited in comparison to that of some developing countries in Asia and South Africa.

The above data illustrates the limited production and marketing capacity of the African pharmaceutical industry. The production capacity of the 3 African countries account for only 27 percent of the total production, representing half of the production of Malaysia’s pharmaceutical enterprises. The gap is even wider in terms of sales. The percentage of pharmacies with a license is derisory; only 13 percent of the pharmacies in the three African countries have licenses, compared to 43.9 percent of pharmacies in Malaysia alone. The weak position of the African drugs industry is due to lack of the capital and human resources required for setting up a pharmaceutical industry. This also accounts for the insufficient number of licenses granted to drugs marketing agents (suppliers and pharmacies). The problem is compounded by the fact that African pharmacies tend to be concentrated in urban areas, deserting the rural areas that are more densely populated, but with a low purchasing power. It is self-evident that the number and quality of experts involved in the manufacture and marketing of pharmaceutical products is of paramount importance. For instance, Glaxo, the multi-national pharmaceutical corporation, employs 16,000 researchers and 40,000 salesmen. These figures underscore the decisive role played by human capital (Oppenchaim, 2001).

However, the existence of drugs manufacturing enterprises in African countries (Tunisia, Uganda, Zimbabwe, Kenya, Ethiopia and DRC, among others) is a first step towards the establishment of a genuine pharmaceutical industry akin to that of India and Brazil, which could in future constitute a base for large-scale production of generic drugs.

Brazil is a showcase in this regard. As a matter of fact, 8 out of the 12 AIDS drugs used in the country are produced locally. Brazil’s high production capacity makes drugs available to patients at low cost. This has cut by half the number of AIDS-related deaths. Since 1996, the AIDS mortality rate has dropped by 73 percent, while the number of reported cases has fallen by 2/3 enabling Brazil to save US$470 million on its health budget (Lethu, 2001; WHO, 2002).

**The Role of the World Trade Organization (WTO)**

The WTO plays an important role in the manufacture and international marketing of pharmaceutical products by regulating the issue of patents and licenses. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) protects patents and one of its articles (Article 30) provides for “limited exceptions to the exclusive rights conferred by a patent”. However, the article further provides that the said exceptions apply on condition that “they do not unreasonably conflict with a normal exploitation of the patent and do not unreasonably prejudice the legitimate interests of the patent owner” (Tethu, 2001).

This clearly means that the manufacture of generic drugs, including AIDS drugs, is protected by patents and therefore comes under the exclusive jurisdiction of the corporation that has ownership of the patent. Since the overwhelming majority of pharmaceutical corporations are based in developed countries, they have a real monopoly buttressed by WTO provisions regarding intellectual property rights. Whenever a developing country manufactures an imitation drug without the authorization of the patent holder, it is in breach of WTO regulations and can be prosecuted. That was the case with South Africa which recently had a dispute with some pharmaceutical corporations because it was manufacturing imitation AIDS drugs without those corporations’ authorization. Brazil had the same problem at WTO.

**Possibilities of Reducing Prices and Increasing Global Access to Generic Drugs**

Manufacturing generic drugs in developing countries and selling them to African countries poses certain problems which should be studied in an in-depth
manner with a view to identifying ways and means of providing quality treatment at lower cost.

The use of generic drugs continues to pose a problem at the international level. The problem has two dimensions: safety and accessibility.

**Safety and Accessibility**

Regarding safety, there is still no international harmonization system capable of guaranteeing both the quality of drugs and their effectiveness in treating HIV symptoms. Hence the doubts cast on the effectiveness of Nevirapine, one of the drugs used to prevent HIV transmission from mother to child. It is important to note that HIV transmission from mother to child is one of the most common modes of infection. It is estimated that 600,000 children worldwide are infected every year during pregnancy (WHO, 2002). In 1997, the University of Makerere (Uganda) and Johns Hopkins University (USA) jointly conducted a study to test the effectiveness of Nevirapine in preventing AIDS in new-born babies. The results of the study were positive and WHO approved them. That study was important because Nevirapine is one of the low-cost retroviral drugs that are accessible to low-income African households.

**The Role of the Internet**

The internet can be a very useful tool for scaling down drugs prices. In fact, drugs bought on the internet seem to cost at least 20 percent less than their normal market value. African drugs importers could avail themselves of this opportunity. In Germany, where such e-business has already been experimented, an internet pharmacy with 1.8 million clients has been set up. That system has enabled health insurance companies to save $US363 million (WHO, 2002). African countries, with their growing internet services, could draw inspiration from the system. Public and private drugs procurement agencies could reduce their prices by ordering directly on the internet.

**The Role of United Nations Agencies**

United Nations, particularly WHO, can play a decisive role in the fight against AIDS, similar to the role it has played and continues to play in eradicating certain diseases in Africa, such as measles, poliomyelitis, tuberculosis and leprosy, among others.

This project, initiated by the World Bank, is of paramount importance. In fact, the World Bank, in partnership with such UN agencies as WHO, UNICEF and UNAIDS, and the Pharmaceutical Inspection Cooperation Scheme, has set up a project aimed at financing the supply of retroviral and other drugs that treat AIDS opportunistic infections. That project will enable UN agencies to assist countries experiencing difficulties because of the high drugs prices. An invitation to tender for selected products has been published and some multi-national corporations have already responded (see list in annex). Considerable progress seems to have been made in that initiative which was launched in October 2000. It draws inspiration from the HIV vaccine trials supported by UN agencies and is expected to make essential drugs more accessible to a large number of developing countries, notably African countries.

**Debt Relief and the Fight against AIDS**

Funds from the joint World Bank/IMF HIPC (Heavily Indebted Poor Countries) Initiative could also be used in fighting AIDS. In this regard, one of the requirements for eligible countries to benefit from HIPC relief could be that they adopt an AIDS control policy whereby the funds that should have been used to service the external debt are reallocated to the fight against the pandemic. Such funds would then be used for purchasing large quantities of drugs and setting up adequate structures for effective treatment of all infected persons.

**The Role of Private and Public Corporations**

The big private and public corporations should also develop a health care system for their staff, that would prevent HIV infection and treat reported AIDS cases. This is necessary since the cost of treatment would be far lower than that of replacing infected staff, particularly where the infected workers are executive officers who, by virtue of their training and experience, cannot easily be replaced. Even when they can be replaced, this would be too expensive for the corporation, in view of the considerable financial resources and time required for training a senior executive officer or a highly qualified worker.

**Breaking the Monopoly on Drugs Supply**

International regulations could be adopted to oppose drugs manufacturers’ cartels so as to guarantee fair competition in the pharmaceutical sector. Anti-trust laws should be enacted to prevent mergers and alliances designed to control the drugs market and to impose monopoly prices. Admittedly, fair competition in the sector will trigger a drop in prices of pharmaceutical products, including AIDS drugs of course. This would be beneficial to African AIDS patients since a large number of destitute patients would thus have access to treatment.

**Relocation of Drugs Supply**

Experience has shown that essential drugs manufactured in developing countries are less expensive than those manufactured in developed countries. This is true of drugs manufactured in India and Brazil. Relocating drugs manufacturing facilities therefore would seem to be beneficial to patients if the said facilities were relocated from industrialized countries to developing countries. It is thus important to know the measures that could encourage and facilitate such relocation.

Such measures could include tax and customs exemptions on imports of equipment. The host country could also assist by providing appropriate land for the drugs production unit and also contribute in facilitating the establishment of production subsidiaries. Clauses could also be inserted in regulations obliging pharmaceutical firms to relocate production units. Brazilian legislation contains such clauses. In fact, Article 68 of the said law, obliges firms exporting their products to Brazil to build a local production unit within three years of the granting of an export license.

**Development of a South-South Trade in Drugs**

Importing retroviral drugs from developing countries seems to be one of the strategies envisaged by African states for reducing the cost of treatment and making drugs accessible to patients. Côte
d’Ivoire has decided to purchase its drugs from countries like India and Brazil. Burkina Faso has adopted the same strategy. South Africa has opted to establish a local retroviral drugs manufacturing industry. Such an industry would help meet not only the drugs needs of South African hospitals, but also those of a good number of African countries through drugs exports.

**Revision of Certain Protective Provisions relating to Intellectual Property Rights**

The protectionism supported by developed countries is an obstacle to the manufacture and marketing of generic drugs in developing countries. Such protectionism prevents price reductions since Western pharmaceutical corporations, by manufacturing the drugs in developing countries, could reduce production costs and thus sell the drugs at lower prices. The question here is how to attain that objective. It is possible to increase the number of unpatented generic drugs or at least to set a timeframe beyond which the generic drugs could be produced and marketed freely on the international market. Such a decision presupposes multilateral negotiations between the drugs manufacturers, the governments of the developing countries and United Nations agencies.

**Promotion of Medical Research**

The promotion of medical research is crucial to the fight against AIDS. Research aimed at finding drugs that could contribute in treating the disease must be prioritized by public authorities. Such research could lead to the discovery of alternative products that are both inexpensive and better adapted to symptoms of the disease in each country or group of countries with the same epidemiological traits.

The exorbitant prices of drugs are a result of the monopoly that a few multi-national corporations have on research. It is important to understand that the funding of medical research by African countries is one way of curbing such monopoly. The benefits accruing from such research are by far greater than the social and economic cost of AIDS.

**Conclusion**

We have seen how the industry and international market for pharmaceutical products, notably those meant for treating AIDS, is organized. The pharmaceutical industry and market are mainly characterized by the monopoly that a small number of corporations have on them. Such a monopoly keeps drugs prices high and unaffordable for the overwhelming majority of patients. Several solutions can be envisaged, such as relocation of drugs manufacturing facilities, review of certain protectionist provisions relating to intellectual property rights, development of South-South trade in drugs, among others. What matters is, above all, to understand that African countries must develop their own pharmaceutical industry which is still in a rudimentary phase. The debate remains open and further research is needed to explore new avenues to adopting a genuine international drugs policy that would make AIDS drugs accessible to the poor.

**References**


ONUSIDA Groupe Thématique, 2001, Lutte contre le sida, meilleurs pratiques, l’expérience sénégalaise.


Ratanawijitrasin, S. and Wondemagegnehe E., 2002, Effective drug regulation, a multicountry study, WHO.

Living Conditions in Migration and HIV-infection High-risk Behaviour among Internal Migrants in the River Senegal Valley

Abstract

Studies on the spread of AIDS were quick to point to geographical mobility as one of the factors perpetuating the spread of HIV (Hunt, 1989; Anarfi, 1993; Kane et al., 1993; Pison et al., 1993). In Sub-Saharan Africa, where HIV is mainly transmitted by sexual intercourse, it is generally postulated that migrants tend to adopt high-risk sexual behaviour at their place of destination, thereby exposing both the contact population and themselves to infection. It is also believed that migrants continue with such behaviour on their return, aided by the force of attraction they exert on women of their community, thanks to their income which is higher than that of non migrants (Anarfi, 1993; Chirwa, 1997). Migrants pose an additional threat to their communities of origin because of the risk of infecting their spouses, thereby spreading the disease within their extended families in situations where levirate and sororate are practiced. One of the models mentioned in the literature explains the greater propensity of migrants to adopt high-risk sexual behaviour through their low perception of the risks and consequences inherent in their behaviour. This low perception, it would appear, results from pre-migration factors which make them more daring (age, sex, marital status, education, etc.), factors resulting from migration (separation from spouse or regular partner) and, finally, from the contact with a new environment considered stressful and more sexually permissive (Brockerhoff and Biddlecom, 1998). This paper seeks to test this model using the case of migrants from the River Senegal Valley, one of the high-mobility regions of the country and one of the hardest-hit by the epidemic. In this regard, we will be looking at migration trends inside Senegal during the 1985 – 2000 period, that is, since the first cases of HIV/AIDS were reported in the country. The paper rounds off by examining the implications of the findings for research and prevention strategies.

Literature Review on Migration and High-Risk Sexual Behaviour

A good number of surveys on the correlation between mobility and AIDS in Sub-Saharan Africa have brought out the tendency for migrants to have riskier sexual habits than non migrants – multiple sexual partners, recourse to prostitution or casual partners and failure to use a condom on a regular basis during sexual intercourse (Hunt, 1989; Packard and Epstein, 1992; Anarfi, 1993; Prison et al., 1993; Lalou and Piché, 1994; Chirwa, 1997; Lurie et al. 1997; Lydié and Robinson, 1998). Among the theoretical models that attempt to explain such risk taking is that of Brockerhoff and Biddlecom (1998) which draws from theories on behavioural change and the correlation between geographical mobility and adoption of new habits. These authors identify three types of factors accounting for the relationship between migration and AIDS which explain the high-risk sexual behaviour of migrants. First, there are the inherent characteristics of the migrants which have nothing to do with migration and which make them prone to riskier sexual behaviour, even if they did not migrate. Such characteristics include youthfulness, celibacy and the fact that one is male. The second type of factor has to do with characteristics that migrants acquire with migration, the most common being separation from the spouse or the regular partner. Finally, factors relating to the environment of desti-

Macoumba Thiam
Demography Department
University of Montreal
Montreal, Canada

nation also account for high-risk sexual behaviour. In their new environment, migrants have to adapt to different standards and to the existence of new sexual opportunities and constraints. These three types of factors influence the behaviour of migrants. Weakening their perception of the risks inherent in such behaviour (Brockerhoff and Biddlecom, 1998).

This approach is more relevant to migrant workers who have been a major vector in the spread of the virus in Southern, Eastern and Central Africa (Lalou and Piché, 1994). Faced with difficult working conditions, acute emotional and psychological isolation, due to separation from their spouses and regular partners, migrant workers, generally men, fall back on prostitutes in their host environment as these are directly accessible partners who do not require any proper integration in the host environment (Packard and Epstein, 1992; Anarfi, 1993).

