

# **Journal of Scholarly and Scientific Perspectives**

**An International Journal of  
Scholarly and Scientific Research**

**HIV/AIDS: The Triadic Triplets**

**Number 2  
Spring 2006**

**Published by LUISSO at Langston University Press  
in Oklahoma, U.S.A.**

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# JSSP

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## Contents

Cover	
Preface .....	<i>Meshack M. Sagini</i> .....v
HIV/AIDS and Tropical Africa: The Past, the Present and the Probable Future. Anthropological Perspective .....	<i>Maxwell Owusu</i> .....1
The Political Economy of HIV/AIDS .....	<i>Meshack M. Sagini</i> .....21
Impediments in the War on HIV/AIDS among the Rural and Urban Poor in Kenya .....	<i>Solomon Monyenye</i> .....45
Transformational Leadership Role in Creative Awareness of HIV/AIDS Infection in Minority Populations: A Theoretical Analysis .....	<i>Nathaniel Goodman</i> .....67
Legal Issues Impacting Individuals with HIV/AIDS .....	<i>Aliya N. Chaudry</i> .....83
Urban Poverty Management in Nigeria: A Critique of the National Poverty Eradication Program in Surulere, Lagos, Nigeria .....	<i>Danmole T. Olaitan</i> .....99
Adoption of Innovative Rural Development Technology.....	<i>O.B. Ekop</i> .....114
Instructions to Authors	
JSSP Standards	

## Preface

This scholarly and scientific journal rationalizes HIV/AIDS and its Triadic Triplets- in urban, rural and poor environments of the World particularly in Africa and the United States of America. The global HIV/AIDS pandemic is one of the greatest human tragedies whose evolution and fusion negates, belittles and bedevils the promise and spirit of human ingenuity. Its scientific creation in a laboratory in Philadelphia makes every sane mind, both the novice and the sage, the student and the scientist, the laborer and the bureaucrat, the lay member and the priest or clergyman, to think about the meaning of life and the purpose for human existence, the value of rational and empirical knowledge and its relevance and motif in human civilization, and the globally established structures of governance and interconnectedness via interconnectivity. All people are at a loss for sound answers. The many whys, whens, wheres, hows, and whats are difficult to answer in order to satisfy the millions who have lost their loved ones in the age of plenty, scientific and materialistic victories and political and diplomatic savviness.

Humanity, what has gone wrong? Where are your children? Why is Rachel grieving and weeping? Are the children dead? Who has killed them? What did they do to deserve this kind of treatment? Why do the innocents get punished, tormented, terrorized by the use of germ-warfare measures and eventually killed for their innocence and lack of understanding? Is human civilization doomed? Why are the unsuspecting, the nonessential and the unwanted innocently victimized. Do their ghosts have a voice for discourse and dissent? Who will speak on their behalf?

The living among us and in every civilization have the right to represent these ghosts whose victimization demands legitimate measures in order to provide reparations for the holocaust survivors. Has humanity lost its conscience for the compassionate sanctity of human life? If not, why doesn't humanity use its might to eliminate this mess they created? This is another question only the mighty can

answer. If we cannot solve the problem we created, are we mighty? Who knows? May be hell. These guys are midgets.

Those of us who have lost family members are familiar with the language expressed in the first three paragraphs whose expression the families use to ask the Western powers to stand tall by eliminating the scourge they created. The experiment backfired and criminalized the eugenic "innocents" for the death of millions at home and abroad. If the death rate at which the disease kills continues unabated for the next fifteen to twenty years, its largely negative impact will predictably produce social, economic and political instability. The same instability will have potential to cause states to fail or collapse for the absence of leaders and resources for managing them. It is imperative for states to eliminate this deadly disease from the face of earth. They should have a domestically, internationally and scientifically well rationalized three-prong strategy for combating the HIV/AIDS pandemic.

First, at the national level, a thorough effort should be invested in creating a super agency composed of major international organizations, governments, corporations, pharmaceuticals, multilateral bodies such as IMF, and the World Bank and the NGOS. The agency should be sanctioned by the political leadership of the nation while being coordinated by the Ministry (Department) of Health and a Western international agency. These bodies should be provided with innovative research findings by professional scientists and research teams. The researchers should analyze society in all its facets and shade new light on the social structure of society and the associated barriers affecting effective prevention, treatment and care. Each nation should be encouraged to identify transformational governance leaders who cognitively, organizationally, and decisionally possess the "synergistic clout" and talent for effective deployment of resources in order to translate dreams into reality – prevent and eliminate the spread of HIV/AIDS.

