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AIDS and development: an inverse correlation?

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There is no question about the seriousness of the AIDS epidemic in Africa.[1] It has been clear for some years that problems associated with the epidemic are enormous. The depth of the problem has been documented repeatedly.[2] Now that we have moved into what is described below as the 'acceptance-response phase', it is timely to look beyond present problems to the legacy that will remain once the epidemic has been confronted by medical science and endured by its millions of victims and their families, most especially in Africa. This article argues that as a result of many pre-existing conditions, having little to do with AIDS, aggressive responses to the epidemic, especially by the international community, are likely to undermine African autonomy and impede future development, particularly politically and psychologically. While AIDS is one of many deterrents to development,

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[1] I am grateful to two anonymous reviewers for constructive comments and suggestions. 'Africa' and 'development' are not terms that have universally accepted meanings. For the purposes of this paper, Africa refers to the 45 or so states of the sub-Saharan portion of the continent, recognising there is great diversity on virtually every conceivable scale. Development refers to the process of moving toward the Western model of economic, industrialised, consumerist societies. AIDS and HIV infection are treated interchangeably here since the general impact of the disease is undifferentiated in societies where resources are insufficient to provide medical treatment for the great majority of HIV patients. While great advances have recently been reported on the medical front, their effects will be confined to the Western world for the foreseeable future. The AIDS model that is assumed here is a sexually transmitted condition, invariably fatal, reaching fruition in about ten years.

[2] See John C. Caldwell *et al.*, 'Underreaction to AIDS in sub-Saharan Africa', *Social Science and Medicine* 34, 11 (1992), 1169–80; J. Wilson Carswell, 'Impact of AIDS in the developing world', *British Medical Bulletin* 44, 1 (1988); Kevin de Cock *et al.*, 'Measuring the impact of HIV/AIDS in Africa', *AIDS* 8 (1994), 127–8; G. M. Desmond, 'The impact of AIDS on economic development; an approach to a case study in Africa', paper presented at African Studies Association conference, 1989; Richard A. Fredland, 'AIDS in Africa: a political Overview', *University Fieldstaff Reports*, April/May 1989; Dan Grossman, 'The economic impact of AIDS in sub-Saharan Africa', unpublished manuscript, Stanford University Medical School, 1991; Indrani Gupta, 'The economic impact of fatal adult illness in sub-Saharan Africa', paper presented at African Studies Association, Boston 1993; Kathleen Hunt, 'A nightmare in Africa', *The New York Times Magazine*, 12 August 1990, pp. 25ff.; Jonathan Mann *et al.*, *AIDS in the World* (Cambridge, MA, 1992); US Bureau of the Census, Health Studies Branch of Population Division, 'HIV/AIDS in Africa'; World Health Organisation, Global Programme on AIDS, 1993, 'The HIV/AIDS Pandemic: 1993 overview', 1993.

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it has, in many affected countries contributed significantly to undermining their future prospects.

From several perspectives the AIDS epidemic can be seen to have levelled an enormous toll on Africa, especially in the eastern and southern regions. This article confines itself to the non-medical consequences of the epidemic where it has been most profound. Although the epidemic has possibly passed its peak,[3] evidence of the toll of the disease, with its related health problems is now clear.[4] In its wake are serious multidimensional problems: anthropological, sociological, economic and political. AIDS has greatly diminished prospects for increased autonomy in many countries, and dashed hopes for major improvements in their quality of life. These multisectoral dimensions of the AIDS impact are likely to affect African development negatively for many years to come. As an extreme example of the enormous difficulties, a recent report suggests an HIV rate of 50 per cent in seven armies in central Africa.[5] Such reports highlight consequences that affect development prospects in general. These and related problems undermine the sense of nationalism and national identity so eagerly fought for in all parts of Africa during the independence era. This article focuses on these dimensions of the epidemic and suggests possible consequences in terms of national development in those countries most affected.

The present challenges are unprecedented. While called on to react to the potential effect of AIDS on national economic and political development, leaders are being drawn into global reactions and responses. The responses to this latter challenge are likely to reveal weakness and vulnerability within societies. Therefore, it is important that steps be taken now by governments to avoid the inevitable

[3] At least the number of new cases reported has stabilised for much of Africa (US Bureau of the Census, 'HIV/AIDS in Africa').

[4] See Carswell, 'Impact of AIDS'; de Cock, 'Measuring the impact'; Joseph Foumbi, 'Orphans', Presentation by UNICEF at African Health Conference, Washington, 1993; Edward C. Green, *AIDS and STD in Africa* (Boulder, CO, 1994); PANOS Institute, 'AIDS: The second decade', Panos AIDS Media Briefing No. 1, 1993; Gary Shannon, *The Geography of AIDS* (New York, 1990); US Bureau of the Census, 'HIV/AIDS in Africa'; WHO, 'The AIDS pandemic'. *The Directory of Fellows 1963–1996* lists over 2,500 alumni of programmes administered by the African American Institute. For Malawi, one of the most seriously affected states, 67 alumni are noted, 7 of whom are deceased. Among them, they held six MA and four Ph.D. degrees from American institutions plus other unspecified degrees. This substantial investment in human potential has been lost; while there is no specific indication that AIDS was the cause of all seven deaths, it certainly was a major factor.

[5] Jim Hoagland, 'Preparing for a new threat', *The Washington Post*, 7 April 1997. Data from the epidemic is vast as well as biased. Many epidemiological studies have been derived from urban populations, often high risk. While it is not possible to generalise to entire populations from these data, the numbers do suggest that there is a huge and growing problem.

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outcomes of control from sources external to the continent. For Africa, the focus must be specifically on curtailing the spread of AIDS while minimising the effects of that effort on other development goals.

Progress towards addressing the AIDS threat is undermined by associated problems of poverty and political turmoil. To the extent that they ever existed, resources with which to deal with this epidemic have been depleted as a result of several factors including disorder, excessive population growth, corruption and international economic activity. The global political-economic situation is such that there is a decreasing likelihood of substantive assistance being received from outside the continent, a consequence of global priority changes. African governments, after failing to address problems at the outset of the epidemic, are now faced with even greater difficulties than might otherwise have been the case.