With respect to migration in West Africa, the social and emotional isolation of the migrant is less pronounced than elsewhere on the Continent. Here, the migrant worker is often accompanied by the rest of the family, or they join him subsequently (Lalou and Piché, 1994). In addition, integration assistance networks made up of people from the same village, members of the same ethnic group, etc., provide a kind of cushion the newly-arrived migrant can recline on to cope with loneliness and stress, even though such a cushioning effect diminishes with subsequent migrations (Anarfi, 1993). Besides, these networks exercise the same societal control which exists in the place of origin, thereby reducing the stimulating effect which anonymity at the place of migration has on the high-risk sexual behaviour of migrants (Lalou et Piché, 1994). More specifically with regard to the “Vallée” region, Saez (2002), for example, found that societal control and influence of elders were present in the city (Richard-Toll). He, however, observed that such control and influence were counterbalanced by peer pressure in favour of multiple partners and the existence of enclosed houses where prostitution was practised with a certain degree of confidentiality. Frequent trips to the village also give West African migrant workers the opportunity to meet their spouses and regular partners, thereby alleviating the loneliness and isolation (Saez, 2002).

Internal migration from the River Senegal Valley thus offers an opportunity to explore all these aspects of migration in West Africa with a view to testing a theoretical model which integrates several types of traits in the same conceptual framework.
Data and Methods of Analysis

The data used in this paper is gleaned from the survey “Mobilité IST/ SIDA au Sénégal” [STI/AIDS Mobility in Senegal] (MISS). The data collection phase of the survey took place in January and February 2000 in two contrasting parts of the River Senegal Valley: the town of Richard-Toll and the Matam area. The following section gives a more detailed presentation of these sites. The MISS survey had a qualitative component and a quantitative one. The quantitative component involved a sample of 1,320 men and women, with ages ranging from 15 to 50 years, chosen on the basis of a sampling technique which was representative of each of the two areas under survey and the returnee migrants.

During this phase, detailed information was gathered on households, socio-demographic characteristics of the sample population as well as norms, beliefs, attitudes and knowledge on sexuality. All the instances of migration, both internal and international, from birth were documented. The survey also explored in an in-depth manner, living and integration conditions and sexual habits during the last internal and international migrations over the last fifteen years before the survey as well as short trips made during the last three months.

In this paper, we are going to limit our analysis to the last internal migration which took place within the last 15 years before the survey, that is, since 1985. This date corresponds, more or less, to the time when the first cases of AIDS were reported in Senegal. Internal migration is defined as a stay of at least six months in a part of Senegal other than the province of residence at the time of the survey. Although the survey covers the last 15 years, the last waves of internal migration are not the less recent for that. More than a third of them took place during the last five years and about 70% during the last years. Besides, we will be examining only internal migration of men, that is, 123 migrants in all, because of the low number of women who admitted to having indulged in high-risk sexual behaviour during their last migration. A migrant is considered to have had high-risk sexual behaviour if he had sexual intercourse with a casual partner or a prostitute at any time during his last internal migration. Because the use of a condom during these encounters was not taken into consideration, the risk assessed here is more potential than real. As such, we will henceforth use the expression “comportement sexuel potentiellement à risque” [potentially high-risk sexual behaviour] borrowed from Piché et al. (2002).

A logistic regression will be made on potentially high-risk behaviour with independent variables relating to migrants before departure and to their living and integration conditions during migration. The model does not include awareness of the danger of AIDS at the time of migration since date on such awareness was not gathered during the survey. Finally, because of the low number of persons interviewed, we will limit the independent variables to be included in the model to the most significant in terms of the theoretical model to be tested. All these variables are discussed in the “Results” section.

Presentation of Study Sites

The MISS survey concerned two sites of the River Senegal Valley: the town of Richard-Toll and the Matam region made up of the town of Ourossogui and the villages of Bokidiawe and Doumga Ouro Thierno. The choice of these two sites was based on the following criteria:

1) the longevity and intensity of geographical mobility in this area;
2) the peculiarity of their epidemiological status with regard to sexually transmitted infections (STI) and AIDS;
3) the contrast between the two sites which allows for a comparative study (Piché et al., 2002).

Geographical mobility of population is an age-old and intense phenomenon in the River Senegal region (Bâ, 1996). The findings of the MISS survey reveal, inter alia, that 56% of interviewees of both regions have made at least an international or an internal migration during the last fifteen years or made a short trip during the last three months before the survey. As many as 70% of men in Matam migrate. Migrants from Matam, more often than not, move to countries with high HIV-prevalence rates (Côte d’Ivoire and Central African countries) and major Senegalese towns (Dakar, Saint-Louis, Thiès, etc.). Inhabitants of Richard-Toll also migrate to other towns in Senegal, but international migration is mostly to neighbouring Mauritania. As opposed to Matam, Richard-Toll is a centre of attraction for migrants from the rest of the country and even from neighbouring countries, all attracted by its agro-industrial complex. Moreover, Richard-Toll is more urban, has higher school attendance rates and is more heterogeneous in terms of ethnicity than Matam. But the two regions share the same norms with regard to marriage and sexuality and have Islam as religion for almost all their inhabitants. In principle, sexual intercourse is acceptable only in marriage, but the findings of the MISS survey show that a significant proportion of persons interviewed confessed to pre-marital sex (40%) and extra-marital (10%) of men. Finally, levirate and sororate practices are accepted in the region (Piché et al., 2002).

With regard to epidemiology, the scanty statistics available on AIDS in the River Senegal Valley suggest that HIV prevalence here is higher than the 1.77% national prevalence rate recorded at the end of 1999 (UNAIDS, 2000). Migrants are some of the hardest-hit in the area. A study carried out in 1989 in the Matam area by Kane et al. (1993) found that the HIV-prevalence rate was eleven times higher among international migrant workers (5.4%) than among non migrants (0.5%) in a sample population representative of the whole area. In another sample comprising only returnee international migrants and wives of international migrants, the prevalence rates were 27% for men and 11.3% for women.

Results

The results presented concern a sample of 123 men who made an internal migration during the last fifteen years before the survey. An internal migration is defined as a stay of six or more months inside Senegal in a province other than the province of residence of the interviewee.

Description of the Sample of Internal Migrants

Table 1 classifies internal migrants according to some socio-demographic criteria and according to the area under survey. The table shows significant disparities between Richard-Toll and Matam. On the whole, migrants from Richard-Toll appear to be older, more educated and fewer in married numbers than those from Matam. Internal migrants of both regions also differ in terms of ethnicity (Pulaar majority in Matam and Wolof majority in Richard-Toll) and level of participation in economic life. Almost all the returnee migrants of Richard-Toll and 85% of those of Matam were working at the time of the survey.
For purposes of a better grasp of the acquisition of new characteristics as a result of migration along with the living and integration conditions at the place of destination, we have defined a number of variables aimed at operationalizing the concepts of social environment, social isolation, emotional isolation and economic insecurity.

The migration environment is operationalized by the region of destination with three variables: “Dakar” (national capital), “Saint-Louis” (administrative capital of the region in which the two sites of the survey are located) and “other regions”. Emotional isolation is assessed in terms of whether or not the migrant lives with a regular partner at the place of migration (spouse or fiancée/friend). Social isolation is assessed in terms of whether or not the migrant was accompanied by a relative, a friend or someone from the same area or whether or not the migrant was assisted by one of these persons in the search for accommodation and/or work. Economic uncertainty is judged on the basis of occupation during migration. Table 1 presents a classification of these variables as well as that of the “potentially high-risk sexual behaviour” dependent variable according to area of residence.

All these variables will be built into a logistic regression model determined by the age at the time of migration, the level of education and the region of origin of migrants. Because of the low numbers interviewed, we will not present separate models for Richard-Toll and Matam, even though the two regions are quite distinct socio-economic and, to a certain extent, cultural entities. The inclusion of the “area of residence” variable (Richard-Toll and Matam) in the model should, however, address any possible problems arising from this choice.

**Distribution of Sample According to Migration-based Variables**

Table 2 presents the distribution of characteristics of the last internal migration as well as that of the “potentially high-risk sexual behaviour” dependent variable according to area of residence. Like Table 1, this table shows some disparities between the two areas under survey for most of the variables.

Table 2 shows a more or less even distribution of migrants from Richard-Toll in terms of destination whereas Dakar is the principal destination for migrants from Matam. In both areas, the majority of migrants are young people (less than 25 years old) and single persons (single men and women, divorcees, widows/widowers). The majority of migrants lived in emotional isolation (absence of a regular partner at place of migration), particularly those of Richard-Toll. Conversely, the vast majority of migrants (more than eight out of ten) received assistance from networks of friends and people from the same area of origin and in matters of accommodation and/or economic integration. Finally, the majority of migrants were employed during the period of migration although a significant proportion of them was unemployed.

**Results of Multi-variables Test**

Table 3 presents the results of the logistic regression of potentially high-risk sexual behaviour on living conditions during migration as tempered by education, age at the time of migration and area of origin of migrants. Of all the variables considered, only marital status at the time of migration and emotional isolation at the migration destination (living without a regular partner) significantly influence “potentially high-risk sexual behaviour.”

All things being equal, men who migrated as bachelors, divorcees or widowers are 20 times more likely to indulge in potentially high-risk sexual behaviour than married migrants. Similarly, a migrant who does not live with a regular partner (spouse, fiancée, girlfriend) at the place of migration is 16 times more likely to see prostitutes or have sex with casual partners than migrants living with a regular partner. Contrary to expectation, area of destination does not influence the propensity to indulge in high-risk sexual behaviour even though the way migrants perceive sexual freedom at the place of destination varies significantly from the way it is perceived at the place of residence. Similarly, none of the other variables turned out to be significant.

**Discussion and Recommendations**

Literature on the correlation between geographical mobility and AIDS considers migration as a process that goes hand-in-glove with high-risk sexual behaviour as a result of a number of factors relating to the migrants, some independent of migration and others arising from situations created by migration. It is, however, important that any attempt to design and implement effective AIDS prevention schemes should identify some of the numerous factors which contribute in the most significant manner to risk taking and which are the most relevant to be addressed. The case of internal migrants of the River Senegal Valley studied in this paper thus reveals that out of all the factors advanced in the theoretical model tested, only marital status at the time of migration and emotional isolation during migration explain risk taking. None of the other factors, in the final analysis, actually influences the high-risk sexual behaviour of migrants.

Surely, these findings show that the economic uncertainty and the physical and psychological stress at the place of migration which are so often cited in literature do not necessarily or automatically lead to high-risk sexual behaviour. The recourse to prostitutes or casual partners seems, first and foremost, to be a reaction to the lack of an alternative in a context where the migrant is separated from his regular partner. This hypothesis is further vindicated in that the mere fact of being married at the time of migration reduces significantly the likelihood of indulging in sexual escapades. This difference can probably be explained by the reunion with the spouse during the frequent trips home which Saez (2002) talked about, which trips break the emotional isolation.

This conclusion has two implications both at the level of research and at the level of action. First, it goes to confirm further that the hypotheses which depict migrants as necessarily risk-prone are to be taken with a pinch of salt. The said hypotheses throw light on a situation which arises from migration, namely, emotional isolation, as the main reason why migrants take risks. Second, there is a need for further data, particularly qualitative data, to understand the context in which separation of spouses takes place in order to put migrants from the River Senegal Valley region on their guard against risks relating to their sex life. With regard to programmes, this equally implies that action, beyond mere messages aimed at prevention and improving the living conditions of migrants, is necessary to achieve change of behaviour.

1. The correlation between some cultural practices such as levirate and sororate and the spread of AIDS in Africa is increasingly being questioned, *inter alia*, by ethnologists (see, for example, Taverne, 1996).

2. Subsequent papers will examine the other aspects of geographical mobility in relation to sexual behaviour in the River Senegal valley.
3. In-depth interviews with the few female migrants who admitted to having had high-risk sexual behaviour while in migration would have enabled us to understand these findings better. If such interviews were to show that the experience of these women is altogether run-of-the-mill, there is every reason to believe that the other women did not disclose everything about their high-risk sexual behaviour. If, on the contrary, it turned out that the story of their lives is peculiar to them, that could explain their high-risk sexual behaviour, thereby “validating” the testimony of the other women.

4. In 2002, an administrative reform raised Matam to an independent region from Saint-Louis. Richard-Toll, for its part, is still part of the Saint-Louis region.

5. The odd-ratio value is overestimated because of the low number of persons interviewed.

References


Kane, F. et al., 1993, “Temporary Expatriation is related to HIV-1 infection in rural Senegal”, in AIDS, 7: 1261-1265.


Modification of Affective Ties and HIV Infection: A Sociological Study of the Spread of HIV Infection in African Societies

The Problem

These last decades are witnessing the appearance in the world of a deadly, complex virus. Its consequences on the population are beyond telling: thousands of people dead, infected, affected. The efforts summoned to curb the spread of the virus in the social fabric seem insignificant as compared with the enormity of the problem. In countries of the South, more than anywhere else, the death toll is unnerving. According to UNAIDS, 42 million people are living with HIV/AIDS in the world today. Five million of them contracted the virus in the course of last year. The epidemic continues to take a heavy toll on sub-Saharan Africa, with 29.4 million cases1. With respect to Burkina Faso, from ten cases in 1986, official statistics2 put the figure at 13,899 cases as of 30 June 1999, and today, the HIV prevalence rate is estimated at 7.17% of the general population (WHO/UNAIDS), that is, more than 370,000 people infected with HIV, about 7% of them being young adults from 15 to 40 years old… At this critical point in the spread of the scourge, it is, more than ever before, incumbent upon sociology to sound the best points of view to understand the social determinants which underpin this phenomenon. Yet this subject continues to puzzle scholars.

In going through the extensive literature on the problem of AIDS in Africa, one is struck by the recurring question as to what scientific approach to adopt in the face of this research subject. From the epistemological standpoint, the demands of scientific rigour which lead to objectivization of objectivization (Bourdieu P. 1980) are still topical. Such objectivisation raises the question of commitment and distance in the face of social realities as recommended by Elias and echoed by Fassin in another field
(Fassin; D. 1999), and which have been highlighted innumerable times for anyone interested in scientific research. The sense of urgency prompted by the magnitude of the epidemic in Africa and, above all, the wholesale application of some conceptual, theoretical and methodological frameworks spawned in other lands or in other historical contexts—therefore, fraught with ideology—in the apprehension of social phenomena contexts—therefore, fraught with ideology—spawn in other lands or in other historical contexts, is a research project, advances a historical dimension in the analysis of sexual relations, which alone can explain the progression of HIV infection.