Second, in consultation with the political leaders, the bureaucratic and scientific systems should identify creative change agents in every institution or group in society. Each educational, political, religious, familial, corporate and legal institution should have a change agent who hierarchically, directly and instrumentally communicates with his/her superiors at the local, district, regional (provincial) and national levels. The change agents should become the medium of communication between the organizational, group, local, rural or urban settings and the centralized and decentralized national centre for strategic coordination. This second level is the entity for strategic policy implementation. The level should be a laboratory for decision making, decision implementation, program evaluation, discussion, dissent, problem identification, problem elimination and program recommendation.

Third, the coordinated national and group or bureaucratic strategies should be directed at the individual and the group concerns. Individuals and groups should regularly be informed that certain behaviors present risks to their lives and the lives of other people who are important to them personally and collectively. They should be encouraged to take action to reduce risk by initiating preventive behavior. Reinforcement of risk-reduction behavior should be emphasized in the context of knowledge about people's age, experiences, beliefs, values, knowledge and relationship with others. The unscientific structure of individuals and groups should be sensitized to emotional, cognitive, behavioral, interpersonal, cultural, structural and scientific awareness in terms of the gravity, magnitude and effects of this scourge. In addition, individuals and groups should be conversant with the ways of transmission and what could be done to avoid such risks –

abstinence and condom use. Finally, schools and other agents of socialization should establish a curriculum for the inculcation of curative, preventive and diagnostic and treatment measures.

HIV/AIDS is a complex pandemic that is a multi-system illness, which is influenced by a variety of the aspects of the individual, general health systems, cultural behavior and states of mind. The "co-occurrence of HIV, substance abuse and mental illness poses unique challenges for the management and treatment of the disease" (Institute of Medicine, 2005: 2). As "a result, each year, there are missed opportunities to reduce mortality, morbidity and disability among individuals with HIV infection" (p.5). Although the disease is a chronic illness devoid of a death sentence in technologically advanced and industrialized Western Countries, poor and minority communities are constant victims of HIV/AIDS. In the U.S., of the 40,000 people infected annually, 16,000 of them die due to several barriers some of which are also common in Third World countries. More than 1.5 million are infected and over 500,000 have perished.

The 1990s HIV cost and services utilization study (HCSUS); Morin et al., 2002; Cook et al., 2002; Turner et al., 2001 and Sambamoorhi et al., 2000) are studies that were conducted to reflect nationally determined factors that are barriers to the therapeutic treatment of the disease in the United States. These studies and particularly the HCSUS found "large variations in insurance coverage for HIV infection, in part reflecting the relative restrictions on the Medicaid programs in different states." (Institute of Medicine, 2005: 129). In general, 20% of adults in care for HIV did not have health insurance. Fifty percent received care through Medicaid and Medicare. Specifically, 15 % of them had both Medicaid and Medi-

## Preface

care. Also 31 % received care through private insurance. Because of geography, distances were a hindrance to effective therapy. The percentage of the uninsured was 11% in the Northeast and 30% in the South. In addition, based on the conclusive evidence of the studies in question, and in respect to the Northeast, 50 % of the patients had Medicaid as the primary payer compared to 20% in the South (Bozzette et al., 1998 and Institute of Medicine, 2005).

The HCSUS study also showed that there were substantial disparities in therapy across the affected groups. For instance, though these disparities dwindled with the emergence of new decades, “blacks, women, the uninsured, and Medicaid beneficiaries were all less likely to receive protease inhibitor therapy when it became the Standard of care” (Institute of Medicine, 2005:129). Also, the lack of or insufficiency of Medicaid insurance made it difficult for HIV/AIDS patients to receive HAART without which life can not be sustained. With respect “to experimental drug therapy, Gilfford et al. (2002) found that blacks and Hispanics were less likely to have received experimental HIV therapy or to have participated in an HIV Clinical drug trial, and that these findings could not be explained by difference in the desire to receive such therapies....Blacks, Hispanics, women, the uninsured and Medicaid beneficiaries also had less favorable patterns of use of hospitals emergency departments, and ambulatory office or clinic settings.....patients in rural areas were also less likely to receive antiretroviral therapy (pp.129-130).

In another recent study (Bhatta charya and Goldman (2003), patients with public health insurance (Medicaid) experienced lower death rates than the uninsured. In the same study, the researchers found that states which have Medicaid programs and less restrictive eligibility regulations and

more generous drug coverage had lower death rates than those with more restrictive rules and less generous coverage. Further analysis by HCSUS found that “Women, blacks, those with less education, and injection drug users were least likely to have received early access to HAART” (Institute of Medicine, 2005:130).