As recent efforts have demonstrated, it has been difficult to achieve a globally accepted policy on how governments and other organisations should address AIDS. The African health situation may have been different had there been an aggressive response when the epidemic first became apparent. During its early stages, it was assumed by much of the outside world to be simply an African problem, one which could be ameliorated by generous donors. Alternatively, the spread of AIDS in Africa could have initially been examined not as a regional phenomenon by other nations, but as one with global implications and local variations.

Naturally, it has been treated by both donor and recipient countries in terms of their own interests and priorities, with resources having been focused regularly on problems other than AIDS. Left behind are serious medical, political and epidemiological issues. This has affected prospects for an improved quality of life, and has renewed dependence on more developed countries and inter-governmental organisations (IGOs) for essential support, curtailing the growing sense of nationalism in all parts of Africa.

PHASES OF THE EPIDEMIC: AN OVERVIEW OF RESPONSES TO AIDS

Over the past fifteen years, the AIDS situation in Africa has moved through five phases. Individual states and the continent as a whole have experienced these phases as overlapping phenomena. They have influenced African relationships with assisting institutions and governments.

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The *first phase* was fear, a not unreasonable reaction to a disease, as Sontag observes, 'that doesn't knock before it enters'.[6] This fear prompted denial by most African governments.[7] Solomon argues that this is still the case in South Africa.[8] Some combination of fear and denial must explain the situation in the 1980s of a Zimbabwean minister of health ordering physicians not to report AIDS as a cause of death. Zimbabwe and Kenya were long reluctant to reveal the extent of the problem in their respective countries because of 'racist overtones and the sensitivity of the tourist industry' (as a major foreign exchange earner).[9] The president of another seriously affected country refused to deliver a statement on World AIDS Day, remarking that it was a problem for the Health Ministry.[10] Attempts to move beyond denial to structured institutional responses were thus frustrated. This pervasive reaction became an invitation to the rapid spread of the virus that was already widely present.[11]

Blaming became the substitute for acknowledgement and action; this constituted the *second phase*. Virtually from the outset, productive dialogue was stalled. People in the West looked to Africa when placing blame. In South Africa, a newspaper headline stated in about 1985, 'African AIDS comes to South Africa'.[12] Conversely, Africans blamed the CIA, the US military, and others for causing the epidemic.[13] Around the world, leaders concomitantly placed blame on various segments of the population for bringing about the problem. Blaming thus became the opportunity to avoid accepting responsibility for seeking indigenous solutions.[14]

With the epidemic expanding and problems compounding, medical and social science professionals responded with critical notice. This *third phase* evolved when the biomedical profession could no longer avoid coming to grips with the problem, regardless of their level of knowledge

[6] Susan Sontag, *Illness as Metaphor* (New York, 1977).
[7] Caldwell, 'Underreactions to AIDS'.
[8] Greg Solomon, 'An evolving life industry', *AIDS Analysis Africa* 7, 3 (Oct./Nov. 1996).
[9] Ken Mufuka, 'The disease AIDS and sex in an African social context (Zimbabwe)', Paper presented at African Studies Association, Boston, 1993.
[10] Conversation with a national AIDS director.
[11] Caldwell, 'Underreaction to AIDS', p. 5. A Tanzanian survey found that one-fifth of the population thought that AIDS affected only barmaids, truck drivers, prostitutes and prominent people (*Information Afrique*, 6 August 1996).
[12] Reported to the author by a Botswanan who was a student in South Africa at the time.
[13] This was exacerbated by Wolff Geisler, a German author, who alleges in *AIDS – Origin, Spread and Healing* that AIDS originated in US military research. A. Olufemi Williams, *AIDS: An African Perspective* (Boca Raton, FL, 1992), provides air route maps from Western Europe to West Africa in support of this thesis that aids was imported into Africa by European tourists.
[14] Fredland, 'AIDS in Africa'.

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(or lack thereof, as it turned out). AIDS is a curious phenomenon, in that science determined how to prevent the disease long before a cure was available. Concomitant with medical interventions was the need for social responses, e.g. counselling patients and their families. In the West, this was as slow in coming as it was in Africa. An institutional approach did not occur till several years into the epidemic. Health workers began recognising this as a human tragedy that required 'science to confirm and explain but human services to ameliorate…'[15] That response spawned a two-pronged development: first, in several African states institutional structures emerged primarily to provide education and/or research.[16] Simultaneously, the international community spurred a growing effort to provide a modicum of assistance to African states as they confronted the problem with their limited resources.

In the *fourth phase*, institutions reacted to mobilise resources for systematic study and possible treatment. The World Health Organization responded when it became clear that governments in the most affected countries did not have resources to deal with the epidemic. Outside support was needed, but the reasons for and targets of that support were continually evaluated in terms of the interests of outside agencies. In the waning days of the Cold War, assistance was the avenue to influence and leverage. Propaganda was often skewed (especially when it came to placing blame), causing exaggerated, and at times negative, responses to the crises. Beset by problems, the most severely affected African countries were unprepared to offer timely institutional responses to the epidemic. Some medical personnel did attempt to provide rudimentary assistance. This resulted in Westerners coming to Africa to advise Africans about their needed behaviour changes in order to confront this plague. Not surprisingly, this was not an effective approach, and in spite of substantial effort, the epidemic raged on.

There are concerns that educational strategies can be too general. Fisher explains that the 'safe sex' message is not, *ipso facto*, adequate. 'Monogamous' relationships could be interpreted to mean a series of sequential relationships. Yamba recounts his findings that a Zambian

[15] *Sociétés d'Afrique & SIDA* 14 (October, 1996) argues that there appears to be a communications gap between social science researchers and the 'field' to which the findings apply. The editorial argues for the simplification of results 'so that the richness and diversity of [researchers'] contributions can be heard [and presumably acted upon]'.

[16] David L. Heymann, *et al*. 'AIDS-related research in sub-Saharan Africa' (World Health Organisation, 1990).