The first step is to refute the reduction of the relationship between the sexes to mere sexual valences. Common sense shows that the direct cause of transmission of the virus is sexual urges, and, by direct extrapolation, “sex”. To our mind, this fallacy which is practically accepted as an absolute truth comes from the Freudian theory of child sexuality (Freud, S., 1962) which lays emphasis on the biological and desire-related aspect of sex. According to Freud, sex is the expression of a strong biological urge which the individual tries at all times to satisfy directly or indirectly, the only checks being the constraints, mostly external which society imposes on him. The pre-eminence given to the biological and erotic basis of sex is criticised by a good number of scientists (Bozon, M. and Leridon, H., 1993). For, sexual activity is neither natural nor biological; it is a social construct. Moreover, considering the bare sexual attraction, that is, singling them out, amounts to eliminating the influence of the entire affective system on the latter, thereby taking away the very means of understanding the historical development of sexual relations, which alone can explain the historical significance of sexuality and that of HIV infection.

Is it possible to isolate from the structure of sexual relations the determination of emotional structures in their entirety to retain only the effect of sexual urges? Is it not judicious to integrate them into the emotional structure in order to see how modifications of the whole affect them in a significant manner? We believe that by failing to adopt this approach, that is, by considering sexual attraction per se, we limit sexual relations to them and, by so doing, fail to grasp the influence of the entire emotional set-up. Sexual urges per se do not give enough answers to the analysis of sexual relations. We must seek to discover the importance of the dynamics of the affective system (in which sexual attraction is only one of the dimensions) for it is these dynamics that map out sexual relations to a considerable extent.

According to Leroi-Gourhan, such sexual attraction, which metamorphoses in the course of historical evolution, is to be found in all the depth of perceptions. Basically, he maintains, the idea is figuring out how a code of emotions gradually develops in time and space, which code gives the ethnic subject the purest form of affective integration in his society. This code of aesthetical emotions which is underpinned by ethnic memory and which draws from deep visceral and muscular feeling, skin sensations, the senses of smell, taste, hearing and sight, and finally, from the intellectual image which is a symbolic reflection of the sensory tissues in their entirety, is shaped, in the course of time, not only by material experience, but by the capitalist principles of the market economy as well (Braudel, F., 1979; Marx, K., 1982) and these impose a perpetual reconfiguration or redefinition of sexual attraction. The resultant modification of ethnic memory, which can be clearly seen through the dialectics of individual experiences and mental structures (Bourdieu, P., 1981), automatically brings about a modification of emotional behaviours. Then the latter, influenced by the perception of values, forms and rhythm, and which constitutes the framework of relations between the sexes, encounters the virus in the course of their manifestation: such is the historical dimension of the HIV infection. However, if we admit that the infection is the outcome of the encounter of affective behaviour with the virus, what follows is for us to understand this “object” which is the virus, grasp its meaning, its performance force. In this respect, we should avoid considering the virus as being active in its own right. To define it methodologically as a singular object is to take away any active status from it. It should instead be seen as a function of For according to Elias, to understand representations, possible methods of definition or speeches individuals make on things, such things must lose the character of concept of action and become functional concepts (Elias, N. 1981). So, the “object” which is HIV, its method of action and manifestation and the speeches and representations which refer to it, take their meaning, their performance force from the transformation of human interdependences. Thus, from the infection through the etiology and the classification of symptoms to treatment and, above all the representations which refer to it, in a word, the “disease” phenomenon necessarily bears the traces
of human interdependence and historical social contradictions.

A second endeavour closely linked to the first is to state that even as the modification of emotional structures is going on, what Christian Falloix called the process of socialization is unfolding, that is, a mechanism which forever creates a belonging among things considered separate. We cannot overlook the fact that the control of sexual relations is more than a mere political challenge. This fundamental issue has always pitted in every society, the central authorities, the organs of state, against the social peripheral orders. But what is the real challenge, the basis of such opposition? If the immediate goal of this competition is to curb HIV infection as soon as possible, we think we are dealing here with the invention of a universal and acceptable vision of relations between the sexes, a modernity which is peculiar to African societies.

The depiction of African affective systems as being rigid and unable to cope with the emergencies of the day has led some analysts to explain the spread of HIV in terms of the inadequate efforts made by the state in the fight against the epidemic. Thus, the whole problem hinges on the drawing up of a multi-sector strategy to fight the epidemic, on the one hand, the strengthening of state standardization, on the other hand, and more specifically, regulatory initiative and involvement of civil society through community-based organizations. Such thinking amounts to asserting the pre-eminence or efficiency of the state in the regulation of African social structures, whereas the regulatory role of the state so much advocated as legitimate means of fighting the epidemic leaves a lot to be desired.

It is widely accepted that the spread of the virus in African societies is disquieting. What is less well known is the failure of government action plans aimed at rolling back the scourge. Why this failure? We believe that, basically, the crisis of the initiatives put in place to fight the scourge reveal the torpor of education and socialization structures. One would be mistaken to think that the technical mechanisms (condoms, adverts, etc.) intended to change social behaviour will succeed just because they are technical. That is not the case. The technical factor is never neutral; it is interpreted socially. (Braudillard, J., 1968), for its integration in social relations takes place, first and foremost, in a field of forces within which, as Serge Moscovici states, the object transforms and is transformed. He states that before entering the universe of an individual or a group, the object goes through a series of reconciliations with, and adjustments to, the other objects already present from which it borrows some properties and to which it adds its own. Becoming distinct and familiar, it transforms and is transformed... Indeed, it ceases to exist as such and is transformed into an equivalent of the objects (or notions) to which it is subjected through the relations and links established.7

However, this fight whose means and consequences are both the inculcation of the initiatives aimed at fighting the epidemic in customs and habits and the imposition of a universal and acceptable vision of relations between the sexes, continuously pits central forces against peripheral ones. This confrontation which is clearly seen through individual experiences, informs the body which is the seat of sexual attraction. The body being at the centre of social conflicts, the social determinants never influence it immediately by direct action on the biological order. They are relayed by the cultural order which re-configurates them and transforms them into rules, obligations, prohibitions, repulsions or desires, tastes or distastes.8 Accordingly, the representations as well as the practices which individuals come up with or make of their bodies and the bodies of others, that is, the way this body is used, bear the signs of these general social conflicts everywhere. This situation gives rise to links. For, even as the dynamics of the competition between antagonistic social orders unfold, new behavioural norms and relations between the sexes emerge.

Indeed, in the competition between the central authorities and those of the periphery played out through the federation of the latter to the “central civilisation,” the affective systems of the individual are profoundly influenced. Most often, at this stage, prohibitions strengthened by social penalties are imposed on the individual in the form of self-restraint. The compulsory suppression of urges and desires and the sense of decency which surrounds them integrate at this point with habits which the human being cannot shun... There develops an internal conflict in his subconscious between the urges and desires which promise pleasure and the prohibitions and restrictions pregnant with threats, the feelings of decency and social discomfort of social origin?9

Further, the invention of the modern code of social conduct, unstable and precarious in balance, which is the result of this historical process, first engulfs the dominant strata and then goes on to the broader and broader strata of the general social fabric. This modern code of social conduct which is always mutating finds its unstable and precarious balance in the fact that it bears the marks of historical level of separation of social orders and, above all, in the process of socialization as a mechanism which forever recreates belonging to entities considered separate. As Christian Palloix10 maintains, “social change is not just an affirmation of the separation, but that of the development, the conquest and reconquest of this uniqueness in the socialization process.”

Thus, it is only though the interplay of the modification of emotional structures and the pivotal role of the socialization process in the unification of peripheral social systems to the “central civilization” that we can understand the spread of the HIV/AIDS epidemic in African societies. Without such a perspective, one cannot grasp African modernity as an ongoing process.

**Methodology**

Studying the spread of HIV in African societies is a daunting task. The complexity of the subject is evidenced by the difficulty in choosing an appropriate methodology. For the purposes of this survey, we think it will be futile to try to hem the phenomenon into one discipline. The idea here is rather to break down barriers between the various disciplines involved forthwith in order to efficiently tap into the contribution of each of them. Hence, in our approach to the subject, we have drawn from history, biology, physiology, psychoanalysis, anthropology and economics. The second point, which is closely related to the first, is the consideration that a study of the spread of HIV infection should take into account the long duration. This reference to historicity is fundamental for it is thanks to it that we will, through an analysis of the dialectics of personal experiences and social structures, chart out the progress, through time, of the transformation of affective systems influenced by material civilization and the capitalist principles of the market economy. This historicity which profoundly influences the body, the seat
of affective values in all their dimensions, reveals at all times, that is, at every moment in time, the historical movement of separation and unification of peripheral social orders from, and with, the central civilization. This historical movement or this civilization process which has left its imprint on the body and which can be analysed, inter alia, through the transformation of family and religious structures, fashion in clothing, bodily care and methods of use, etc., profoundly and differently affects sexual attraction and social categories, leading to the encounter with the virus and, by the same token, the infection. So the analysis, mindful of making effective use of the data collection techniques set forth below (that is their advantages and disadvantages according the demands of field survey), will strive to relate these affective manifestations to history, that is, to constantly changing social configurations.

Survey Population
The survey involves individuals and institutions chosen on the basis of research needs. It involves:
- State institutions such as the National AIDS Control Committee (Comité National de Lutte Contre le SIDA), the Ministries of Health, Women affairs, PROMOCO, etc.;
- officials of associations and NGOs working in the areas of AIDS, women, the youth, etc.;
- officials of religious institutions (pastors, imams, priests, animists, etc.);
- people infected with HIV as well as persons not infected, without distinction of category;
- people whose occupation contributes to the invention and transformation of aesthetic codes (dressmakers, blacksmiths, joiners, etc.);

Data Collection Tools

Documentary Research
It will be very useful. The above-mentioned institutions have data which will be invaluable to us. Such data could be on the epidemic, its evolution, state initiatives to fight it, obstacles encountered, strategies implemented, prospects, etc. This official data will be relied upon and interpreted as and when appropriate.

Questionnaire
We used it with a view to gauging social practices. It will be used sparingly because of a number of shortcomings with regard to the effectiveness of the tool itself. This tool leaves out some important information because of its standardized format. Furthermore, making large-scale use of it is very costly. It is not indispensable in this kind of survey but it is important to a certain extent because it can be used to quantify some social or emotional bearings, which the individual experiences could reveal.

Semi-guided interviews
This data collection technique was largely used. The idea is to gauge in the spread of HIV, the impact of the transformation of aesthetic codes on the gender balance of power, which is the hallmark of historicity. Based on the dialectics of historicity, we try to carry out in-depth personal interviews with the above-mentioned target population.

Data Processing

Analysis
There are two methods of analysis depending on the data collection tools used. For the in-depth personal interviews, the analysis is manual. For surveys by questionnaire, the analysis is computerized. It should be noted that manual analysis has the advantage of bringing the researcher closer to his subject while computerized analysis has the advantage of matching a wide range of variables and doing so in a much shorter time.

Variable Test
This is the principal method of data processing. Jean Claude Passeron defines it as a technique which introduces, by multiple matching, new variables into an original equation of two variables in order to study the effects. The procedure seeks to monitor the effect on the primary relation of each of the sub-cases (subsets) corresponding to the different values of the new variable analysed. It is for this reason that the procedure is called a variable test.

1 Statistics culled from the bulletin of the “Agence Nationale de Recherches”, No 38, November/December 2003.
5 Leroi-Gourham, A., op. cit., P. 83
6 Official sources, op. cit.
7 Moscovici, S., La psychanalyse, son image et son public, PUF, Paris, p.61.
10. Palloix, C., op. cit., p. 6

Références
« 1981, Qu’est-ce que la sociologie? Clamecy, éd. Pandora.
The Role of Faith Healing in an HIV High-Risk Area: A Case Study of Balokole Churches in Masaka District, Uganda

Abstract

Diverse modes of health care — western bio-medicine, African traditional therapies, herbalism, Eastern mysticism and alternative therapies such as yoga and ayurvedic medicine, faith healing based on psycho-spiritual models, and many others — co-exist in most African countries (Last 1990, Turner 1968). Medical anthropologists (Kleinman 1980, Helman 1994) have suggested that three basic sectors of health-care can be identified: the popular sector, the folk sector and the professional sector. These sectors overlap and interact, but each sector has its own ways of explaining and treating illness, defining who is the healer and who is the patient and specifying how the healer and patient interact in their therapeutic encounter. Up to now research on health care in Africa has focused mainly on the folk and professional sectors. Yet the popular sector is very dynamic and is constantly evolving in response to contemporary social-cultural phenomena. This paper examines the role of contemporary faith healing in an HIV high-risk area. It is based on field research in Masaka District of southwestern Uganda on modern faith healing churches whose ideology emphasises supernatural, ‘miracle’ healing.

Several studies (Rwomushana 2000, Asiimwe-Okorir et al. 1997, Mulder et al. 1995) have attributed Uganda’s success in fighting HIV/AIDS to a rigorous multi-sectoral strategy combining holistic health care services with health education, information and communication directed at the rural and urban masses. Under the much praised leadership of the president of Uganda, government departments, public enterprises, non-governmental organisations, community-based organisations, multi-national companies and faith-based institutions have all joined hands to combat the epidemic with considerable success. HIV infection rates have fallen from as high as 38 percent to less than 7 percent. This paper focuses on the role of one sector in this multi-sectoral partnership, faith healing and miracle churches.

Why Study Faith Healing?

Balokole is a Luganda word which literally means “the saved ones.” It is used in Uganda for all born-again Christian denominations and many African independent churches. Becoming one of the Balokole requires a religious conversion often accompanied by dramatic spiritual/out-of-world experiences. At conversion a higher spiritual power, called the Holy Spirit, possesses the convert and gives him or her various abilities to overcome sin and the problems of this world. The vox pop

| Stella Nyanzi |
| Virus Research Institute |
| Medical Research Council of Uganda |
| Entebbe, Uganda |

in East Africa, particularly the print and broadcast media in Uganda, have been reporting a fast-growing contemporary social phenomenon of HIV/AIDS healing in Balokole churches (Nyanzi 2000). This is in direct contradiction to biomedical discourse, popularised through anti-HIV/Aids social marketing campaigns, which insists there is no cure for HIV/AIDS. The Balokole claims have caused mixed reactions: total disregard by biomedical scientists and academics, antagonism from other folk healers, curiosity from the media, and keen interest from diverse sectors of the population, particularly those who urgently need healing.