In a study by Morin et al., (2002) cited earlier, mortality reductions for Latinos and African American were found to be lower than for non-Latino whites. These disparities were associated in part with policy barriers such as limits on Medicaid eligibility based on disability requirements and state imposed income requirements and state imposed income and benefit limits on ADAP, as well as social barriers” (Institute of Medicine, 2005: 130) particularly in California, New York, Florida and Texas. Over all, policy analysts and researchers have correctly and conclusively determined that the combination of financing structures and systems and the characteristics of people e.g. race/ethnicity and low income collectively interact to exacerbate disparities in health care. In addition, the many actors of the health care system (people living with HIV, providers of medical care, the Congressional Ryan White Planning Councils and Committees, and policy makers at the federal, state and local levels) do not see themselves practically as serious and interconnected components of the whole complex system. Since each had different goals and objectives, the missions tend to be more conflicting rather than complementary and solvent. The systems’ goal should be “to improve the quality and duration of life for those with HIV and promote effective management of the epidemic by providing access to comprehensive care to the greatest number of individuals with HIV infection” (p.134).



Although no organizational or system model for treatment and care is better than another largely due to regional, state, local, geographic and demographic variations, every delivery system or model should place emphasis on safety, effectiveness, patient centeredness, timeliness, efficiency and equality in treatment. In other words, every organization should establish centers of excellence for the delivery of HIV/AIDS related medical services. Of necessity, similar centers of excellence, pending the availability of resources, should be replicated in the Third World into which HIV/AIDS has been advertently exported.

For comparative purposes, and at the international plane, HIV/AIDS is driven by factors of vulnerability to infection and illness, such as gender, age, sexuality, drug use and addiction, poverty, incarceration, threat of violence, and/or nationality or ethnicity. In the United States, it is caused by lack of access to health care, poverty, drug addiction, incarceration, homelessness, gender inequality, homophobia, stigma and discrimination.

### **In This Issue**

Dr. Solomon Monyenye has lamentably employed a philosophical and interdisciplinary analysis of HIV/AIDS in Kenya to show how Kenya's inability to grapple with responsible and accountable structure of governance has contributed to the nation's gross ineffectiveness in handling the serious problems of development of which the fight against HIV/AIDS and other opportunistic illnesses and poverty is paramount. With the use of UNAIDS and the Ministry of Health's statistics, Monyenye's journalistic literature review and scholarly reference and ideas drawn from the works of Classical, Medieval and contemporary European philosophers contributes to his thematic and descriptive

assertion that if the Kenyan institutional elites do not understand the gravity and magnitude of the HIV/AIDS pandemic, which they seem to carelessly and negligently deal with, their failure to solve the crisis would be largely attributed to the fact that this form of inattention and ineffectiveness has contributed to their loss of national conscience. A nation whose national consciousness has been lost wallows in colonial blueprints, administrative malaise, graft, and bureaucratic corruption. Because they are incompetent and ill-equipped to dynamically address the challenges of development with any degree of ethical, moral and utilitarian significance, the plight of the poor, homeless, orphans, and others will skyrocket. Though poor governance and inability to address the subject in question have been exacerbated by modern materialistic competition and individualism, institutionalized policies of transparency, bureaucratic accountability, and administrative efficiency and effectiveness would reinforce good governance responsible for charting new directions and progressive development reforms.

Professor Maxwell Owusu has employed an anthropological and historical style to theoretically, meticulously and brilliantly trace the evolution and development of the HIV/AIDS pandemic in Africa. One of Owusu's greatest contributions is not necessarily the assertion that the pandemic and other opportunistic infections have killed and continue to torment millions of Africans largely due to their cultural innocence, abject poverty and natural simplicity as opposed to creative enlightenment, economic viability and scientific awareness, but rather, that this deadly and largely femininized scourge has its original and scientific roots in the U.S. germ-warfare laboratory in Philadelphia. Owusu also correctly argues that while preventive measures such

## *Preface*

as habitual use of condoms, abstinence, and avoidance of casual sex should be reinforced with a nationally and internationally well planned, well coordinated and well funded development strategy for better nutrition, education, sanitation, and social security, more often than not, these measures have been undercut by domestic and Western material and intellectual prescriptions whose motivational undercurrent negates the universally desired effects.

Dr. Nathaniel Goodman's unempirical analysis is a sharp critique of the role of transformational leadership in HIV/AIDS policy construction and implementation in minority sectors of the U.S. population. Though he correctly argues that absence of, or manipulative arrogance of the leadership in question lacks humane sensitivity and empathy that are essential for enhancing HIV/AIDS awareness, his superficial treatment of the AIDS related issues may contribute to the absence of scholarly analysis and intellectual poverty which renders the prevailing condition its unmeritorious viability. In other words, this well-written theoretical work should have been more illuminating on the subject of HIV/AIDS in African-American and Hispanic communities in the United States.

Professor Meshack M. Sagini has used historical, political, economic and sociological theories to argue that imperial creators of intellectual know-how and the policy elite tend to create restrictive policies on researchers, scientists thinkers and society at large in order to rationalize, control, predict and theorize about human laboratory experiments whose raison detre ratify the motives of the drug industry and scientific and political establishment. Such official policies as those are capitalistically market-driven rather than needs-driven, particularly in a continent whose economic crisis, state decay and health

paralysis have left less to be desired. Worst of all, political repression, armed conflicts, permanent corruption, the brain drain, abject poverty and the HIV/AIDS pandemic have individually and collectively contributed to the continent's in viability.