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'anti-witch' traditional healer had 'succeeded in just a few months in completely wiping out all the information on the transmission of HIV that the population had until then managed to absorb', because it ran counter to traditional notions which lacked scientific bases.[17]

These and other structured institutional responses to the overwhelming problems have political dimensions, if not thoroughly political characteristics.[18] Fear, blame, and finally recognition, influenced this stage of political responses. All too frequently, politics associated with the epidemic, and obviously a prerequisite to the formulation of policy, has impeded effective responses to the AIDS situation. Bayart argues that governments responding to the problems African countries face should apply a 'moral-economy' analytical framework.[19] The first step was to identify what was expected from African governments. There then came a level of acceptance by a growing number of governments, often under external as well as internal pressure. An example of leadership which has become a classic is the Ugandan minister of health standing on Kampala streets dispensing condoms. On a political level, the Organisation of African Unity passed several resolutions and implemented monitoring programmes in order to raise states' consciousness. This facilitates collaboration with external institutions, which, inadvertently, further erode autonomy.

Government policies that openly address the problems associated with the disease have advantages. Cohesive and comprehensive approaches can be developed to strengthen connections with outside resources, fostering a global network and response to the potential harm to achieving any development goals. Such open and aggressive responses, most importantly, will put the government in control of its own future by enabling it to establish priorities and programmes of its own choosing.

[17] Bawa Yamba, 'Current research', *Sociétés d'Afrique & SIDA* 14 (October 1996), 11; another aspect of mis-education is reported by Caldwell, 'Underreaction to AIDS', who tells of men ironically assuming that 'plump women are safe' because the effects of AIDS leave its victims wasted.

[18] Fredland, 'AIDS in Africa'; Richard A. Fredland, 'The politics of AIDS: a comparative perspective: South Africa and other Africa', *Proteus* 9, 2 (1992), 35–40; Norman Miller and Richard C. Rockwell, *AIDS in Africa: The Social and Policy Impact* (Lewiston, NY, 1988).

[19] Jean-François Bayart, Remarks at African Studies Association, San Francisco, November 1996.

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COLLATERAL CONDITIONS CONTRIBUTING TO THE SPREAD OF AIDS

Implicit in any discussion of AIDS is the risk of making generic observations across cultures and over time; as Towers reminds us: we 'must be cautious of the methodological trap of "presentism"'; i.e. attempting to interpret past actions and actors in terms of the cognitive structures, analytical paradigms and critical agendas of the present'.[20] Tradition rules with a more powerful hand in much of African society than it generally does in the West, and our scientific understanding of AIDS is continually evolving.

While AIDS is a fearful health problem in its own right, its consequences are exacerbated by other prevalent health conditions as well as the social stigmatisation and segregation of infected persons, conditions that relate to poverty and ignorance. These conditions prevail in many parts of the world. In the West, where AIDS emerged, by happenstance, among two pariah communities – intravenous drug users and homosexuals – their outcast status compounded the difficulty of devising policies to focus resources on the problem. In the minds of many, the appropriate response to AIDS has been to stigmatise and segregate AIDS patients. This stigmatisation has moderated as the epidemic has spread both geographically as well as culturally to other segments of the population and to all regions of the globe. Africa is often viewed in the West in much the same way – as a place to avoid or isolate. It is poor, seen by many in the West as pervaded by problems and instability, and economically and politically marginal.[21] AIDS becomes simply more of the same.

Conditions in many African countries facilitated the spread of HIV: malnutrition, as evidenced by the 20 per cent of Africans who are underfed,[22] or the marginal existence of many living in drought-prone regions. The relationship between malnutrition and other sexually transmitted diseases (STDs) has been established since the onset of the epidemic.[23] Africa's economic problems have assured the continuation of food deficiencies for the foreseeable future.[24] Twenty years ago,

[20] Bridget Towers, 'Methodology', in Virginia Berridge and Philip Strong (eds.), *AIDS and Contemporary History* (Cambridge, 1993), p. 55.

[21] Immanual Wallerstein, 'The three stages of African involvement in the word-economy', in Peter Gutkind and Immanuel Wallerstein, *The Political Economy of Contemporary Africa* (Beverly Hills, CA, 1976) argues that the international nature of the markets for which Africans produced primary products ensured peripheralisation.

[22] UNDP.

[23] 'AIDS and the socio-economic determinants of the epidemic in southern Africa – a cycle of poverty', *Journal of Tropical Pediatrics* 40 (February 1994).

[24] The average African is no better off today in economic terms than at the time of

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Tanzanian President Julius Myerere recognised the problem but lacked resources to address it; Tanzania is now besieged by AIDS. Economic problems assure a continuation of food deficiencies because the essential inputs to food security such as fertilizer, wells, seeds and marketing will continue to be unaffordable. In sum, AIDS has neutralised substantial portions of even modest development successes of the past three decades.

There are social dimensions associated with AIDS which have negatively affected Africa in terms of development. Some examples: 85 per cent of prostitutes in Nairobi were found to be HIV positive.[25] Life expectancy in Uganda has declined from 60 to 40 years for a child born today.[26] In some cases, the segment of the population most severely affected is the educated elite.[27] Perhaps 20 per cent or more of the *entire population* of Malawi or Zambia is estimated to be HIV positive.[28] 'By the year 2010, 37–46 per cent of the Tanzanian adult population will be HIV infected.'[29] Life expectancy in Malawi is predicted to drop to less than 30 years by 2010.[30]

Social dislocation, common in Africa, contributes to the problem. Political disturbance and military actions have resulted in insecurity for many Africans. The United Nations estimates that a substantial percentage of the 20 million refugees worldwide are Africans from, *inter alia*, Liberia, Sudan, Rwanda, Somalia and Mozambique. Despite such social deterioration, basic biological drives persist. It is common, therefore, to find that the HIV virus has spread rapidly throughout areas where portions of the population are displaced or temporarily employed away from home.

Any effective AIDS programme must take into account another consequence of poverty: migrant labour, as seen in the mining communities of South Africa.[31] Men attracted to the cities often live in

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independence three decades ago (United Nations, *World Economic and Social Survey*, New York, 1996).