There has been a dramatic boom in the frequency of mass Balokole healing crusades as one component of expansionist evangelism at public rallies in Uganda.
Renowned evangelists from North America and Europe, as well as local Ugandan evangelists, have staged crusades, each one up to a week long, in major towns, cities and trading centres in the rural districts, where healing rituals involving prayers, songs, dances and testimonies of converts who claim to have been healed are major drawing cards. The most common illnesses treated at these meetings are bio-medically incurable illnesses, particularly HIV/AIDS and cancers. The Balokole phenomenon is important in the context of HIV/AIDS research for several reasons. First, statistics reveal a huge increase in the number of miracle-healing Balokole churches. Many of this is at the expense of mainstream denominations, but the dynamics of fusion and fission also help Balokole congregations to mushroom. Internal conflicts resulting in splinter groups are common. The break-away groups are often led by a member of the original congregation who believes that he or she has been gifted with healing powers but feels unable to fully utilise these powers in the original congregation. In addition a number of behavioural intervention programmes, condom acceptability research studies and sexual risk reduction programmes have reported absolute rejection of condom use among Balokole believers in both rural and urban areas. However there is a paucity of social science research on the role of faith healing in the HIV/AIDS epidemic in Uganda or in Africa in general. Much more research has been done on traditional alternative medicines.

This paper investigates the local meanings and lay interpretations of HIV/AIDS among Balokole in one of their strongholds, Masaka District in southwestern Uganda, as a means of examining the role of faith healing in the HIV/AIDS epidemic in Uganda or in Africa in general. Much more research has been done on traditional alternative medicines.

The Research Project

The study population comprised pastors who believe in faith healing, including some who claim to have been healed of HIV/AIDS by faith; three types of ordinary

members of Balokole congregations – those who claimed to have been healed, those who were still praying for healing and those who did not have HIV but believed in miracle healing; and Roman Catholic priests, as Masaka District has traditionally been mainly Roman Catholic. Other informants included district medical staff and condom promoters from non-governmental organisations working in the district. This was a qualitative study conducted in 1999 and 2000. Several methods were employed to collect data. Participant observation of Balokole healing services, rallies, overnight prayer meetings, evangelism crusades, anointing missions and church clinics produced experience of Balokole practice. Eight focus group discussions and twenty individual interviews were then used to investigate emerging themes in depth. Ten life histories of Balokole who claimed to have been healed were compiled and analysed. Content analysis of Balokole popular culture including sermons, songs, music, testimonies, prophetic utterances, visions, prayers, slogans, “tongues”, dreams and revelations provided insight into their symbolism and ideology. Lastly a literature review provided a historical perspective on the development of the movement in Uganda. All the formal interview data was recorded on audio tape, transcribed verbatim and translated from local vernaculars into English. Together with the field notes, they were entered into a computer, formatted into narrative texts and subjected to discourse analysis using Atlas.ti (Scientific Software Development, Berlin). This computer program, based on the grounded theory (Strauss and Corbin 1998), is designed to assist in the analysis of large volumes of qualitative data.

The Balokole Interpretation of HIV/AIDS

The Balokole interpretation of disease causation corresponds with their social construction of the cosmos. This is a reconceptualised syncretism of Judeo-Christian and traditional African animistic ideologies. According to the Balokole the cosmos is divided into three worlds: the supernatural, the natural and the prenatural. The supernatural and prenatural worlds are in constant combat over the affairs of the natural world in which human beings live. The prenatural world is ruled by a chief spirit called the devil (or Satan). It is constantly oppressing human beings with all sorts of misfortunes, evils and sins. The agents of the devil are spirits called demons. They conduct their business among men. The supernatural world (heaven) is ruled by a tripartite spirit: God the Father, Jesus Christ the Son and the Holy Spirit. Their role is to protect and bring good to the world of human beings. The agents of heaven include angels as well as the Holy Spirit. They carry out God’s directives on earth. Curses, misfortunes, deaths, barrenness, poverty and illnesses are from the devil, while blessings, prosperity, health, peace and everything good are from God.

Illnesses, like all other misfortunes among human beings, are caused by demons working for the devil. Thus Balokole believe that disease-causing agents such as HIV are transmitted by demons through various sins or curses which are social processes that disrupt the equilibrium in people’s relationships. For example a demon of lust will enter a man through his eyes after he has watched a pornographic film. This demon will then possess his sexual organs and his mind and lead his feet to a brothel and his lips to negotiate for sex with a prostitute. Under the influence of the demon of adultery he will have a depraved sexual encounter with her. This will in effect invite the demon of death into him through the demon of HIV. All of the orifices of the human body are potential entry points for demons (Nyanzi 2000).

African traditional medical systems attribute disease causation to either natural agents such as diet, insects, weather and so on, or to supernatural causes such as gods, orisas, ancestors and witchcraft. The concepts of microbes and viruses are alien to this etiology. Thus local vernacular calls all microscopic organisms akawuka – meaning “little insect” because this is the smallest recognised animal. HIV is akawuka ka silimutu – “little insect that slims”. Unlike the bio-medical model of disease causation the traditional African model is very similar to the Balokole model in which demons (evil spirits) manipulate
nature and social interaction to cause illness. Most participants identified more with traditional and Balokole models because they provided locally amenable frameworks for grappling with the meanings of HIV. The logic of HIV as demon is closer to the traditional logic of evil spirits.

**The Balokole Healing System for HIV/AIDS**

The Balokole believe that since HIV/AIDS has a spiritual origin, it can only be defeated spiritually, not medically. Only a higher spiritual power can get rid of the foul spirit responsible for HIV. This spiritual healing then manifests itself in the physical body. To the Balokole healing means several distinct but related things. It can be a physical transformation manifesting as a ceasing of symptoms, a change in blood test-results from HIV positive to HIV negative or a failure to sero-convert even though a partner died of Aids or is HIV positive. Healing can also refer to the mending of social relationships or the creation of new relationships. This is evidenced by church members’ practice of referring to each other as “Brother” or “Sister”. Many healed members acquire new spouses through the church, an option that is considered potentially high-risk in the bio-medical model. Finally healing can also mean acquiring an enhanced social status. People living with HIV or Aids who have been ostracised, discriminated against and marginalised are brought into the church clinics. When they are “healed”, they become heroes who are paraded around at the evangelism crusades to testify about the miracle they have received. Thus healing raises outcasts to the status of heroes who have experienced the touch of God.

**The Role of Balokole Faith Healing in an HIV High-Risk Area**

Unlike bio-medicine and traditional healing, which do not offer a cure for HIV/AIDS, miracle healing churches are popular because they offer accessible and free techniques for dealing with the psycho-

**References**


The Social Geography of the Spread and Impact of HIV/Aids in Uganda

Abstract

Since the first identification of HIV/Aids in Uganda in 1981, at Kasensero and Rukunyi locations of Rakai District on the shores of Lake Victoria, the government of Uganda has demonstrated an open and supportive response to the epidemic. The Uganda Aids Control Programme (ACP) was established in 1986 with a mandate to control the spread of HIV and to assist people and families infected and affected by HIV/Aids. In 1991 the Ugandan government adopted a multi-sectoral approach to fighting HIV/Aids by establishing the Uganda Aids Commission (UAC). Despite these efforts HIV/Aids has continued to seriously affect Uganda. At the beginning of 1998 an estimated 800,000 people out of a population of 17 million were HIV-positive. This included at least 25,000 children. By 2002 approximately two million out of a population of twenty-two million were thought to be infected. Most are between 15 and 35 years old. Thus the epidemic affects the most productive age group and greatly hinders development. Uganda has a mainly young population with a tremendous dependency burden. The economy is based on labour-intensive agriculture with the agrarian sector contributing 54 percent of GDP and accounting for 90 percent of exports (MFPED 1998).

The terrible irony of Aids is that HIV infection is concentrated in the countries that are least able to cope with the sickness, death and loss of productivity it brings. Close to 90 percent of all people with HIV live in sub-Saharan Africa and other developing countries. Yet these countries account for a mere eight percent of global economic production. Moreover the gap between rich and poor countries with regard to HIV/Aids is increasing. Investment in HIV prevention and access to expensive life-prolonging drugs are cutting new infection rates and progression to Aids in industrialised countries, but in the developing world infection rates are still on the rise, and drugs to slow the progression from HIV to Aids are largely unavailable. In Uganda the rural labour force is expected to fall by two million by the year 2010 due to Aids (Stover 1990). The loss of so much of the economically most active population, along with their skills and experience, further increases the dependency burden as the children and old people left behind are unable to contribute meaningfully to economic activity.

HIV/Aids and Gender

The nature of the Aids pandemic in Uganda can only be understood in the context of the country’s cultural norms, values and customs. There are a varied array of cultural constructs that pose a potential threat to the lives of both male and females. For example in some cultures in Eastern Uganda female circumcision is widely practised and involves sharing knives as a symbol of sisterhood. A study carried out on circumcision practices among the Bagisu found a relationship between the circumcised age group and an increase in Aids cases in this group (Ankrah 1993).

Another potential danger is posed by the fact that circumcision ceremonies are crowned by overnight celebrations that have sex as part of the menu. Another important aspect of culture related to the spread of HIV/Aids has to do with the traditionally unlimited access of husbands to household resources, including the sexuality of the wife. Sex is the prerogative of the man regardless of the feelings of the woman. This effectively negates concepts such as safe sex in marriage, therefore increasing the incidence of infection if the man is infected with HIV. Even if a wife suspects her husband to have a sexually transmitted disease, she cannot request that he use a condom; this would contravene her cultural obligation of submission. Moreover failure to produce a son and heir is blamed on the woman, and in such cases the man is expected to find himself an heir outside marriage. Indeed extramarital relations are generally expected and accepted for men, but not for women. This helps explain why more teenage girls are infected than boys. Nuwagaba (1999) found that girls are being harassed by older men (“sugar daddies”) as well as by their age mates. In any case polygamy is acceptable in most Ugandan traditional cultures. All these factors put women at higher risk of HIV infection.

The Ugandan legal regime has not been fair to women either. Under the divorce law, for example, proof of adultery by the wife is sufficient for a man to secure a divorce, but a woman requires, in addition to proof of adultery by the husband, proof of neglect or cruelty before she can obtain a divorce. Thus the same double standards evident in the socio-economic and political fabrics are institutionalised in the law. With regard to HIV/Aids the law effectively confines a woman in a risky relationship. Moreover the husband is sole owner of the household property and assets. As a result most women are economically dependent on their husbands and would rarely even contemplate separation. Seventy-five percent of Ugandan women do not work outside the home (Ministry of Gender, Labour and Social Development 1999), and those who are in paid employment are mainly in low-paid occupations where they are equally dependent on men, but now as employers instead of husbands. To get or keep their jobs they often have to give in their employers’ or supervisors’ sexual demands.

Aids and Poverty

The Aids pandemic has tremendous effects on aggregate expenditure, especially in meeting the costs of health care. The total expenditure on the care of Aids patients in Uganda has been projected at five million US dollars by the year 2013. This compares with a projection of 1.5 million in the absence of HIV/
Aids. The high cost of care is compounded by the prolonged, serious illnesses that characterise Aids. Patients need constant attention and care which in the absence of affordable alternatives is normally provided by other members of the household (Armstrong 1995). In a country where small-scale, labour-intensive agriculture is the mainstay, caring for family members with AIDS has an enormous impact on agricultural productivity. The reduced productivity then culminates in lower incomes and savings, which constrain capital formation for further development. Indeed household assets often need to be sold off to meet the costs of treatment and care of Aids patients. The situation is similar in most of sub-Saharan Africa. Governments are increasingly withdrawing from social service provision, and poor households are selling even key assets such as land and cattle in order to meet increasing health costs (Nuwagaba and Lucas 1999).

**HIV/AIDS and Infant Mortality**

HIV can be passed from mother to child in the womb, at birth or through breast-feeding. Some 3.8 million children have been infected with HIV since the start of the epidemic, and over two-thirds of these have already died. Most infected children live in the developing world, and the proportion is growing all the time. In wealthy countries fewer than 1,000 children were born with HIV in 1997. In the same year over half a million children in the developing world were infected with the virus (WHO 1999). In Uganda as in most of sub-Saharan Africa this situation is compounded by the fact that most women do not know their HIV status and cannot make choices about pregnancy or breast-feeding that might reduce the number of infected children. They have limited access to safe, affordable alternatives to breast milk or to the drugs that can dramatically reduce the transmission of the virus from mother to baby. Children born to HIV-positive mothers are far more likely to die in infancy than children born to uninfected mothers. HIV is thus reversing gains in infant and child survival in Uganda and many other sub-Saharan countries. In Uganda it is estimated that infant and child mortality rates are expected to more than double (WHO 1999).

**Discrimination, Stigma and Denial**

At the onset of the Aids epidemic in the early 1980s many people died “mysteriously” as far as the rest of the community was concerned. Little was then known by ordinary people about HIV/Aids, and a great deal of fear was instilled among the population. Not knowing how to respond to the epidemic, people stigmatised those with Aids, who were seen as “marked for death” or as “walking corpses.” However stigma did not disappear as more was learned about HIV/AIDS. Instead people with HIV/AIDS were associated with promiscuity, prostitution and “perversion.” When they became ill, this was seen as punishment for sin. Stigma increases the infected person’s sense of isolation and encourages him or her to withdraw from society. Fear, ignorance, lack of knowledge and denial of Aids have severely affected individuals, families and whole communities. Thus there is an urgent need for psychosocial and values-based responses to Aids. As the famous Ugandan musician Philly Bongole Lyutaya put it in the last song he wrote before dying of Aids, “Today it’s me, tomorrow it’s someone else...” For Africans there cannot be worse torment than being disowned by one’s very own. Predictably it has been shown that the poor suffer more discrimination than the rich (Nuwagaba 1998).