This is not the time to give up. It is time to think big and plan well. Such a situation has created a climate that necessitates the evolution of creative and revolutionary political, social and scientific leadership essential for charting new directions in African civilization. Africa must rise up again. In order to rise up, it must do thorough homework in analyzing the origin and causes of its problems and eliminate them. Africa must use science effectively in order to eliminate a nexus of chains of inequality, taboos and ill will. The continent must learn to stop crying and begging by starting to think, create and produce. It will take awhile, but it will get there.

Ms. Danmole T. Olaitan of the University of Lagos, Nigeria, has produced an excellent and empirically prepared professional paper without serious reference to theoretical sophistication. The author analyses urban poverty by treating Surulere local government area of metropolitan Lagos as a case study in reference to the country's historical development of poverty reduction for 3.5 decades. With the use of naturalistic observation, survey interview and secondary sources, the author argues that though the challenges of globalization, poor governance and problems associated with the social structure of society have largely exacerbated urban poverty, particularly in Suralere metropolitan section of Lagos, this cancerous scourge has largely and persistently eluded preventive measures due to misapplication of sustainable development theory; misuse and misallocation of funds set aside for project development and person-

nel; and administrative inefficiency due to lack of coordination, collaboration and citizen participation in projects and lack of transparency and accountability in decision making related to public management. Worst of all, this form of poor governance is reinforced by bureaucratic corruption, nepotism and absentism. To turn the situation around, the author recommends the employment of effective governance as a prerequisite for unleashing energy for providing citizens with the necessities of urban living of which adequate shelter, clean environment, health care, education, nutrition, employment and security are paramount.

Dr. O.B. Ekop has empirically analyzed the role and centrality of urbanization in the dialectic of change. Low productivity in agriculture and other economic endeavors are recognized problems of most rural settings in Nigeria. This study examines innovative diffusion process as a phenomenon of change for higher agricultural productivity in the rural areas of Adamawa State in northeastern Nigeria. Using a stratified random sampling technique, 154 settlements in fifteen local government areas in the northern part of the State were selected for the study. These include the headquarters of three local government areas and five districts. Kendal's ranking coefficient method was applied to categorize the settlements. The rank scores were converted to 'z' scores and the settlements stratified on two urbanization scales of low and high. A chi-square test was applied to test the significance of the difference between the high and low urban groups. The results showed that settlements in the high urban group were susceptible to a faster rate of adoption of improved innovations for higher productivity than those in the low urban group, thus confirming the hypothesis that urbanization is an important factor in rural economic and social processes of change

and that the effects are proportional to the size of the urban centers. Therefore, urban areas that are centers of specialization, civilization and enlightenment tend to influence, modernize and civilize the nature of tradition-bound, agricultural practices for better productivity. In this case, the dynamic role of the central place theory of urbanization, in which this case study is theoretically rooted, cannot be overemphasized.

Dr. Aliya N. Chaudry, a lawyer, has relied predominantly on interdisciplinary virtual reality sources to write *Legal Issues Impacting Individuals with HIV/AIDS*. She argues that Acquired Immune Deficiency Syndrome (AIDS) is caused by the Human Immunodeficiency Virus (HIV), which was first reported in the United States in 1981. Since that time, however, AIDS has fast grown to become a major pandemic, not just in the United States but all over the world. This epidemic has brought with it a multitude of legal issues and dilemmas for individuals with HIV/AIDS. For example, individuals with HIV/AIDS have been discriminated against, fired from their jobs, denied access to Medicare and have had their privacy invaded. Fortunately, however, individuals with HIV/AIDS, like other individuals with a disability, are not without recourse. The United States has a variety of laws in place to protect the rights of such individuals. HIV/AIDS individuals, while they seek therapy amidst a continuous discriminatory environment, need to be aware of their legal rights. Having such knowledge will enable them to triangulatively navigate societal huddles in their search for justice in the workplace as well as in the distributive political and judicial environment.

This research project is a feat for Langston University. The editors are extremely grateful for the support they have received from Presidents JoAnn Haysbert

*Preface*

and Ernest L. Holloway as well as Vice President for Academic Affairs, Dr. Jean Bell Manning.

Meshack M. Sagini, Ph.D.  
Editor-in-Chief

# HIV/AIDS and Tropical Africa: The Past, the Present and the Probable Future. An Anthropological Perspective

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## Introduction: Performing HIV/AIDS

The lyrics of a 1987 Ghanaian high life hit song in Akan (Fante) by a popular young urban musician, Rex Omar faithfully capture the spirit, if not the letter of my paper. In a manner characteristic of African traditional theistic philosophy, and deism the proverbial African reliance on God ultimately for a solution to difficult problems, the song implores God Almighty to come and save His helpless people from the wicked disease HIV/AIDS.