[25] US Department of Commerce, 'Trends and patterns of HIV/AIDS infection in selected developing countries', Research Note No. 22 (June 1996), p. 8.

[26] *The New York Times*, 10 June 1990, reported 40,000 orphans in Uganda in mid-1990.

[27] A British anthropologist attributes 'breezy hedonism' to high risk populations, both in the West as well as Africa (quoted in *Africa News*, ANB, 1 June 1989).

[28] See, for example, 'The public health implications of AIDS research in Africa', *Journal of the American Medical Association* 272 (1995), 481–85. For example, one 75-year-old gentleman in Malawi has lost six sons and a daughter to AIDS.

[29] N'nali Mbilinyi, 'The economic impact of AIDS on Tanzania's development', Paper presented at African Studies Association, Boston, 1993, p. 8.

[30] US Bureau of the Census, 'HIV/AIDS in Africa'.

[31] Despite its relative affluence, a South African health officer recently characterised his country's response to the AIDS epidemic as 'bad'; Pravin Maharaj, MD, Director of Health, Kwa-Zulu Natal, Lecture, Indiana University, Indianapolis, 1996.

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crowded, unsanitary hostels, arrangements which easily lead to prostitution (as well as tuberculosis – now of epidemic proportions).[32] This in turn facilitates the spread of AIDS as migrant labourers return to their homes, having been infected in the city.

Prevention efforts are predicated on some grasp of science: that the presence of the disease is unseen and unseeable, that it does not manifest itself for a number of years, and that it is transmitted primarily in the course of the most intimate of human interactions. The widespread lack of scientific education in Africa has facilitated spread of the virus. A scientifically accurate message is not easy to formulate and deliver to peers, much less other social groups.[33] Yamba points out the contradictory messages Africans receive from biomedicine, religion and tradition. The first source advocates STD treatment and condom usage. Other segments of society, especially churches, advocate abstinence. Traditional healers, on the other hand, who play a substantial role in African health, respond in a variety of ostensibly curative ways, some of which are decidedly unhelpful.[34]

Even modest prevention efforts are confounded at times by poverty. A report in the *Johannesburg Star* indicated that condoms made available (presumably by an international agency) in Mozambique were being sold at a profit in neighbouring countries.[35] Short-term needs take precedence over deferred benefit.

POLITICAL-SOCIAL PERSPECTIVES

'Health is never apolitical',[36] and the AIDS epidemic, which is much more than a 'medical-epidemiological event', is no exception. It 'has spawned social, political, economic, and other consequences that are far beyond the purview of medicine'.[37] As noted above, there are cultural implications on several levels of education.[38] Therefore, if there

[32] I am grateful to an anonymous reviewer for pointing out that TB rates have increased as a result of HIV, and while that does not make people more susceptible to HIV – except in so far as generally poor health may facilitate the potential of the HIV virus – the spread of TB has a geometric quality.

[33] Not surprisingly, I have met with resistance and hostility on occasions when addressing African audiences on this topic.

[34] Yamba, 'Current research', p. 10.

[35] *Johannesburg Star*, 5 November 1991.

[36] M. Freeman, and M. Motsei, 'Planning health care in South Africa – is there a role for traditional healers?', *Social Science and Medicine* 34, 11 (1992), 1187.

[37] Fredland, 'Health, education, and the decline of culture: AIDS colonizes Africa', International Studies Association – Midwest, Indianapolis, September 1995, p. 3.

[38] Douglas A. Feldman (ed), *Culture and AIDS* (New York, 1990); Sally J. Scott and Mary Anne Mercer, 'Understanding cultural obstacles to HIV/AIDS prevention in Africa', *AIDS Education and Prevention* 6, 1 (1994), 81–9.

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is to be hope for an international response to the epidemic, it must be apart from criticism of African political systems, or their inability to deal with the problem. Rather, the approach must be one of understanding the enormous burden of dealing with an epidemic of this proportion while, at the same time, struggling to compete in an international environment that has superior resources.

Political responses are critical to affecting the AIDS situation. Educational challenges are difficult, without local political attention and economic resources.[39] Because of the difficulties of finding a cure, many governments, including those in the West, attempted to minimise the epidemic or postpone consideration to a future time, its mere presence indicating the limits of political power.

Patriarchal societies, as are most in Africa, must go especially deep within their communities to look for ways to address the threats they face from this disease. It is relatively easy to wean people away from a visible and fearsome threat, such as a rampaging animal or a coughing or wheezing person, but there is no immediate sign of HIV infection and it may remain quiescent for years. Thus, how can one make the requisite case, and can it be done without stigmatising AIDS sufferers further?

Some African social practices which remain foreign to Westerners also affect responses. Behavioural changes required by AIDS prevention programmes in the absence of medical prophylaxis affect mores which have evolved over centuries. The Masai (and others') tradition, for example, of brothers taking in widowed sisters-in-law assures much-needed economic security for that second family, but also provides a mechanism for the efficient spread of HIV if the deceased died of AIDS, as has been the case with many Masai. What the West often describe as promiscuity is seen in many African cultures as a form of community or initiation into adulthood, without censure or shame;[40] it is not therefore susceptible to blanket condemnation.

The pervasive problem of bridging the gap between the rich (and formerly colonising) West on the one hand, and the new and often impoverished nations in Africa on the other, will continue. Resources

[39] I was told by a national AIDS director that what her country needed was a Michael Jordan – a widely recognisable African public figure who could articulate the reality of AIDS. The Ugandan singer, Philly Lutaya, served this role to some degree, but only in his home country. He was not sufficiently well known beyond its borders; his untimely death cut short his efforts.

[40] Puppets are used in South Africa to convey AIDS education messages because they are able to 'say' whatever is deemed necessary without regard to cultural implications of distances, according to Gary Friedman, Presentation at IXth International Conference on AIDS Education, Jerusalem, 1995.