**Planning a Multi-Sectoral Response**

In a few years Aids has destroyed decades of steady improvement in life expectancy in sub-Saharan Africa. Since three times as many people are currently infected as have died so far, it is expected that life expectancy will continue to deteriorate in most regions (USAID 1997). Projections indicate that it will take decades to recover the levels of life expectancy achieved in the mid-1980s. In Uganda as in most developing countries new infections are still on the rise, especially among young people. Yet young people are all too rarely equipped with the knowledge, skills and services they need to avoid HIV infection. The full impact of Aids on society in terms of adult deaths, lost investment and productivity, overwhelming health care costs and huge numbers of orphans will only be felt years or even decades after new infection rates have started to fall. This should compel us to intervene to equip the younger generation with life-saving skills while the toll of HIV/AIDS is still reversible. Vigorous and focused programmes to cut new infections must go hand in hand with forward planning to meet the inevitable rise in demand for services by infected families and communities.

Tragically even the information that does exist is frequently not taken into account when planning prevention policies and programmes to slow the spread of HIV and minimise its impact. The potential for Aids to thwart decades of development must be clearly communicated to leaders at all levels of the political and religious hierarchy, as well as to community opinion shapers throughout the country. Information about the potential effects of the disease in different sectors must be made available to policy makers, business and community leaders. The Ugandan government acknowledged this as early as 1991:

> [T]he fight against Aids is the responsibility of all individuals. It is not only directed at the prevention of the spread of HIV but [must] also address the active response to and management of all perceived consequences of the epidemic (Republic of Uganda 1991).

The single most important objective in this fight is to reduce the toll of HIV/AIDS on the productive population, especially those most at risk, while critically rethinking interventions to mitigate the effects of HIV/AIDS on the populace. Specifically an appropriate hub for research and innovation should be established for the better understanding of HIV/AIDS impacts on the labour market and production relations. Eclectic and multidisciplinary forums for information-sharing, along with inter-institutional collaboration and linkages are also required.

**References**

Ankrah, 1993

Armstrong, 1995

MFPED, 1998,

Ministry of Gender, Labour and Social Development, 1999

Stover, 1990,

Nuwagaba, 1998

Nuwagaba, 1999

Nuwagaba and Lucas, 1999

Republic of Uganda, 1991

USAID, 1997

WHO, 1999
Reflections on the Changing Patterns of Care for Orphans

Abstract

Patterns of childcare are changing in Africa in these times of Aids. Millions of children have been affected directly by becoming orphans or indirectly by, for example, having to share meagre household resources with orphaned relatives. In such circumstances the traditional extended family mechanisms are strained to the utmost, and it is not uncommon for adults to refuse to take care of orphaned relatives. While the extended family system seems to be disintegrating, numerous non-governmental organisations have enhanced their capacity to care for children affected by Aids, especially orphans. Susan Hunter (1990) argued that orphans could be studied as a window onto the Aids epidemic. Likewise the patterns of care for orphans can be understood as a window onto the situation of families and other social networks. Research on patterns of childcare for orphans has produced knowledge on the immediate impacts on orphans’ health (including their psycho-social situation), education, nutrition and vulnerability to HIV. However research on the long-term consequences of the care given to orphans and other vulnerable children, such as how childcare by people not belonging to the extended family influences children’s long-term well-being, competences and sociality, is comparatively absent. Besides the obvious time constraints the literature on changing patterns of childcare is often neither contextualised in the local setting nor in social science. However such in-depth knowledge is crucial. The phenomenon of a large number of children growing up as orphans poses new problems for development at local, regional and national levels. For families, communities, national authorities and aid organisations a central aspect is the network of links between childcare and sociality, particularly the long-term influence of changing patterns of childcare for the organisation of civil society. This paper addresses two central issues that have been neglected in the new field of Aids orphans: changing concepts of care and the long-term influence of Aids orphans on emerging institutional settings for childcare.

Reflections on “Care”

Even though “care” is the keyword for a whole domain of HIV/AIDS research, the concept is rarely defined. Instead of defining the concept researchers often narrow it down by attaching another word and thereby creating a range of types of care such as medical care (Mwabu 2002), health care (Ndulu 1999), home care (Radstake 2000), Aids care (Nnko 2000), self-care (Smide 2000) and orphan care (Chirwa 2002, Ntozi 2000). The avoidance of any criteria to determine when something is care or is not care, and the failure to contextualise with local notions about care, for example, when someone is being careful, caring or being careless, makes care a rather blurred concept.

In order to define care I think we can begin by pinning down two basic features: First, as a noun care expresses culturally objectified notions and is related to local morality about the proper allocation of resources, including emotions, knowledge and material support. To receive a certain kind of care may be an entitlement. Second, as a verb care is an interpersonal phenomenon, a fundamental component in the relationship between (at least) two human beings, where one is paying attention to the other in particular ways, responding to the needs and promoting or protecting the well-being of that person. And since care in this sense is part of a social relationship, it must be understood as part of the reciprocity within the actual relationship. These two features of care are so intertwined that to divide them is only an exercise for analytical purposes. I do not propose an actual split, but I do propose that in order to understand concerns about the changing patterns of care for orphans, research must approach these two aspects of care as theoretically separate. Therefore I will first outline notions about childcare as a dimension of cultural ideas and then consider “to care” as part of social practice.

Care as Culturally Objectified Notions

Care is a social phenomenon that involves many aspects of everyday social life. According to Weisner (1997) the care of children has certain universal features such as affection, physical comfort, assistance, shared solving of problems, provision of food and other resources, protection against harm and a coherent moral and cultural understanding of appropriate ways to provide this support. While it is possible to recognise in this definition certain common features of childcare throughout the world, showing emotions, allocating material resources, passing on values and taking action find very different cultural expressions. Perceptions of care also differ between and within localities, as they are related to ideas about gender and inter-generational relations, practices of marriage, priorities of schooling or tilling the land, and to the social, economic, and demographic circumstances. Thus notions of childcare are deeply embedded within the local context and relate both to children’s general position in society and to caretakers’ ideas about the children’s future as adolescents and adults (Swadener 2000; Weisner 1997; Kilbride and Kilbride 1990; Goody 1982).

I propose that notions of care entail immediate as well as developmental aspects, especially when the focus is on caring for children. In the immediate sense the care of orphans is about providing for needs such as food, schooling and access to health facilities. In the broader developmental perspective it is also about approaching orphans as youngsters who are persons in the making and who must
recover from the loss of one or both parents and develop competences (Jenkins 1998; Meinert 2001; Weisner 1997) in order to manage as adolescents and later on as adults within the local reality. Providing care entails increasing or limiting competences and therefore influences the child’s future options and place in society. In addition the social virtues of caring for others’ well-being may be intertwined with cultural notions of personhood. I make this suggestion on the basis of my previous findings among the Samia people of Uganda that a “good person” is one who is sharing and trustworthy, whereas a “bad person” is someone who does not care about others (Christiansen 2001). Katahoire’s (1998) findings (also among the Samia people) show inextricable connections between being a good person and one’s social identity and maintenance of social relations. Notions of care are thus associated with moral assessments of one’s feelings, intentions and competences as a social person.

The point of departure for research on how to care for orphans must be to explore local cultural perceptions and practices of childcare and contextualise these with related aspects such as children’s social position, patterns of care for children living with or without their biological parents and notions of childhood and of care in general. At all times it is vital to tie findings to the wider social, economic and political currents that impinge on local people. However it is particularly important to do so in relation to a social phenomenon as challenging to established practices as Aids orphans.

Care as an Interpersonal Phenomenon

In Uganda as in many other African societies the traditional patterns of care depend primarily on kinship. Until recently kin-based support mechanisms have had the capacity to absorb most vulnerable children and orphans (Ntizi 1997, 1995; Heggenhougen et al. 2003). When a parent dies, the first option still seems to be leaving the children in the care of relatives of either parent, which implies that the changing patterns of care include an increasing use of matrilateral kinship ties. Other options are to leave the orphaned children in the care of their surviving grandparents, of friends and strangers, of church organisations or simply leaving the children on their own. This latter option seems to be more common in central (Ntizi 1997) than in eastern Uganda (Gilborn et al. 2001).

Thus caring for children is intertwined with notions of kinship. The kinship between the care-giver and the care-recipient influences the care that is given (Kirimira 1996; Mogensen 1998). Grandparents’ care for children’s children is about ‘mutual help, enjoyable company, and emotional commitment’ (Whyte and Whyte 2002), whereas parental care is often more about discipline and developing the child’s skills (Ntizi 1999, 1997). As with other social practices childcare is part of the ongoing negotiations between relatives of different genders and generations on commonly shared ideas such as notions of care, family virtues and children’s growing responsibilities as they mature (Meinert 2001). Childcare is also part of family status, as cases from western Kenya suggest. For example patrilineal kin might hinder matrilateral kin in taking care of orphaned relatives because this exposes ‘their inability to provide support to members of their own patrilineage’ (Nyambédha et al. 2002).

Nevertheless caring for children is not confined to notions of kinship. It also engages cultural norms about being related to one another through neighbourhood, church or other social networks. This non-kin involvement is mostly described in cases of community “shared management” of child rearing, but seldom when (foreign) organisations are the non-kinsmen providing childcare. Considering that a substantial part of the assistance given directly to orphans or indirectly to households caring for orphans is given through non-governmental organisations, often Christian-based, this raises a range of issues: Can non-kinsmen provide culturally accepted childcare or perhaps even “desired” childcare? How will such assistance influence the children’s lives and social networks, especially their relationships with kinsmen?

I have been surprised to find that there are no terms to describe the care relationship. There are terms for those providing care, but there is no term to describe (or to speak from the position of) those who receive care. These young people are mostly described as “orphans who are being cared for”, thus in passive terms. I find this problematic, as this terminology may well indicate that orphans (and others receiving care) are not recognised as social actors and that they are not involved actively in the studies conducted. I strongly request that orphans be recognised as social actors (some are even care-givers to younger siblings), and I suggest using the term “care-recipient”. Thus the relationship is formed by care-giver(s) and care-recipient(s). Since children often become closely attached to their care-givers and care entails some kind of reciprocity (Weisner 1997), it is important to study the changing relatedness between the involved persons. Research must also move beyond the indication of relationships in general terms such as matrilateral and patrilateral and explore in depth the relationship between care-givers and care-recipient(s). Since children often become closely attached to their care-givers and care entails some kind of reciprocity (Weisner 1997), it is important to study the changing relatedness between the involved persons. Research must also move beyond the indication of relationships in general terms such as matrilateral and patrilateral and explore in depth the relationship between care-givers and care-recipient(s).

Patterns of Care for Orphans

Orphans form a particularly exposed group of children. The research on this group of children reveals higher levels of mortality, malnutrition, HIV prevalence, crime rates and lack of basic needs than is normal for their age groups (Yamba 2001). However our understanding of the immediate influence of care on orphans is mainly limited to the affects on nutrition, health and schooling. Research needs to become more comprehensive and address the influence of diverse care options and the general connections between care for orphans and their social well-being. This contention is based on the recognition that it is necessary to assist societies afflicted by Aids to take appropriate care of orphans. To do so requires an understanding of the social processes taking place in these societies. How does providing – or not providing – care for orphaned relatives affect local notions of kinship and the extended family system as the basic social unit? How does care influence the lives of orphans in the long term? Considering the high proportion of orphans in some societies, it is vital for the stability and development of civil society to find ways of ensuring orphans’ social integration and well-being. Research must therefore be positioned within the context not just of the individual child, close relatives or even the single extended family, but of civil society on a...
national level. In other words the socio-cultural locality must be related to the national context, the time perspective must be long-term as well as immediate and the analytical frame must be grounded within social science.

The point of departure must be the settings of care for orphans. Approximately five percent of orphans in sub-Saharan Africa live in institutional settings and thus receive care from non-relatives. But many orphans who live with kinsmen are supported indirectly by non-kinsmen such as non-governmental organisations. Care-givers may thus consist of both kin and non-kin. By briefly focussing in turn on the household and institutional locations of childcare, I will outline some reflections on the patterns of care for orphans.

**Household Living**

The majority of orphaned children, especially in the rural areas, live in households. For that reason it is strange that there are so few studies of the effects of Aids on households and that most focus only on economic impacts (Barnett and Whiteside 2002). Households vary considerably in terms of composition, dynamics, access to resources and resource distribution. Moreover households change in HIV/Aids high-prevalence areas. There are fewer working-age adults, more single parent households, more youth-headed households, more three-generation households, more households with a missing middle generation and more fostering of other people’s children whether or not they are related (Haddad & Gillespie 2001). Furthermore households may be severely affected by the loss in agricultural productivity and by new labour arrangements (from adults to children, perhaps from family members to hired labour) as well as by the expenses of Aids care such as drugs, burial, transport expenses and so on. Such demographic changes raise questions about households’ capacity to care for orphans (Chirwa 2002).

Among the Samia people in Uganda polygyny is widespread. Since each woman is responsible for the well-being and education of her own children, rivalry for resources and lack of co-operation among co-wives in the household is common (Christiansen 2001). Since mothers are vital in direct childcare (Weisner 1997), being fostered in polygynous households raises questions of how maternal orphans are integrated and cared for. Care given to “extra” children seems to be closely linked to the adult relationship between the mother of the children and the caregivers, even when the mother has died (Bledsoe 1995, 1991).

How do relatives react when they must care for one or several orphaned relatives? We know that in many areas, at least in Uganda, other kinsmen – and clan members – are not able to provide much support. People who care for orphans often struggle to the extent of reducing the general well-being of the household (Ntzozi 1997). At the same time it has been shown that many orphans live miserably with their relatives; they are treated as second-rank children, given more work to do and denied access to schooling and health care. How does this affect the relationship between the young orphan and the related adults, or the relations with the other children in the household? In eastern Uganda the children of your mother’s co-wives are called stepisters and stepbrothers, and there is often much rivalry among them. Are orphaned relatives equally a rival for resources? Which adults are responsible for their care? Do these changing circumstances influence the conception of familial relatives? The widespread perception within close family relations that your mother’s sister is like your mother – and likewise that your nephew or niece is like your own child. But what happens to these perceptions when an orphaned child experiences a huge difference between the care given by the deceased mother and the care now being given by an auntie – or on the perceptions of the adults who find themselves having to care for orphaned nieces and nephews?

