

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

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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 indiscriminate 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-

rica 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 far 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 mi-

grants, 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 do 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. Phillipson'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 measures 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 Aids to men and have been elevated to the role of disease vectors.

Indeed, in Zimbabwe single urban women have been seen as prostitutes or potential prostitutes who must be contained:

The perception of single urban women as prostitutes pertains in contemporary Zimbabwe with the enforcement of periodic "cleanup" campaigns in Harare in which women unaccompanied by men at night may be arrested unless

they can produce marriage certificates' (Pateman 1996: 32).

Zimbabweans may have copied these cleanup 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 seesawed 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 transformed. 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 phenomenological actors 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.

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