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as well as creative diplomacy will be needed to bridge this gap. The need is for rapid modernisation in traditional societies. African states are not yet organised to achieve this, Berman suggests, for reasons which are complex and delicate.[41]

The dichotomy between societies which suffer from the virus and those which have resources to search for cures, is an additional problem with broad political implications. When the day comes for trials for AIDS drugs, it is probable that primary research will occur in wealthy industrialised countries where resources are easily available. The largest number of potential patients for vaccine trials, on the other hand, will probably be in Africa, or perhaps Asia. Such trials of Western drugs in developing areas can be expected to contribute to further widening the gap between the West and Africa, once again exacerbating tensions and diminishing Africa's autonomy in one additional way. Vaccine trials are never without risks. This acknowledgement of a potential political and economic gap contributes to recurring accusations and blame for the epidemic being bounced from one side of the world to the other.

Until recently, attention has been devoted, not so much to medical solutions, as to behaviour change: abstention, monogamy, condom usage, i.e. 'low risk' sexual behaviour.[42] This has constituted less of a political and economic risk than other approaches to the problem. All of the above strategies cause conflict within various social groups, and depend upon a grasp of post-Newtonian science. These prescriptions are especially applicable to their effectiveness among African social groups.

Societies with child mortality approaching 50 per cent and brief life expectancy – or with perceptions of such – can hardly be expected to abstain from procreation. Political responses reflect the strengths and weaknesses within a political system. While it may be useful for the international community to bolster Africa's response to the AIDS crisis, it simultaneously highlights the ineffectiveness of African political systems, even in dealing with matters within their own purview and of great interest to their well-being.

It is often difficult to understand fully cross-cultural interpretations of policies and relationships. For decades, the intrusion of desultory Western mores has pervaded modern Africa: language, dress, education, technology, consumer goods, politics. Often these mores have

[41] Bruce Berman, remarks at African Studies Association meeting, San Francisco, November 1996.

[42] 'Zero grazing' is the term employed in Uganda's AIDS education campaign.

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been accepted on only a superficial level. 'The puritan values held by middle class Europeans are definitely not condoned or practiced in the Zimbabwean society under discussion.'[43] While public behaviour is readily perceived, it can be deceptive in its lack of depth and the complexity of the traditional values and mores governing intimate relationships. These practices in African cultures remain foreign to all but the most aware of Western observers, making understanding and interpretations of such practices difficult.

Sensitive cultural issues are at the heart of solving problems associated with AIDS; addressing these issues appropriately is generally difficult for persons new or alien to the culture. The behavioural changes required by AIDS prevention programmes in the absence of medical prophylaxis affect patterns of behaviour that have evolved over centuries. For example, condoms are more expensive than peasant farmers can afford, and mores often militate against them. Scott and Mercer suggest ways to overcome cultural impediments, e.g. with humour and frankness in an effort to overcome or bypass social impediments – but this is a daunting challenge.[44] It is, therefore, understandable that there are increased difficulties when persons from Western countries attempt to understand and analyse a problem so affected by cultural and social behaviour. While at present economic resources remain primarily in the West, the transmission belt for information, drugs and condoms must pass through a variety of local filters before they are acceptable and effective.

Political responses have been uneven, and in the aggregate, less than the devastating problems warrant. On the macro level, there have been disputes between bureaucracies, relating both to international agencies,[45] as well as within governments. These 'turf' battles are very real in terms of their impact upon education efforts though they are irrelevant to the epidemic. Governments have the responsibility to publicise their intentions to address the problems of AIDS and to find adequate resources to deliver the message. DeLoenzien, for example, finds AIDS knowledge lacking in Senegal and Cameroon.[46] Education efforts require coherent, energetic and forthright government action.

[43] Mufuka, 'The disease AIDS', p. 9; the author has recently spent time in Malawi, one of the most seriously affected states, which is at the same time, for all appearances, deeply religious. One is left to draw one's own conclusions.

[44] Scott and Mercer, 'Understanding cultural obstacles'.

[45] To use Bowen's term, IGO's are the 'new missionaries' in Africa, in that they come bringing the expectation of new behaviour, one aspect of recolonisation; Merle Bowen, 'A vent for surplus South African white settlers: the politics of land reform in South Africa', African Studies Association, San Francisco, November 1996.

[46] Myriam deLoenzen, 'Knowledge, opinions and attitudes toward AIDS in rural Africa', *Sociètés d'Afrique & SIDA* 13 (July 1996).

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Relating traditional medical practices to the processes of modernisation has not come easily, especially to those health professionals who are trained in science, not social science, and in medicine, not anthropology. It is only recently that the role of traditional medicine has been taken seriously, including the complex effect it has had on the epidemic.[47] Many educated Africans hold to traditional beliefs about medicine, some practices of which are high risk, such as scarification or bleeding. AIDS education threatens to permeate this last bastion of tradition, the door to one's home, not to mention one's bedroom.

From the perspective of Western religion, there are direct contradictions to social customs, for example, a 'Christian' response to the epidemic. If people were monogamous, the virus would not spread. The Catholic Church opposes artificial birth control – which condoms are perceived to constitute, even when used for disease prevention. One bishop was reported to me as saying:[48] 'if one is to be considered a good Catholic, one must forego all "traditional" practices, including male circumcision'. Since circumcision is recognised as one way to lessen the likelihood of AIDS transmission, this demonstrates a direct contradiction between the modern and traditional to be addressed in effective education programmes.

The end of the Cold War has been a mixed blessing from the African perspective: The often meaningless rivalry between superpowers has ended, but with it has come a diminution of the political 'need' for assistance to impoverished states; hence, fewer resources flow to Africa.[49] With the end of the Cold War, great power competition in Africa has dissolved. The Russians have virtually withdrawn from the continent, leaving the US and other Western powers to be involved, in terms more of economic and humanitarian interests than strategic considerations.

The return to more 'conventional' international politics with the demise of superpower competition has not, however, automatically led to rational policy development. A United States official charged with AIDS assistance in East Africa told me that in six months on the job he had not met with any representative of another state or international agency in order to coordinate efforts; his agenda was generated in Washington.

In the future, as in the recent past, we can expect an increase in AIDS-related assistance tied to behaviour-change programmes, and

[47] Freeman and Motsei, 'Planning health care'.
[48] Author's conversation with clergy.
[49] The US in 1997 announced a new investment initiative toward Africa, the results of which remain to be seen.