I argue that reflections on the changing patterns of childcare must focus on notions about kinship and other social relations. A promising approach seems to be the anthropological interest in “social relatedness”, as this addresses such questions as how people relate to others, what makes a person a relative, what is the meaning of being related and so on (Carsten 2000: Schweitzer 2000). According to anthropologists kinship is one among several fundamental ways of being related to other people. By approaching social relatedness as part of everyday practice as well as in times of need, social scientists can develop important knowledge of vital relations within the social positioning and networks of orphans, their care-givers and the broader social organisation of African societies (Kirumira 1996). This approach is applicable to various locations of childcare, household and institutional settings alike.

**Institutional Life**

Researchers and aid organisations generally consider institutions to be the last resort for taking care of orphans and other vulnerable children (Hunter and Williamson 2002; Heggenhougen et al. 2003). This is because of the high cost of running an institution compared to assisting orphans in households, the psychosocial disadvantages of removing children from the family setting and the increased risk that institutionalised orphans, especially boys, will not be able to inherit land from their fathers. I propose that there is a great need to make further studies into the institutional option of childcare in African settings, especially for orphans. The approach must move away from the normative assumption that childcare should take place in family settings and to an objective position that focuses on the childcare practiced in institutional settings.

First of all the lack of literature on this topic bears witness to the fact that the variety of institutional settings has not been studied in-depth, either quantitatively or qualitatively. This is strange, as there seems to be a public culture of institutionalised child care in many African countries (Swadener et al. 2000). Moreover the evidence that “extra” children in the household can negatively affect the lives of other children (Gilborn et al. 2001; Ntzozi 1997; Thiru 1996) suggests that both orphans and their relatives may benefit if the orphans are cared for outside the household. Placing children in the care of institutions is not entirely new in most African settings. Indeed some of these institutions are highly desired because they provide the children with important competences.

Yet institutional settings may lead to radical changes in the idiom of care-taking, just as formal educational and medical institutions have done in their respective domains. Institutions for orphans might be perceived as the most recent symbol of modernisation, or they might be marginalised and disregarded. A broad range of orphanages, children’s “villages” and boarding schools for orphans will probably reveal a continuum ranging between associations with modernisation
to associations with poverty, marginalisation and breaking of tradition. Can such institutions provide children with competences that may enhance their future options and help them provide for households instead of being a burden? Do institutionalised orphans usually return to the village, or is the institution the first step away from the village? How do orphans enrol in and depart from institutions? While they are at the institution, what connections, if any, do they maintain with relatives? Is it possible to combine the familial and the institutional networks? Do the organisations operate on the basis of different notions of care, personhood and sociality? If so, how does this affect the children? Do orphans feel that they are caught in a web of reciprocity to their care-givers? Do care-givers expect similar reciprocity from orphans as parents commonly expect from their own children? Do orphans who have lived at, for instance, a Catholic institution feel more closely related to other orphans and the Catholic Church than they do to their kinsmen? If so, do they remain within Catholic networks when they later on seek employment, marriage partners and so on? Social scientific research needs to explore this extensive (though not exhausting) list of issues in order to develop models of care appropriate for the children, their families, and the social context at large.

**Recommendations**

There is a tendency in the literature on HIV/AIDS-related issues to refer to similar studies carried out in other geographical areas rather than taking for granted the research within general conceptual frames such as modernisation, religion, social organisation or governance. Much attention is given to the methodology of how the research was carried out, but there is little attempt to contextualise the location of the research, let alone people’s views and responses. It often seems that the main aim is to make policy makers aware of problems and needs rather than to contribute to more general debates. While the devastating conditions of people struggling with HIV/AIDS place an ethical demand on researchers to publish their findings and propose interventions, it can compromise interventions if researchers do not contextualise findings in the local cultural setting. Their findings are not tied to the wider social, economic, and political currents that affect local people (Heald 2002). Another problem is the use of concepts such as care in a common-sense manner without questioning the differing notions of the cultures and the actors involved. This produces much literature in which one must guess whose interests, orientations and priorities are being reflected.

In my opinion the literature reflects the fact that there are two types of researchers involved in HIV/AIDS-related research. The first type work full-time on HIV/AIDS issues, and their findings are mainly directed towards policy makers. The second type is actually studying another topic but, due to the astounding impacts of HIV/AIDS in most African countries, have to integrate HIV/AIDS into their empirical field (Whyte 1997). Such “part-time” HIV/AIDS researchers situate the data within general social scientific debates and direct their findings mainly to academic audiences. The communication between these two types of researchers seems to be very limited, a matter, which should be of serious, concern both for policy makers and for social scientists. The development of a rather isolated HIV/AIDS literature within the social sciences is to a large extent a result of the failure to contextualise findings within the local setting and to establish analytical frameworks capable of drawing conclusions beyond prevention, treatment and care.

In order to develop an adequate understanding of the changes taking place in the care-taking of orphans – as well as to narrow the gap between “applied” and “academic” research, I recommend that all researchers focus on more fundamental issues. The concept of care, for example, needs to be studied in it rather than taken for granted. We need to further elaborate approaches to the study of care and contextualise actors’ notions of care and practices of caring. A fuller understanding of links between notions of care and notions of kinship is also required. The concept of orphans also needs to be studied. Local terminologies for “orphans”, “children living in distress”, “children not living with their biological parents” and so on should be carefully unpacked, as should the implications of other locally defined subgroups of the category “children”, such as children of divorced parents and other vulnerable children. Orphans need to be contextualised as social actors and given a voice to speak for them.

The local perceptions of institutions are very important. Are orphanages regarded like boarding schools, which are usually seen as prestige institutions, or are they disregarded and the orphans marginalised and perhaps even more stigmatised? Is it possible to maintain kinship relations while living in an institution? Do orphans grow more closely related to other orphans and to the aid organisations? Is receiving care from an organisation the entrance to a life related to that organisation and if so are aid organisations producing the new elite? What are the long-term consequences of such a change within the social organisation? The patterns of care of orphans are another important field of study. We need to look at both the immediate and the long-term influences of the various types of care provided for orphans, especially in relation to orphans’ social well-being and social networks and the relationships between care-givers and care-recipients in both household and institutional settings.

Finally we need to study the immediate and long-term influences of growing up without adult care. Do the children’s experiences, whether in an institution, in the household of a relative or on the streets, produce Africans who are no longer orientated towards their family or clan?

**References**


Hunter, S., 1990, ‘Orphans as a Window on the Aids Epidemic in sub-Saharan Africa: Initial Results and...
Surviving on the Streets: Sexuality and HIV/AIDS among Male Street Youth in Dessie, Ethiopia

Abstract
The increasing number of street children is one of the most serious social problems facing Ethiopia today. As many as 200,000 children may be living on the streets. Studies in other countries have shown the importance of understanding sexual attitudes and behaviour among street children, particularly with regard to HIV/AIDS. However in Ethiopia almost all studies of adolescent sexuality and HIV/AIDS have been conducted among high school and college students. Out-of-school and street children, who are much less accessible, have been neglected. This study in Dessie, a provincial town in Ethiopia, is part of the research for an ongoing PhD project titled ‘Ethnography of Sex: An Exploration of the Socio-economic and Cultural Context of Sexuality and HIV/AIDS among Ethiopian Youth’. Three focus group discussions (FGDs) with a total of 30 street children, as well as numerous informal talks and discussions, were conducted during the fieldwork period between October 2001 and February 2002. The study reveals the importance of understanding young people’s sexual behaviour not as a matter of isolated, individual risk-taking, but as aspects of collective behaviour deeply embedded in their way of life.

Introduction
The following is how a street boy in Dessie, a provincial town in Ethiopia, responded to a question about the day-to-day concerns and problems of street youth:

There is no place where we can find work, so we are forced to think of other undesirable alternatives which we would have previously been glad to avoid, things like theft and the like. We are very worried right now. We have no parents or relatives or anyone who can take care of us. Our labour is our only means, and now that we have been prevented even from earning our bread from our own labour, we can only make a living out of theft. This is your work [pointing to the microphone]; if the government prevents you from doing it and even goes as far as chasing you, you will surely be in a great mess about how you are going to make a living. What will you do and where will you find work? That isn’t easy if you are in our condition. You will be forced to feel isolated, and you will not feel any respect for society and won’t be at peace with it. You might even be forced to go into politics [probably meaning forceful opposition to the government] rather than thinking of how you could learn or improve your condition or how you can contribute to your country. All your plans and goals will be disrupted. Why should I be made to lose all hope and see my plans and goals will be disrupted. Why should I be made to lose all hope and see your plans and goals will be disrupted. Why should I be made to lose all hope and see your plans and goals will be disrupted.
Street children engaged in shoe-shining expressed similar feelings of helplessness and frustration. One shoeshine boy said:

I want to quit shoe-shining and do something else because students at school treat me as an inferior just because I clean people’s shoes, and it really enrages me. Therefore I am worried about how I can find another source of livelihood and quit shoe-shining . . . . What worries me more [than HIV/AIDS] is whether I can do anything better than shining shoes . . .

All the other street children agreed that HIV does not worry them. What concerns them is only how they can improve their miserable lives. When one participant in a focus group said that ‘what worries us very much is AIDS’, most of the other participants told him to speak for himself and stop pretending to be their spokesperson. It appeared that for most street children, unemployment, lack of money and other problems of mere survival overshadow the fear of HIV/AIDS infection.

This paper mainly focuses on how male street children understand and express sexuality and HIV/AIDS in their daily lives. I decided to write on male street children only, as the data obtained from female street children was not comparable. Most of the female street children included in this study are engaged in different kinds of hawking during the day, and stay with their families during the night. Moreover almost all of them attend school for half the day. As a result the information obtained from them closely resembles that of other informants attending school (non-street children). Compared to male street children the street girls appeared well informed about HIV/AIDS and sexuality.

Background to the Study

Dessie, with a population of about 97,000 according to the 1994 census, is situated 400 kilometres from Addis Ababa on the road that runs north to Mekele in Tigray. Because it is located on a main trucking route, there are many hotels and bars which form an important centre of business life. Prostitutes service passengers and drivers who pass through the town, as well as local residents. There are also numerous illegal pornographic video houses that operate underground to avoid legal action, and young people frequently visit such places. Therefore hotels, bars and sex work are an integral part of the town’s formal and informal economy along with small retail business.

Past regimes used the town of Dessie as the administrative capital for the province of Wollo. Until the 1974 revolution the town served as a seat for the crown princes and governors who were assigned by the emperor to administer the region. Between 1974 and 1991 Dessie served as the administrative capital of what was then the Wollo province and also housed the regional headquarters of the ruling party. From 1991 onwards, although its scope of administration has diminished, it has continued to serve as the administrative capital for the South Wollo Administrative Zone, and houses a number of civil service, NGO and religious offices. Due to its location between mountains much of the town’s land is hilly, and the water that runs down the surrounding mountains has caused a great deal of erosion. Landslides are frequent. In addition to damaging or destroying infrastructure, the landslides discourage investment. For this and other reasons, including a fast-growing population, Dessie has a major problem with urban poverty. The growing size of congested neighbourhoods chiefly populated by low-income families, the deteriorating condition of the town’s roads and sanitation facilities and the ever-growing number of street children (and adults) are all evidence of increasing urban poverty.

The increasing number of street children is one of the most serious social problems facing Ethiopia today. It has been estimated that as many as 100,000 children are engaged, to varying degrees, in street life nationwide (Veal and Adefreshe 1993). This may well be an underestimate; recent unofficial reports estimate up to 200,000 street children. The vast majority of these children live in conditions of severe deprivation, which make them vulnerable to all kinds of health risks. Inadequate nutrition, long working hours, exposure to adverse weather and physical abuse severely endanger their physical, mental and social development. The numbers of street children have been exacerbated by high inflation, structural adjustment, increasing urban poverty and the lifting of restrictions on the movements of individuals, which has resulted in an influx of economic migrants and displaced persons to urban centres throughout the country. During the period of instability before the fall of the Derg regime in 1991, tens of thousands of families were dispersed, parents and children separated and many children abandoned or lost, which contributed heavily to the problem.
of street children (Veal and Adefresew 1993). More recently the problem of street children has worsened largely because of the Aids pandemic, which is reported to have killed an estimated 300,000 Ethiopian adults so far. As a result there are about one million Aids orphans. Many of these children have ended up on the streets, or will eventually end up there.

**Current Research on Street Children and Sexuality**

Richens (1994) discusses the prevalence of STDs, the scant knowledge about HIV/AIDS and the part played by sex as a medium of exchange among street children. Other studies have emphasised the need for more research focusing on a cultural and contextual understanding of the circumstances in which street children pursue and engage in sex (UNAIDS 1999). A South African study on street children noted the inadequacy of rational choice models of risk assessment and decision making (such as the Health Belief Model and the Theory of Reasoned Action) in the face of coercive sexual contexts, pointing to social conditions of risk-taking beyond the control of the individual (Swart-Kruger and Richter 1997). The same study noted that HIV was not one of the children’s main concerns, and the Theory of Reasoned Action) in a study of the early and diverse sexual experiences of street children in Brazil. These and other studies underline the importance of understanding street life as a culture that contextualises risk-taking behaviour in Colombia. Raffaelli et al. (1993), using a combination of qualitative and quantitative methods, describe the integrated nature of sex as a means of exchange for goods and services and as a source of sexual pleasure (an important and often neglected aspect in street life) in a study of the early and diverse sexual experiences of street children in Brazil. These and other studies underline the importance of understanding sexual behaviour among street children, not as isolated, individual risk-taking, but as aspects of collective behaviour deeply embedded in their way of life (UNAIDS 1999). Available data suggests that in many countries HIV sero-prevalence rates for street children are ten to twenty-five times higher than in other groups of adolescents. This is because street children are reported to become sexually active earlier than most other groups of adolescents, have more sexual, are more likely to be raped or forced into sexual relationships, use condoms less frequently and get inadequate information about sexuality and protection due to illiteracy and non-attendance at school (Swart-Kruger and Richter 1997).