‘Yare bone bi aba oman yi mu  
Obiara nmim beebi a efir  
Obiarannim ano edur.  
Kum a na okum amamba  
Ewurade eei bewe hen so  
Yenni obiara, Egya se woambe ntem a  
Wobe ba na hen so atew o?’

A dreadful disease has entered this country.

Nobody knows its origin  
Nobody knows its medicine (cure)

But it is killing the citizens  
Lord, come to our assistance  
Because we don’t have anybody (helper)  
“Father, if you delay (hesitate) in coming  
(sending help)

By the time you arrive (help comes)  
The number of your children would have  
dwindled (died, through, weight loss no  
pun intended, symptomatic of advanced  
state of HIV/AIDS).  
(Sackey, 2001:67).

The song speaks eloquently of the origin (largely unknown), present status (genocidal effects) and probable future control, prevention, protection from or miraculous cure of the AIDS epidemic. The UNDP Epidemic, update 2004, launched World AIDS Day – Wednesday, December 1. It was estimated that about 5 million people in 2003 contracted HIV, the virus that causes AIDS, and predicted that another 5 million would do the same in 2005. Most of these people – 3.1 million, or 63 percent – are in sub-Saharan Africa (*The Christian Science Monitor*, Wednesday, December 1, 2004: 6). For

2005, the estimate was that about 40.3 million people world-wide would be infected, a small majority of whom are male. But women are catching up fast. In sub-Saharan Africa, 77 percent of those infected are female. Among young South Africans, Zambians and Zimbabweans the figure is 75 percent (*The Economist*, November 27, 2004: 82).

Of the 10 million people aged 15-24 with HIV at the end of 2003, nearly two-thirds live in Africa. The global distribution is as follows: a) sub-Saharan Africa - 62 percent; b) Asia - 22 percent; c) Latin America and the Caribbean - 7 percent; d) Eastern Europe and Central Asia - 6 percent; e) U.S., Western Europe, Canada, Australia, and New Zealand - 2 percent, North Africa and Middle East - 1 percent. There were about 14,000 new HIV infections a day in 2003, more than 95 percent of them in low and middle income countries; there were almost 2,000 cases in children under 15 years of age and about 12,000 in people ages 15-49, 50 percent of them 15-24 years (*The Christian Science Monitor*, Wednesday, December 1, 2004: 7).

HIV/AIDS statistics released by UNAIDS and WHO for the end of 2004 show wide variations in each of the following categories: a) adults and children living with HIV/AIDS; b) adults and children newly infected with the HIV/AIDS virus; and c) adult and child deaths due to AIDS, with sub-Saharan Africa leading all regions of the world in all three categories. In tropical Africa 25.0 - 28.2 million people are living with HIV/AIDS with another 3.0-2.4 million people newly infected with HIV, as well as 2.2 - 2.4 million AIDS related deaths in sub-Saharan Africa (*World Press* February 2004:15).

Within sub-Saharan Africa itself, there exists sharp contrasts in sub-regional and local rates of HIV/AIDS infection or HIV sero-prevalence. The countries with the highest number of reported cases of

HIV/AIDS - most of them in Eastern, Central and Southern Africa- include South Africa, Namibia, Botswana, Swaziland, Lesotho, Zambia, Zimbabwe, Malawi, Congo-Brazzaville, Kenya, Tanzania and Uganda.

The AIDS cases per 100,000 population in these countries vary from 424 in Zambia to 1449.8 in Namibia (*The Economist Pocket World in Figures*, 2004 Edition, 2004:81). The countries with relatively lower (in some cases gradually rising) rates of HIV/AIDS cases are mostly in Western Africa and these include Ghana, Nigeria, and Senegal, the last country of which has successfully maintained one of the lowest infection rates (between 1 and 2 percent in tropical Africa) where HIV prevalence stands on average at about 9 percent of the adult population (David White, *Financial Times Special Report. Business and AIDS*, Monday, December 1, 2003:8).

The wide variation in age, gender, local, sub-regional, regional and continental distribution of HIV/AIDS cases naturally raises a number of important questions deserving scholarly research, and there exists a large and growing body of literature - scientific and journalistic - on HIV/AIDS, by scholars, NGO AIDS activists, business and religious leaders, etc., that continues to document the incidence and spread of HIV/AIDS in various countries and, provide intriguing and often contradictory answers to some of the questions posed by my paper (Walker, Reid and Cornell, 2004. Shilts 1987; Stillwaggon, 200; Barnett, and Whiteside 2002; Liebowitz 2002; Kiragu, 2001, World Bank 2003).