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institutional programmes carefully focused on a narrow spectrum of activity. During the Cold War, assistance was an end in itself: the construction of a bridge across a river to nowhere; a fish processing plant without fish; a stadium where there were no games. With purposeful interventions, there will be an expectation of accountability, and this suggests greater influence by outside powers through economic means rather than the heavy-handed political tactics of the past half century. These disparate conditions have led to a series of consequences, which we now examine.

CONSEQUENCES

An invisible barrier between social interaction and social science research is perhaps being removed as a consequence of the extensive research which is taking place in light of the epidemic. Medical and social science professionals' responses have put governments on notice that this is a human tragedy to be confronted on the basis of cross-disciplinary knowledge.

The first step is identifying what is expected from African governments. Those countries where the disease is less prevalent can take steps now to prevent its spread, such as cultivating low risk behaviour, fostering scientific education, emphasising family planning and birth control, and continuing affordable efforts which enhance economic well-being.

Once the epidemic was recognised, it spawned a two-pronged development: in several African states, institutional structures to provide care, education, and/or research were created. In the international community similar responses evolved, supported by an effort to provide a modicum of assistance to cooperating states.

As Africans are further 'peripheralised',[50] their sense of hopelessness grows. The more they understand, the more likely they are to sink into despair: AIDS presents itself as a mysterious disease which is barely comprehensible, for which there is no cure or vaccine, which intrudes into the most intimate areas of human interchange, and for which no adequate response has appeared. What should be the logical reaction for informed individuals? Does one simply follow low-risk behaviour at the cost of pleasure and adherence to tradition, or does one throw care to the winds and live fatalistically without regard for the future? Longstanding poverty and the absence of hope reinforce the fatalism of living for the present in large segments of the population. At the same

[50] See Wallerstein, 'The three stages'.

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time, Egejuru reminds us of a perspective shared by many Africans: if one engages in reckless behaviour, one deserves the consequences.[51]

Such fatalism comes easily to societies beset by daunting and uncontrollable factors. When life expectancy is in the 40s or below,[52] when the quality of life remains the same decade after decade despite the promises of independence and development, when access to those modern devices that ameliorate the miseries of poverty, malnutrition, ignorance and dependence are unavailable, fatalism is logical. Thus, when AIDS strikes there is not the frantic reaction so often observed in the affluent West to search for a cure, for medical treatment, or for amelioration from anguish, uncertainty and fear. Africans have had to accommodate to human circumstances beyond their control, not to mention natural disasters, for several centuries; AIDS is not much different.

AIDS has a variety of consequences for most African countries. In economic terms, the general malaise which has pervaded Africa for the past decades has been accompanied by the intrusion of Western technology, resulting in rapid population growth through inexpensive health improvements without a corresponding increase in economic opportunities, especially food production and other basic human needs. It goes without saying that current AIDS treatment is expensive (up to $100,000 per patient in the United States; multiple times a family's annual income in pre-revolutionary Zaïre, for example) and is consequently unattainable for Africans.[53] Many African medical facilities are so inundated with AIDS patients that diseases which could be treated successfully are forced out of the health care system. Grossman observes also that AIDS patients are more expensive than others.[54] In resisting an all-out effort to target AIDS, a Nigerian official argued that many more people succumb to treatable maladies than to AIDS, so why devote inordinate resources to a hopeless cause?[55] Effective treatment of AIDS is essentially a luxury of the affluent, both within and between societies, at this point in evolving medical developments.

As a result of the combination of fatalism and the inability to provide

[51] Phanuel Egejuru, Remarks at African Studies Association, San Francisco, November 1996.
[52] US Bureau of the Census, 'HIV/AIDS in Africa'.
[53] A. Whiteside *et al.*, 'Planning for HIV/AIDS in developing countries', Poster presentation, IXth International AIDS Conference, Berlin, 1991.
[54] Grossman, 'The economic impact', p. 10; a Japanese physician estimated that 80 per cent of patients in the internal medicine ward of the district hospital he served in Malawi were HIV positive (conversation with author, 1997).
[55] A similar problem is identified in Russia. A health ministry official is quoted: 'We don't have money for the most elementary things, so how can we spend money on AIDS?' in 'The Soviet AIDS crisis', *AIDS Link* No. 21, January 1993.

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effective treatment, it is not surprising that political systems evade responsibility. African political systems have demonstrated their inability to confront other quality of life problems, such as illiteracy, overpopulation and insufficient food production. What incentive is there for them to assume an additional burden? No political leader would want to admonish his people about a plague that can only be prevented by wholesale behavioural changes which contravene long-held mores, and are unlikely to reach fruition during any given leader's tenure in office. Compounding the difficulty in confronting this, Fortin observed, early in the epidemic, the probability of 'government tampering with AIDS statistics and major gaps in the reporting system' in Kenya;[56] the same is likely to be true elsewhere, as a consequence both of incomplete data and of purposeful management. This questionable political reaction leads to a further loss of trust in government.[57]

While not the most significant effect, perhaps, there has been a return to previous prejudices against Africa and Africans, now seen as carriers of this plague by those outside the continent. Several states prohibit entrance to Africans who are HIV positive; African students studying in parts of Europe are periodically tested. African reactions to such discrimination understandably impede rational discussion among some groups.[58]

The enormous debt accumulated by some states in the wake of the Eurodollar surplus of the 1980s has perpetuated the colonial relationship encouraged by aggressive economic domination, especially by former metropolitan powers (France, Belgium and Britain). The terms of trade problem, by which manufactured goods from the industrialised West have increased in value many times faster than primary goods from Africa, has worsened Africa's balance of payments problems and sense of disadvantage even further. A World Bank economist has hypothesised that an unchecked epidemic in Zambia, for example, would probably result in its no longer being internationally

[56] Fortin, 'The politics of AIDS', p. 912.

[57] A point made clear in Harriet Birungi, 'Injections: risk and trust in Ugandan health care', African Studies Association, San Francisco, November, 1996.