In Ethiopia almost all studies of adolescent sexuality and HIV/AIDS have been conducted among high school and college students. Less accessible young people (out-of-school and street children) have been neglected (Fantahun and Chala 1996; Taffa 1998). In Africa in general and in Ethiopia in particular, where only about one-third of school-aged youth actually go to school, out-of-school adolescents clearly deserve more attention. To date, little is known about the sexuality of street children and youth, how HIV affects this group, whether they have access to Aids prevention information and, if so, to what extent (Carballo and Kenya 1994). This study aims to help fill this gap.

**Sources and Methods**

For the purpose of this study, the terms “street children” and “street youth” will be used interchangeably to refer to a broad age group of 15 to 27 years of age. The majority of street children who participated in this study were recruited randomly from around the town’s bus station on the basis of their willingness to participate. A peer research assistant and I went to the bus station and asked for volunteers. By promising to pay the equivalent of about 1.20 USD for the time they spent with us, we got a lot of volunteers. As for recruiting shoe-shiners I befriended one and he recruited all the other participants engaged in shoe shining in the central square of the town called the piazza. Almost all the informants recruited from the bus station were marked with the signs of street life. Their tattered and dirt-encrusted clothes looked as if they had been rinsed in tar. Their hands were dirty, and their fingernails were filled with black filth. Their hair was overgrown and dirty, their mouths and lips were dry and cracked and their bare feet were covered in scaly skin. Some of them, especially the older ones, were better dressed, but their clothes, hands and fingernails were also packed with filth. Some had fresh scratches all over their faces. Their general physical condition clearly reflected the life they were leading, a marginalised life that proceeds precariously from day to day.

The informants in this study had been on the streets for three to nine years. None had completed their schooling or gone beyond elementary level. Some were born and grew up in Dessie, while others came from other places. They were very mobile because they sometimes worked on lorries and buses as assistants. Washing cars, assisting drivers and performing a number of odd (sometimes backbreaking) tasks are the main means of survival on the streets for most of the participants. Their dependence on the transport sector and their closeness to drivers is even expressed in the language they use to express sexual issues. Some of the terms they use have their origins in the name of spare parts for cars. Most of the participants have lost one or both parents and were homeless, spending their nights in dangerous, unsheltered, cold environments. Some of them slept in the streets while others slept on floors rented for the equivalent of about six US cents per night. They sleep very close to one another for warmth. Most of them smoke and an increasing number chewing catha adulis (qat). All but one were sexually active and engaged in sex with prostitutes whenever they could afford to.

Unstructured interview questions were designed to guide data collection in FGDs. With some limitations FGDs are an effective way to explore in-depth attitudes about sensitive and complex issues such as sexuality. They are particularly effective when dealing with delicate, intimate topics among Africans with strong oral traditions. If moderators can arrange open and informal discussions, FGDs encourage spontaneous expression of individual ideas as well as the exchange of ideas between group members (Irwin et al., 1991). The discussions covered general information about sexuality and HIV/AIDS, perceptions of current problems and expectations for the future. The discussions also addressed the start of boy-girl relationships, marriage and premarital sex, sexual socialisation, the act of sex, sexual norms, values and deviance, safe sex, condoms and condom use and other issues related to HIV/AIDS. Three FGDs involving a total of 30 street children were conducted on the premises of the branch office of the Family Guidance Association of Ethiopia. The participants in each FGD showed signs of intimate knowledge of each other’s behaviour. When the participants were not pleased with what one of the other participants said, they told him to stop lying and tell the truth.

All the discussions were in Amharic (the official language of Ethiopia). They were tape-recorded, transcribed and translated. Notes were taken concerning group
dynamics, particular refections and the number of informants endorsing a particular statement or position. These were incorporated into the transcriptions. All FGDs were conducted in two-hour sessions. At the end of the second session the informants were given the chance to clarify issues and concerns surrounding sexuality and HIV/Aids. In addition to formal FGDs a lot of informal talks and discussions were held during the entire fieldwork period between October 2001 and February 2002.

**Sexual Morals, Manners and Taboos**

When the participants were asked if there was such a thing as “normal” sex, and how they felt about anal and oral eroticism, some of them argued that unrestrained (*lige*) sexual intercourse is not “normal” sex. Asked what they meant by the term *lige*, some said it meant very free or loose sex such as sucking the penis or licking the vagina. Others said that homosexuality is also *lige*. Still others said it is *lige* when a married man goes to prostitutes while keeping his wife waiting for him in his house. Some even said that sex without condoms is *lige*. When probed further about other sexual values and norms, some stated that heterosexual partners should feel free to engage in any sexual practice that pleased them but that homosexuality or lesbianism remained *lige*. Others disagreed that any kind of hererosexual sex that pleases couples was acceptable. They said even married couples should stick to the usual methods of having sex because sex has only two purposes: to satisfy one’s sexual desires and to reproduce, and that both purposes can be satisfied through “normal” intercourse. They added that it wouldn’t be good for children to grow up hearing or seeing oral or anal sex in their families. One informant said that he heard that when semen is released inside the rectum during anal sex, worms begin to grow internally. The receiving partner will then become a sexual being – in order to practice what they have seen on video. Perhaps due to such thinking the government closed most of these underground pornographic video houses in early 2002. I am not aware of the current situation.

As far as sexual positions were concerned the informants identified thirteen different ones. All these positions were considered to be deviant. “Normal” sex occurs only when the man penetrates while the woman lies on her back “as our fathers and forefathers have done”. The other positions were described as harmful to the women because of potential damage to the uterus. Prostitutes submit to them for money, not because they like them, and are sometimes even forced into them. Such positions are also not good for males because they exhaust and harm them. A final reason is that they involve much struggle and friction between the two bodies, which cause condoms to be torn. Most of the boys agreed that these positions should be avoided and are usually only resorted to when under the influence of alcohol. As for circumcision it was considered necessary because it was “the culture of our fathers” as well as a hygienic imperative. They added that they have heard that uncircumcised men (*woshela*) cannot impregnate women and easily contract STDs because their semen remains in the foreskin and can develop into fungus or even STDS. Moreover women were said not to consider uncircumcised men as masculine.

Regarding modes of dress some said they saw no problem with girls wearing revealing clothes, as their bodies are part of their beauty and they have the right to display them. However other participants insisted that girls dress this way to attract men, and this causes some men to do what they wouldn’t have done otherwise. They said some men come to the piazza to see women’s bodies, which is not good. Especially in the evenings part-time students (evening students as they call them) wear very revealing clothes. This induces men to have unplanned sex and leads to the spread of HIV. All the participants agreed that masturbation (*sega*) is not a good thing to do. They believe it leads to sterility, mental disturbances, spinal deformation, reduced sex drive and vision problems. When we hinted that some young people consider masturbation the best means of abstaining from sex and avoiding HIV/Aids, they asked how it can be seen as an alternative if it shatters one’s hope of one day living with a wife and children by causing sterility, madness and reducing interest in girls. They added that *sega* is not good because it will make one lose weight (losing sperm is thought to cause weight loss). One boy said that if you buy sex, you will not do it frequently because you need money to do it, but *sega* requires no money and if you are used to it you are likely to do it often and lose weight quickly. He only tried it once, and that was enough to convince him never to do it again because, he claimed, it made him feel so drowsy that he couldn’t even walk properly. In any case most said they saw no need for masturbation as long as there are enough prostitutes. All the participants said they
had heard of homosexuals and homosexuality (both gay and lesbian) but had never met such people. They unanimously agreed that homosexuality is detestable and said they had never engaged in it. In discussing these sorts of matters one encounters one of the shortcomings of FGDs. One problem with an FGD is that taboo behaviours might be practised by individuals but not revealed in the group setting. Homosexuality and masturbation are possible examples. Masturbation in particular may be more prevalent than the boys admitted, but the group norm was clearly anti-masturbation and anti-homosexuality. It would be worthwhile checking, through individual interviews, whether homosexuality and masturbation are more commonly practised.

**Love and Relationships among Street Children**

Almost none of the informants knew anything about relationships except for buying sex from prostitutes. Desperate boys hungry for sex go to women and girls who are equally desperate for cash. Unlike the students involved in this study street children didn’t report having girlfriends with whom they had a romantic relationship. Their reasons related to low self-esteem and social status. The informants said that non-prostitutes accept or reject a boy on the basis of his socio-economic status and his family background. They noted that some people treat them as inferiors just because they polished shoes: ‘some people consider us as if we are under the soles of their shoes.’ The view that having a girlfriend requires looking good, dressing well and having some cash in the pockets was strongly expressed by the participants. Thus they agreed that no girl would be willing to be a girlfriend of a shoe-shiner. If they wanted girls their only choice was to go to a distant neighbourhood and convince girls there to have quick sex before their backgrounds could be revealed. One boy said: ‘when girls hear that I clean shoes in the piazza they consider me as if I was less of a man and treat me as an inferior.’ Therefore, it is better to buy sex.

**Levels of Awareness about HIV/Aids**

When we asked the participants to tell us what they knew about HIV/Aids and how it is transmitted, we did not get very detailed answers. What we received were fragments and half-sentences spoken with uncertain looks, such as:

- I have heard that Aids causes one to lose weight and be as thin as a skeleton.
- Aids is transmitted through things like toothpicks.
- Aids is transmitted through sexual intercourse.
- It is an “ugly” disease transmitted through sex and things like needles and razors.
- If the blood of an Aids patient is poured it has the power to penetrate and enter your body.
- You can get Aids by drinking raw eggs (to cure a cough) if the hen that laid the egg had eaten the sputum (aketa) of a person with HIV.

Almost all the informants had heard of HIV/Aids and knew it was an incurable disease. However most of them didn’t clearly understand how the disease is transmitted or how it can be prevented. When asked what they knew about Aids, some of them demanded that we ‘quit throwing all these questions at them’ and start teaching them about Aids. They demanded that someone (most thought the government) do something for them. They even went as far as making us pledge to inform the authorities that they needed education, and not only about Aids. We pitied them, if that was of any value, and told them again that we were not there to teach them but rather to understand their views. We volunteered to answer any queries and clarify any unclear information as much as we could after the FGD.

Knowledge about HIV/Aids was not uniform within the group. Some of the participants were relatively well informed (at least on the ways HIV is transmitted) while some could say nothing more than that Aids is a chastising (gesafi) disease. Most of the participants stated explicitly that they didn’t know anything for sure about HIV/Aids, except what they have heard people saying about it, that it is the worst disease of all and kills after it has wasted the body and made one a sack of bones. The ignorance of the group on the subject of HIV/Aids was clearly expressed by one boy’s naïve query: “Since there is no blood contact, why is it that Aids can enter the body if Aids is transmitted through sex?” Another asked: “Since there is nothing other than sexual urge (semate) during sex, how is Aids transmitted through sex?” Still another, whom we had thought better informed than the others, asked: “Why can’t the virus be seen? How does it enter the body during sex? And where did Aids come from?” He added that he has heard Aids came from America but wanted to know how. Another informant amused himself by responding that maybe it came by foot! Since Aids is closely associated with sexual intercourse, it is difficult to discuss openly, so misconceptions and rumours are likely to prevail. Jackson (1992: 55) noted that “people are often more interested in discussing minor or unproven routes of HIV transmission than the main one.” This was confirmed in our discussions with street children and youth in Dessie.

The participants believed that HIV and Aids are just two different names for the same disease. Their inability to distinguish between HIV infection and Aids can be attributed to the failure of public information campaigns to do the same. Some of them also claimed to have been told by health educators that HIV could be contracted by eating a chicken that had swallowed a condom used by an HIV-positive man. Another street youth claimed that it is not Aids itself that kills but rather a poison of some kind that Aids produces in the body. Most of the informants associated Aids with bodily appearance; healthy-looking persons were thought to be HIV negative. They strongly believed that people with HIV show symptoms such as weight loss, sparse or balding hair, coughing, lesions on the lips and the like. One informant said he had seen a girl speaking at church who said she was HIV-positive, yet she did not look different from any healthy girl. This shocked him and made him feel that he too may be infected.

A large number of mundane activities were also considered to have infective potential. The informants thought they could get the virus from food if an infected maid accidentally cut a finger and spilled blood onto the food. Some even wanted to know if they could get the virus if they happened to drink from the same glass used by an infected person with chapped lips. The informants also expressed serious misconceptions related to other sexually transmitted diseases. When asked to name STDs, one of the informants named gonorrhoea, LGV, and chancre and invited others to add to the list if they knew more. No additions were made. He said that STDs result from poor vaginal hygiene and develop in
women who do not wash their vaginas properly. There was a general consensus that this was the case. One informant thought that STDs cannot be transmitted from the male to the female since, as he put it, ‘the company has its base in the vagina.’ Another informant thought that a man could not pass on STDs to a woman because if he was infected he wouldn’t be able to perform sexually in the first place. Most of the informants reported that they had contracted an STD at least once.

Origins of HIV/AIDS

When asked about the origins of HIV/AIDS, some informants said AIDS was a disease sent to black people by ferengi (foreigners, particularly Americans). One said AIDS was the result of ‘the restless hands of the white man.’ He claimed there was no AIDS in Ethiopia until a certain white man had sex with an ape. However he didn’t know he had contracted any disease and went on to have sex with some Ethiopian girls who then transmitted the virus to others. Another explanation was that AIDS may have been in existence since ancient times but under a different name. One of the informants claimed there was a disease in the old days which the people called amenmin (that which makes skinny) and that this is the same disease that scientists now call AIDS. However another informant objected to this and claimed that in the old days people called any wasting disease amenmin, including TB and many other diseases. Some perceived HIV/AIDS as a punishment sent from God for bad behaviour. Said one:

Look at all that is happening; look at the women, who are supposed to wear long dresses but instead go around with tight trousers that seem to have been fitted on their skin. That is what has triggered God’s wrath. This is only a little punishment compared to all the sins of people.

This participant dismissed the view that HIV came from apes by pointing out that AIDS only occurs in human beings, which rules out the idea of an origin in the animal kingdom. Others argued that God would not destroy his own creation. In general religious ideas about the origin of HIV/AIDS were an important part of the informants’ discussions.