Policy attention, namely: (a) Why are some countries or localities and certain gender and age groups more affected by HIV/AIDS than others? (b) What explains the exponential growth of AIDS in countries such as Botswana, Mozambique, or South Africa? (c) Why are more women

than men in several African countries HIV sero-positive? (d) How is HIV/AIDS understood in various cultures and belief systems in tropical Africa?, (e) What can be done about the epidemic with respect to the spread, prevention, treatment, control or containment if not cure? These are, of course, complex and difficult questions with very few clear and firm answers. The paper is offered as a modest effort in the search for clearer answers to some of these questions. That there exists a seemingly dramatic escalation with which a low prevalence situation can change to a very high one is clearly demonstrated by the South African experience. HIV prevalence among South African women attending ante-natal clinics was less than one percent in 1990. A decade later, it had climbed to more than 24 percent. As UNAIDS correctly points out, "All countries have at some point in their epidemic histories been low prevalence countries" (UNAIDS, 3001:5). What this means is that a relatively low prevalence setting characteristic of some countries, regions, localities or groups in sub-Saharan Africa today does not justify complacency, especially given the fact that in the absence of regular universal, periodic testing for HIV/AIDS, particularly among the poor, illiterate, rural and urban populations of sub-Saharan Africa, there may exist in any country, region or locality hundreds, if not thousands, of symptomatic HIV carriers, who may unwittingly continue to infect others and perpetuate the vicious cycle.

### **The Evolution of the Global Pandemic**

A good part of a satisfactory answer to the question of the uneven spread of HIV/AIDS infection across time and across culture and geographic areas may lie in the origin, nature and causes of the epidemic disease. The first cases of Acquired Immune Deficiency Syndrome (AIDS) were reported in the United States

in 1981. According to *The Oxford Dictionary of New Words* (1992) HIV/AIDS is "a complex condition which is caused by a virus called HIV and which destroys a person's ability to fight infection" (1992:9).

By the mid 1980s, the disease was already reaching epidemic proportions in the US. By March, 1987, 99 countries had reported 44,652 cases to the World Health Organization (WHO). Because testing was not available in many countries and the cases were voluntarily reported, the actual number of AIDS cases was estimated to exceed 100,000 worldwide. Lincoln C. Chen has observed that this clinical case level "implies some 3000,000 to 500,000 infected persons with milder AIDS related symptoms, and perhaps five ten million asymptomatic carriers" (1987:183).

At this period, AIDS cases were scattered across most western European countries, such as France (1,221 cases), West Germany (959 cases), and the United Kingdom (686 cases). In the United States there were 31,982 cases of AIDS according to the United States Center For Disease Control. Only 103 cases in 12 Asian countries had been reported. Indeed, in China and India, the world's two most populous countries, the general view was that, unlike Southeast Asia (Thailand and Philippines particularly) where widespread female and male prostitution that caters to international tourism might facilitate the rapid spread of HIV/AIDS in those countries, conservative sexual behavior and patterns were likely to limit the spread of HIV/AIDS (Chen, 1987:183). However, in a 2003 UN HIV report by UNAIDS a decade and a half later, Peter Piot, head of UNAIDS, warned that China was at "the very, very beginning of an AIDS epidemic" with the number of new infections rising at 30 percent a year in recent years. He also pointed out that the incidence of HIV/AIDS was also rising rapidly in India and Vietnam among oth-

ers (*Financial Times*, Wednesday, November 26, 2003:6).

It is worth noting that in sub-Saharan Africa during the early phase (1980s-early 1990s) of the emergence and spread of HIV/AIDS, countries in central and eastern Africa – Democratic Republic of the Congo (Zaire), Rwanda, Zambia, Malawi, Tanzania, Kenya, Uganda, Burundi, and the Republic of the Congo – were the worst affected. Fewer cases were reported in western and, quite surprisingly, southern Africa even though there were disturbing signs that HIV/AIDS was spreading there as well. In the later phases of the spread of HIV/AIDS (late 1990s and early 2000s) the countries of southern Africa have replaced or joined eastern and central African countries as among the leading most infected sub-regions of tropical Africa. There was a seemingly dramatic escalation of a low prevalence situation to infect others and perpetuate the vicious cycle of the spread of HIV/AIDS. Of course, one of the basic challenges of the fight against the spread of HIV/AIDS in tropical Africa remains the prevalence of a host of untreated, neglected or unknown opportunistic infections from an array of parasites that put at risk thousands of Africans who are immune-suppressed.

Of course, one of the basic challenges of the fight against the spread of HIV/AIDS in tropical Africa remains the prevalence of a host of untreated, neglected or unknown opportunistic infections from an array of parasites that put at risk thousands of Africans who are immune-suppressed.