[58] For example, the Belgian government has required AIDS tests for African scholarship recipients (*Newsweek*, 8 April 1987). This, of course, represented another variety of ignorance, since the presence of the HIV virus is not discernible for some time after infection, and antibodies fluctuate wildly during the course of the disease. In Israel, AIDS produced another form of perceived racism: blood donated by Ethiopian immigrants was discarded on the grounds that HIV infection was much more prevalent among that population than among Israelis in general. When this became known in the Ethiopian community, there were demonstrations and a small riot (*The New York Times*, 29 January 1996).

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competitive in copper production, its primary source of foreign exchange, because of the loss of human capital. Structural adjustment programmes (SAPs), imposed by Western financial institutions to facilitate repayment of debts, have required reallocation of international resources to achieve balanced government budgets, and in turn necessitated passing along increases to the general populace, often in higher food costs.[59]

The most pervasive social 'situation' pertaining to AIDS has to do with gender roles. Women, who in most of Africa are dependent upon husbands for their economic well-being, generally do not have the standing to assert their preferences, for example to insist upon the use of a condom. As a consequence, while most sexually active African women are aware of AIDS and prevention strategies, they report relatively little condom usage for reasons of gender inequalities. Focusing primarily upon wives, Orubuloye *et al*. concluded that, 'Women need support from the community and the government [which is generally dominated by men]… However, they are getting more support from relatives in refusing sex.'[60] Prostitutes exist in a comparable economically dependent relationship with their clients. The Society for Women and AIDS in Africa in Nigeria is a response to this situation, supporting women in responding positively to AIDS issues.

In exchange for AIDS assistance (educational supplies, surveys, condoms) Western states have pressed African governments to overcome the denial that has been prevalent for local political reasons. This increases their sense of recolonisation. AIDS efforts have also been affected by political considerations in the international arena. For example, donor states pursue larger foreign policy purposes; leaving an impact upon the local health situation is not their primary objective.

There are concerns that educational strategies can be too general. Fisher, among others, cautions against relying on overly simplistic solutions. He argues, for example, that the admonition to reduce one's number of sexual partners may lead to 'serial monogamy', if taken literally, hardly what is intended.[61] Or the admonition to 'know one's partner', who could easily be HIV positive, may lead to a false sense

[59] As early as 1990, the British medical journal, *The Lancet*, published an editorial warning against the health consequences of SAPs (335, 8694, p. 885).

[60] I. O. Orubuloye *et al*., 'African women's control over their sexuality in an era of AIDS', *Social Science and Medicine* 37, 7 (1993), 871.

[61] William Fisher, 'AIDS education', Presentation at IXth International conference on AIDS Education, Jerusalem, 1995.

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of safety. Or advice to avoid getting pregnant may be narrowly followed by taking oral contraceptives, obviating AIDS prevention. Thus, the 'safe sex' message is not, *ipso facto*, adequate. AIDS education runs counter to many traditional notions which lack scientific bases and therefore must be completely integrated into a group's consciousness if it is to be effective. If people do not have some sense of Pasteur's germ theory as well as an appreciation of the invisible and causal connections between behaviour and sickness, it is difficult to impart effective AIDS prevention education.

Most of the literature characterising the epidemic has been produced by Western researchers in an *ad hoc* manner, not as the result of systematic analysis of data across borders or systems. Occasionally the research team includes African colleagues; but, as often as not, African 'statistics' are collected without African participation. Siting of trials and experiments has little to do with local needs or preferences or prospects, often stemming from decisions made by Western researchers to suit their objectives, predispositions, or relationships with local institutions or individuals.

Unfortunately, the pre-eminent African scientific response to AIDS has been discredited in the international community, further widening the gap between Western science and the African situation. In 1990, Dr Davy Koech, director of the Kenyan Medical Research Institute, reported a formulation of Interferon, Kemron, which resulted in the reversal of AIDS symptoms in several AIDS patients over a six-week trial period. A leading Kenyan journal noted that only two journalists from the international media attended his announcement, noting the 'inability or refusal of many Westerners to take seriously anything of a scientific nature coming out of Africa'.[62] Within months, however, the Kemron story was mired in doubts, bureaucracy and politics. An American inventor, along with a Japanese pharmaceutical manufacturer, contested Kenyan claims. Availability of the drug declined amidst accusations exchanged among the parties. The absence of a controlled study ultimately raised doubts in the Western medical community. In 1992, *The New York Times* reported that Kemron was 'not an effective treatment and is not recommended … [according to] health officials' in Washington.[63] The current situation is that no African treatment has yet emerged. This had added one additional burden to thinking about AIDS *vis-à-vis* Africa.

[62] *The Weekly Review* (Nairobi), 9 February 1990, p. 13.
[63] *The New York Times*, 28 April 1992.

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These developments, in turn, have consequences, as noted by Mbilinyi: 'the rising cost of living combined with the decline of real wages/income associated with SAPs has led to an expansion of prostitution…'.[64] Data about AIDS for Africa as well as elsewhere demonstrates a related trend: men seek ever-younger sex partners in order to avoid HIV-infected prostitutes. Consequently, the HIV infection rates for women peak several years before those of men. Data for Thailand, for example, similarly show an HIV infection peak among women in the 15–19 age cohort. Anything that worsens a population's economic well-being has the effect of increasing vulnerability to disease as well as to external pressures. 'The use of condoms can't be allowed for it will impede the formation of labour for their family's economic activities.'[65] The social causes and consequences of this process are numerous and substantial, and are difficult to confront in male-dominated societies.

The most visible aspect of recolonisation is economic regression. *The Economist* put the situation this way:[66]

> If the [World] Bank's Africa strategy is to succeed, governments must cut public-sector deficits, raise domestic savings, and increase both the level and efficiency of investment. This will not happen if spending on AIDS victims and their families absorbs a large and growing chunk of the continent's scarce resources… and if personal savings are depleted by soaring medical expenses while personal incomes are truncated by high death rates among the working-age population.

This comes within the larger perceptual context that another major international organ, the World Bank, is not primarily committed to deal with African poverty,[67] but to protecting the economic interests of its major contributors.