Reactions to Being HIV-Positive

We asked participants what they would do if they were diagnosed HIV-positive. With very few exceptions they expressed strongly negative feelings at the thought of being infected. Some said they would commit suicide rather than succumb to the disease. One said: ‘I would kill myself. I see no other choice. I cannot lie down sick one day along a sidewalk without anyone to take care of me. It will be better to die than wait for the disease to take root and lead to a pitiful death.’ Some said they would not reveal their HIV-positive status to others for fear of embarrassment, isolation and discrimination. A common reaction was a concern not to pass the virus on to other people. Some participants said they would speak publicly about their infection in order to teach others not to end up like them. One of these informants, when asked if he wouldn’t feel angry that the virus had infected him at such a young age, said: ‘Why should I be angry? Death is something that awaits me anyway.’ Others said they would pray to God for healing. They said that they would start going to church, cleansing themselves with holy water, soliciting God and confessing. These informants argued that having lost their life in this world, they did not want to lose their chance of a good life in the world to come.

Others’ reactions referred to the government’s response (or lack of response) to their situation. One boy stated:

I would go and seek assistance from the government. If I am assisted I would have no problem in exposing myself and teaching the public to be aware of the disease. But if I am neglected, I wouldn’t feel any guilt in taking my revenge on as many people as I could by passing on the virus to them by any means I could find.

Asking why he would take revenge on other people, he said that he does not see any difference between the government and the people, for the people make the government. Another displayed an unshakeable fatalism by stating that his days were numbered. The day and hour of his death was a thing already decided by God, he said, and so ‘I will die at that hour with or without AIDS. The hour will not come any sooner because I have HIV nor will it be delayed if I don’t.’ Therefore, if he discovered he is carrying the HIV virus, he would just continue living until his last day and hour came. In contrast most of the informants did not want to know their HIV status. To know you are infected, some said they would prefer to not know their HIV status. To know you are infected. Some said they would not want to know their HIV status. To know you are infected. Some said they would prefer to not know their HIV status.

Dynamics of HIV/AIDS among Different Groups

Throughout human history many epidemic diseases have been blamed on outsiders. Epidemic diseases have also been seen as problems affecting only marginal members of society (Kane 1993; Setel 1999). Similarly AIDS has been widely considered a problem of “others” throughout its brief history, and has been a metaphor for human differentiation by race, class, sexual identity and gender (Murray and Robinson 1996). Poverty and other socio-political predicaments have created favourable conditions for the HIV/AIDS epidemic and prevented an effective response. Thus Farmer (1992: 242) notes that ‘Aids is indeed a disorder of poor people, and becoming more so…’. In view of this we asked our informants if they thought the rich or the poor were more exposed to AIDS. Most of them argued that rich people are more exposed because they have the money to do what they want and to win whatever girl they like. The poor think about sex less, as they are preoccupied with earning a living and in any case cannot afford to go out with women often. The students (non-street children) involved in the study also shared this view.

Interestingly, the participants all agreed that ordinary girls or “home girls” (ye bet lijoch) as they put it, particularly students, are more exposed to HIV than prostitutes. They all remarked that it is safer to have sex with prostitutes (sheles) than ordinary girls because prostitutes are more careful and make sure condoms are worn, while ye bet lijoch were described as messy. My own impression, however, is that impoverished prostitutes will not refuse sex without a condom for fear of losing clients. The poor think about sex less, as they are preoccupied with earning a living in any case cannot afford to go out with women often. The students (non-street children) involved in the study also shared this view.

Perceptions of Condoms and Condom Use

Since most of the street children involved in the study reported using condoms, they were asked if they liked using them or only did so from necessity. We also asked whether they felt condoms made a difference to the sexual experience of either partner. There was a general consensus that sex with condoms is not as enjoyable as sex without, and that sex is more
“natural” without a condom. One street boy said he only uses condoms because there is nothing else he can do to protect himself from HIV: ‘This “impolite” (balege) disease forces me to use condoms, but sex would be more enjoyable without them.’ He made these statements with a lot of disgust on his face and later added that putting on and removing a condom is ‘messy’ (mechemaleq). He added that even using condoms might not be safe, as only God knows if they really protect against HIV. He pointed out that one must also choose girls carefully, stating that if the “axle” (differniashalum) — the slang term for the part of the body from the waist to the lower thighs — is beautiful, the girl is safe. The other participants more or less expressed the same disgust over using condoms and said they use them only to be safe. Although the main religions in Ethiopia do not condone condom use, none of our informants associated condom use with sinning. Asked if they feel any shame when buying condoms, they reported that there are some situations where buying a condom is shameful, for example, in a shop when there are many older people within earshot. One informant said: ‘I roam around for suitable shops whenever I want to buy a condom.’ When asked what types of shops are suitable, he replied that shops where a young boy or man is behind the counter do not make him feel ashamed.

Some of the informants were very quick to mention problems with condoms such as tearing or puncturing. Because of these risks they sometimes wear two at a time. They claimed that some condoms are already torn when they are removed from the package. Others insisted that such problems come from not knowing the proper way of using condoms. Asked if they have friends who do not use condoms, they replied that many people dislike condoms and are heard saying: ‘Why should I struggle with a condom? I will do without it!’ They said that some people don’t use condoms because they do not believe that they can protect them, some for fear their girlfriends will consider them unfaithful or untrustworthy and some because they think condoms reduce pleasure. One of the boys said he had friends who do not use condoms because they say sex with condoms is like ‘childhood sex’. None of the informants had complete confidence in condoms, but most felt they are better than ‘going in bare’. One boy compared sex with fire, and a condom with a pair of shoes: ‘It is much safer to step on fire with your shoes on than with bare feet.’ Some said they use them only because they have come to associate condoms and sex rather than because they actually think about the need for protection. One boy added that he sees condoms as equivalent to Aids and only uses them because the prostitutes refuse to have sex if he doesn’t wear one.

Substance Abuse and Unsafe Sexual Behaviour

Most of the boys admitted they use qat and alcohol and smoke cigarettes. Even during the focus group discussions, we saw one informant trying to sneak some qat leaves into his mouth without being seen. We told him it was okay with us if he wanted to use it there. He smiled and brought out a very small bundle of leaves from his pocket. Another participant followed his lead, and then many started chewing. We objected when they lit cigarettes, but they countered that we had to allow them to smoke if we wanted them to keep talking. We had no choice but to let them smoke.

Intravenous drug use is something they neither engage in nor had even heard about. Asked if they used hashish or any other drugs they all laughed. One of them said they only take hashish when they have money left after eating enough to be satisfied. The implication was that this happens very rarely. Life on the street is very stressful, and they explained that they usually take qat to overcome their loneliness and escape the harsh realities of their lives. We then asked if using alcohol or other drugs might influence a person’s decision or ability to use condoms, or influence their sexual behaviour in general. It was agreed that there was a strong association between alcohol, qat, cigarettes and sex. One said: ‘I have to drink first and I also have to have money in my pocket to pay for her [the prostitute].’ Another stated that he only thinks of sex after he has taken qat and has had a few drinks. Asked how often they have sex, they replied that it all depends on how often they can drink and chew qat. Whenever they drink and chew qat, sex follows.

The informants also felt that alcohol, qat and smoking could make them careless about using condoms. Some boys said that when they are drunk they forget to wear a condom or do not use it properly. Some even suggested that the government should ban all drinking places along with the production and distribution of alcohol, because men are usually lured into having unprotected sex under the influence of alcohol. One boy said: ‘You go to a certain hotel just to have a drink or two and then you see those pretty girls in those clothes that leave half their body naked for you to see. When they come and arouse you with all their sex looks and touches, what you know about Aids just leaves your mind and you end up in bed with one of them. I am sure if alcohol was banned, Aids would cease to be a problem.’

In general the informants denied agency and blamed alcohol and qat for unsafe sex.

Conclusion

Male street children are preoccupied with getting money almost to the exclusion of the problems posed by Aids. The first discussion held with each focus group was about the concerns and problems in their daily life in general. When the boys were asked what their problems were, no spontaneous mention of Aids was ever made. They have many other worries, and to little to look forward to, that Aids is a remote concern at best. This sharply contrasted with the attitude of young people attending school. They were very quick to bring up the issue of HIV/AIDS without it being prompted by the facilitator.

Street children and youth in Dessie are also not well informed about HIV/AIDS transmission and prevention. Even the few who showed some understanding of how to minimise their risks of infection still expressed a lot of confusion and misconceptions. The level of knowledge about HIV/AIDS among street children in Dessie is very low compared to that of children attending school. This finding corresponds with Swart-Kruger and Richter’s observations of children and youth in South Africa (1997). The many HIV/AIDS prevention campaigns on radio, television and other media encouraging abstinence, monogamy and condom use are not appropriate to this group except for the message on condom use. Given their precarious living conditions, it is unrealistic to expect these boys to abstain, and their low social status makes it very difficult to have a girlfriend of a similar age or to get married.
The informants also admitted that they did not use condoms in the past when AIDS was not so much talked about. However they still have problems purchasing condoms and using them, and still believe many myths about them. Even those who appear to have adequate knowledge about HIV/AIDS may lack the skills to use condoms correctly or to negotiate safe sex with a partner. Education campaigns should therefore focus not only on information but also provide these young people with the skills to negotiate safe sex and to use condoms correctly. Moreover education alone is not enough. Strategies to improve the acceptability and accessibility of condoms for young people need to be implemented.

Most informants believed that condoms are not a completely effective means of preventing HIV/AIDS. This contrasts with studies from South Africa and Zimbabwe (Ministry of Education and Culture and UNICEF 1993; Swart-Kruger and Richter 1997). They also expressed negative attitudes towards condoms. Some said they did not like condoms and would prefer not to use them. Some believe the lubrication in condoms may be impregnated with HIV. Clearly there is a need for education programs for young people targeting such myths.

Generally the street children and youth involved in this study feel helpless and frustrated with their sexuality due to fears of HIV infection. The majority of informants admitted engaging in sexual activities with prostitutes without using a condom in the past and knew this put them at risk. They therefore fear that they are already living with the virus, and this discourages them from taking more care in their current sexual practices. Moreover they prefer to live with uncertainty rather than knowing their HIV status. It is essential, therefore, that educational programs should focus on encouraging young people to be tested. It appeared that all options for preventing HIV/AIDS are seen as problematic in one way or another. Abstinence seems quite conservative, unless their discourse was a public display and their private behaviour very different.

Contrary to common belief in Ethiopia (and perhaps elsewhere), prostitutes are not high-risk sexual partners as far as these street children and youth in Dessie are concerned. On the contrary they argued that since prostitutes make clients use condoms they are safer than “ordinary” girls. However this sharply contrasts with other studies in Africa and may again indicate an opinion expressed for public consumption rather than the boys’ actual belief or experience. A study of young people in Zimbabwe revealed that prostitutes are the group most strongly associated with AIDS (Ministry of Education and Culture and UNICEF 1993). Furthermore there seems to be a lot of literature that links prostitution with the spread of HIV/AIDS. In Africa and other “Pattern II” areas, where initial and subsequent epidemic phases are attributed to heterosexual transmission (Kane 1993), the prostitute-client relationship is considered to be the critical bridge of transmission into the wider heterosexual population. Perhaps this theory deflects attention away from the more complex realities of the epidemic (Day 1988; Gil et al. 1996; Kane 1993; Murray and Robinson 1996; Neequaye 1990; Peracca et al. 1998; Scambler and Graham-Smith 1992; Standing 1992; Talle 1995; Ward and Day 1997). However there are others who insist that prostitutes as the most vulnerable group for AIDS (Peracca et al. 1998; Sturdevant and Stolzfuß 1992).

In line with the views of street children involved in this study, one often comes across literature arguing that “visible” prostitutes are safer from HIV/AIDS than clandestine practitioners (Kane 1993; Murray and Robinson 1996; Standing 1992). Day (1988) argues that the context has to be specified when considering prostitution as a risk factor for HIV infection. Prostitutes and their clients may play an important local role in transmission in some societies but not in others. Murray and Robinson (1996) dismiss any necessary connection between unsafe sex and commercial sex, pointing out that the rate of HIV infection among sex workers in Sydney, Australia, is lower than that of non-sex workers. One might expect that the explicitly professional nature of a commercial sexual exchange increases the probability of condoms being used. In contrast, where sexual exchange is non-professional, or where the professional nature of the exchange is not recognised, one could expect a lower probability of condom use (Kane 1993: 976).

Nevertheless the consensus among our participants that prostitutes are less risky sexual partners than “home girls” may simply be another misconception that increases the risk of HIV infection in street children. Prostitutes in developing countries like Ethiopia are often believed to be powerless to make their clients use condoms. In Ethiopia and other developing countries, where most prostitutes work in bars and hotels and where prostitution and alcoholic drinks usually go together, consistent condom use by either party is not generally expected. Excessive alcohol consumption coupled with a need to maximise economic gain leaves prostitutes in a very weak position to negotiate safer sex (Talle 1995). Commercial sex in developing countries often also involves a degree of emotional attachment, or even the exchange of gifts and a more or less steady relationship. Such a relationship often seems to obviate the need for condoms, yet as most permanent partners could also be promiscuous, steady relationships are as dangerous as more temporary ones. Moreover condom use in societies such as that of Ethiopia is an issue surrounded by cultural ambivalence. Condoms are used most often when they are easily accessible and free of negative associations, and when there is the capacity (economic or social) to negotiate their use. Unsafe sex is likely to be common in an environment like Dessie where prostitutes barely survive by selling sexual labour and are not free to insist on safer sex because of fears of losing their clients. Further the complexity of the sex industry involves many more people than sex workers, so prostitutes may also be coerced by pimps or owners of bars who discourage condom use for their own financial gain (Murray and Robinson 1996).

To conclude street children and youth in Dessie are living in a precarious environment and are at high risk of contracting HIV, partly because they do not know how to avoid HIV infection. They expressed feelings of helplessness and frustration about protecting themselves from HIV/AIDS. Many of them suggested that people living with HIV/AIDS should be involved in AIDS prevention campaigns. They also emphasised that more vigorous and more
personal face-to-face approaches should be adopted. In other words educational programs should not be limited to television, radio and newspapers. Using peer educators to spread awareness about HIV/AIDS, and involving street children in program planning, may be the most effective ways to reduce the risk of HIV infection among street children and youth.

References