### **Biology, Epidemiology, and the African Origin of HIV/AIDS**

Indeed, it has been claimed that tropical African geography, if not history and culture makes central Africa the ideal host to deadly diseases and epidemics. Randy Shilts, whose *Politics, People, and the*

*AIDS Epidemic* (1987) was a U.S. bestseller, refers to Central Africa as “an undeveloped region” that “seemed to sire new disease with nightmarish regularity” (1987:4). Moreover, the battle between humans and disease was nowhere more bitterly fought than in the fetid equatorial climate where heat and humidity fuel the generation of new life forms. For an illustration, Shilts mentions the example of the Ebola fever virus in 1976 in a village along the Ebola River in the Democratic Republic of the Congo (Zaire) – Sudan border, there was a virulent outbreak of a horrifying new disease named after the Ebola River that claimed the lives of 53 percent of its victims (about 153 people).

The victims of Ebola disease suffered from fevers and uncontrollable bleeding. The disease was once contracted, apparently sexually transmitted and could be passed on through contact with a victims infected blood. In this case, as in the case of HIV/AIDS, sex and blood are two terribly efficient ways of spreading a new virus. The Ebola fever virus shows how endemic new viruses are to an environment of tropical underdevelopment, poverty, ignorance, ‘primitive’ medicine and the dangers they pose to human life and well being.

Moreover, one European historian has argued that humans who first evolved in Africa millions of years ago migrated to Asia and Europe simply to get to climates that were less hospitable to deadly microbes that the tropics so efficiently bred to germinate (Shilts, 1987:103). Be that as it may, Robert S. Desowitz has pointed out that the world’s “real” health problems are “the perpetual, infectious pathogens some of which [become] more pathogenic in the HIV infected” (Desowitz, 2002:5).

In this connection, the recent call by David Molyneux (Liverpool School of Tropical Medicine), Peter Hotez (George Washington University) and Alan Fen-



wick (Imperial College London) for the launch of a “small costs, huge impact” public health program in sub-Saharan Africa makes good sense. The three leading medical specialists warned that concentration on the “big three” diseases of AIDS, tuberculosis and malaria has diverted resources from half a dozen easily treated illnesses, e.g., lymphatic filariasis, schistosomiasis, intestinal helminths, onchocerciasis, and trachoma, that have a greater impact on health care and economic development in Africa. They stress that treatment of several “neglected diseases” would also reduce the risk of contracting serious malaria and TB (*Financial Times*, Tuesday, October 11, 2005: 7). In black Africa, thousands of immunosuppressed people continue to die from gastrointestinal parasites, the most common opportunistic infections of the region.

But there is another more sinister twist to the African origins and early spread of HIV/AIDS story, that is a controversial theory debated by the British Academy of Sciences at a Royal Society conference in London in 2000 and flatly rejected by the Western scientific community on the grounds that the theory lacked hard scientific data to support it.

The HIV virus was first isolated in 1983 by scientists of the Pasteur Institute in Paris. The theory in question, first reported by Tom Curtis in an article in *Rolling Stones* magazine and subsequently elaborated on by Edward Hooper, a writer who defended the theory unsuccessfully at the Royal Society Conference, claims that HIV/AIDS, the worst medical catastrophe ever experienced by humankind is related to the SIV virus carried by chimpanzees, which is similar to The HIV virus and believed to be ancestral to it. According to the theory, the HIV virus originated from contaminated experimental polio vaccine developed in the Belgian Congo (Zaire) by Dr. Hilary Koprowski, a virologist and

former director of Wistar Institute (1957-1991) in Philadelphia, Pennsylvania, and his team. The polio vaccine derived from contaminated chimpanzee blood and kidney tissues which was injected into over one million unsuspecting Africans in a massive polio campaign in Central and East Africa-Belgian Congo (Zaire) Rwanda, Burundi, and Uganda in the mid to late 1950s (see the Sundance documentary film *The Origins of Aids*, co-produced by Multi-Media France Productions in association with Channel 4 (UK), Radio Canada, Canadian Broadcasting Corporation et al; see also Sundance.com).

It is in this context that the recent initial refusal of leaders of the predominantly Muslim northern Nigerian states recently refused to allow the immunization of children against polio, which was spreading across West Africa, believing that the polio vaccine was contaminated or fearing that African children would be used as “guinea pigs”. The decision not to permit northern Nigerian children to be immunized against polio jeopardized WHO’s hopes of eradicating the disease by the end of 2004 and was of little moment to the rightly suspicious leaders. In Central Africa, AIDS was simply called “the horror sex disease” (Shilts, 1987: 510).

It has been suggested and vehemently disputed by Africans that HIV/AIDS probably originated in Central Africa, considered the epicenter of the disease where the disease remains prevalent. An entry in *The Oxford Dictionary of New Words* (1992) claims that the condition was first noticed by doctors at the end of the 1970s, although later research has shown that a person died from AIDS as long ago as 1959 and that the virus which causes AIDS may have existed in Africa for a hundred years or more, carried presumably by monkeys (apes or chimpanzees) and transmitted to humans who unsuspectingly consumed monkey and other types of “bush meat” (see 1992:9-10).