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Cultural destruction has been experienced in Africa from before the colonial period. Some aspects of it were more voluntary (e.g. attendance at Western educational institutions or churches) than others (e.g., imposition of taxes to force colonised peoples into the money economy

[64] Mbilinyi, 'The economic impact', p. 6.
[65] Ibid.
[66] *The Economist*, 25 November 1989, p. 16.
[67] Adebayo Adedeji and Timothy M. Shaw, *Economic Crisis in Africa* (Boulder, CO, 1985), p. 279.

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in West Africa). The ADS epidemic presents African societies with cultural pressures on several fronts. Beyond the usual 'core–periphery' issues affecting all areas of socio-economic life,[68] there are individual relational factors.

The consequences of the spreading AIDS epidemic continue a pattern that effectively leads to cultural as well as economic recolonisation for many Africans and African institutions. Recognising that the impact of AIDS is often as great psychologically as it is physically, because of its protracted period of latency and the absence of treatment, the concept of recolonisation becomes plausible.[69] As the mysterious malady spreads throughout a society, psychological reactions may have numerous ramifications. All of this is enhanced by African states being the passive recipients of AIDS education and prevention programmes developed elsewhere.

This has left the poorer African states particularly vulnerable to various Western intrusions, from economic intervention to commercial dominance to being the passive recipients of AIDS programmes conceived elsewhere. This comes on top of a century of active Western economic exploitation. The consequences of the epidemic have increased malnutrition, exacerbated economic dislocations as people migrate to find jobs, and also diminished their governments' capabilities to provide AIDS education and treatment. For example, Tanzania's per capita health budget in a recent year could only provide for the equivalent of HIV testing for any given individual, but not treatment or amelioration. So neither is attempted.

As noted, the relative affluence of the West has meant that 'cures' are most likely to come from outside Africa – and essentially be 'imposed' upon Africa. Shtarkshall quotes a Nigerian: 'Experts come and say we must be culturally sensitive and then ignore my knowledge, presumably not intentionally.'[70] We have already witnessed trials of Western AIDS drugs in Africa. Whatever is intended or perceived, there is, of course, a rationale for testing among the populations that are most likely to be exposed to the risk. Hence, Africa (along with Asian states) becomes a laboratory. This situation follows on the politicised dispute about the origins of AIDS, and compounds the

[68] Wallerstein, 'The three stages'.

[69] One argument reflecting the perception of recolonisation was articulated by Zimbabwean Vice-President Joshua Nkomo. He is quoted as declaring at the funeral of his son who succumbed to AIDS: '[The epidemic] was harvested by whites to obliterate black people so the whites could take land and wealth', *AIDS Analysis Africa* 7, 1 (June 1996), 1.

[70] Ronny Stharkshall, 'Aids education across cultures'. Presentation at IXth International Conference on AIDS Education, Jerusalem, 1995.

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difficulty of comfortable cross-national discussion and cooperation.[71] Reports that a blood sample taken from a Zaïrean in 1959 contained the virus have strengthened the thesis of an African origin.[72]

Much like previous plagues that struck down all segments of society without discrimination, AIDS regularly attacks broadly, but particularly the economically productive and often better-educated middle-class cohorts in much of Africa. Thus it robs Africa of some of the meagre fruits of development efforts and plays a part in returning it in many cases to pre-independence levels of knowledge, expertise and potential. As parents die, orphans remain, to be cared for by grandparents who have neither the resources nor the training to prepare them for the future they face.[73]

Areas of Eastern and Central Africa have experienced labour shortages from death and sickness.[74] On the other hand, the surplus of labour in many parts of Africa had militated against this becoming a major problem thus far.[75] Population loss *per se* is not a tragedy; many AIDS belt areas are overpopulated.

Africa's economic needs have been exacerbated by a reluctance to 'throw good money after bad'. Mbilinyi points out that 'the risk of investing in people during the epidemic is obvious'.[76] A US Embassy officer suggested cutting scholarship funds for Africans because they are a short-term investment in many instances. With the end of the Cold War, there is less concern about the political dimension of assistance.

When local governments were slow or reluctant to act, AIDS education and prevention programmes have been imposed by United Nations agencies in many instances upon unwilling states, a result of their own self-interest in containing the plague. The WHO Special Programme on AIDS was established in 1987; in 1988 it became the Global Programme on AIDS (GPA). In 1994 the UN reorganised its AIDS efforts into a unified UN Joint and Cosponsored Programme on AIDS to take effect in 1996,[77] further enhancing its potential impact upon any given state.

[71] President Museveni of Uganda reversed his position regarding testing in the face of devastating projections of population decline – from 32 million to 20 million by 2015, *The New York Times*, 30 January 1993.

[72] National Public Radio, 3 February 1998.

[73] Hunt, 'Nightmare'.

[74] I. Gilbertson *et al.*, 'AIDS and commercial agriculture in Swaziland', Poster presentation, IXth International AIDS Conference, Berlin, 1991; Gupta, 'Economic impact'; Overseas Development Administration, 'Potential impact of AIDS on food production and consumption: Tabora case study – Tanzania', Overseas Development Natural Resources Institute, Kent, England, 1989.

[75] Michael J. Mandel, 'The economics of AIDS', *Business Week* 3442 (1995), 34.

[76] Mbilinyi, 'Economic impact', p. 10.

[77] *The New York Times*, 23 January 1994.

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In sum, it can be said that AIDS has neutralised substantial portions of even modest development successes of the past three decades, especially in education and professional development.

As the AIDS epidemic continues to explode in Asia, it is anticipated that the number of victims will shortly exceed the number in Africa; the infection rate in some countries compares to some of Africa's hardest-hit. Then, the question becomes, will the international community retreat from Africa, and turn its attention to the economically more interesting Pacific periphery? If so, we may see a corresponding decline in colonial aspects of Africa's relationship with the West. While that may improve the psychological sense of Africa's elite, it does not necessarily suggest that a more effective response to the AIDS crisis will emerge; it does assure that this disaster's effects will persist for years to come.

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