In sub-Saharan Africa that the first cases of HIV/AIDS were reported in 1985/1986, years after HIV/AIDS had been reported in the US (where technology and expertise for HIV/AIDS testing were easily available) in 1981. For instance, *The Lancet* (19 October, 1985, p. 849) reported that “[a] new disease has been recently recognized in rural Uganda. Because the major symptoms are weight loss and diarrhea, it is known locally as *slim disease*” (my stress). *The Independent* (Sunday, 1, April 1990 Sunday Review Section p. 10) notes that “Because it is the skilled elite...who have most money to spend on womanizing, it is this group which is suffering the worst ravages of slim” (*The Oxford Dictionary of New Words* 1992:267). In Central Africa, AIDS was simply called “the horror sex disease” (Shilts, 1987,510).

### In Central Africa

In Lesotho, southern Africa, the first reported HIV/AIDS case in 1986 involved a foreign white. As a result, the Basotho called HIV/AIDS *Koatsi ea bosolla-tlhapi* (the disease that belongs overseas). But as the virus started to spread among Africans, the name changed to *Mokakallane oa setla-bocha* (influenza that has made a comeback). Historically, *mokakallane* is the name the Basotho gave to the fatal influenza epidemic which is reported to have killed over 15,000 people mostly in the 20-40 age group. The Basotho see resemblances between the historic *mokakallane* and the contemporary HIV/AIDS epidemic as both of them kill people in large numbers and affect almost the same age groups (litsepišo; 2004).

Like Lesotho, the first reported HIV/AIDS sero-positive cases in Ghana were a foreign couple from Germany who had traveled to Ghana in search of herbal treatment in 1986. At this time, there were press reports that a well-known Ghanaian

herbalist claimed that he had found a herbal antidote for AIDS. The first reported cases of AIDS involved foreign citizens, Ghanaians initially came to believe that HIV/AIDS was foreign and therefore an “*unGhanaian*” disease. However, it is interesting to observe that when rumors began to spread across Accra, the Ghanaian national capital, that the Ghanaian husband of the HIV-positive German wife was also HIV-positive, and had sex with several University of Ghana, Legon, female students (the couple were believed to be staying on the Legon campus). Legon female students were automatically stigmatized as HIV-positive. This was not surprising as Legon female students are stereotyped as sexually active and “loose”. For days, frightened Accra Makola Market women sellers of produce refused to have contact with or sell to any young women who looked like university students for fear of contracting HIV/AIDS. Later on, as AIDS cases were reported among Ghanaian sex workers returning from *Cote d’Ivoire*, the disease was thought to be an advanced form of gonorrhea. As a result, AIDS was called in Ghana *Cote d’Ivoire babaso*, meaning Cote d’Ivoire gonorrhea. As more and more Ghanaian women were reported to have contracted HIV/AIDS, the disease came to be identified as a women’s disease. The acronym AIDS came to stand for “Akosua Is Dying Slowly” Akousa is an Akan name for a female child born on Sunday. (dee Sackey, 2001:63). Indeed AIDS may just as well apply to any female child born on any day of the week as all the female names on any day begin with the letter ‘A’: Adwoa (Monday); Abena (Tuesday); Akua (Wednesday); Aba-Yaa (Thursday); Afua (Friday); Ama (Saturday) and, of course, Akosua (Sunday).

In a similar vein, the early prevalence of AIDS among homosexual populations in the U.S. at first earned the disease the

acronym, GRID (gay related immune disease) or *gay plague* before AIDS became better understood (*The Oxford Dictionary of New Words* 1992).

Be that as it may, there is no doubt that since the late 1980s, AIDS has been spreading at an alarming rate among women in sub-Saharan Africa (UNAIDS, 1991). Up to 40 percent of women aged 30-39 are estimated to be infected. In 1993, 45 percent of all new cases of AIDS infections in adults were women (Anderson, 1997).

It has also been noted that AIDS fell disproportionately among women in their child bearing years (Anderson, Schneider, and Stoller, 1995). The trend towards matrifocality of AIDS infection seems to be a reversal of the pattern noticeable during the early phase of the report of cases of HIV/AIDS infection (in the early to mid 1980s). At this time, Lincoln Chen pointed out that two epidemiological patterns of AIDS were identifiable. In North America, a preponderant majority of cases (over 90 percent) were among homosexual, bisexual, hemophiliacs and those exposed through intravenous drug abuse or contaminated blood products. In sub-Saharan Africa, there were as many female as male cases and the age distribution was bimodal-concentrated among adults and newborn children. Heterosexual (rather than homosexual or bisexual) and mother-to-child (matrifilial) transmission were the predominant modes of spread. In the Caribbean (Haiti) the male-predominant North American pattern was the norm initially, but later the African pattern of equal male-to-female ratio gradually evolved (Chen, 1987:183). It is noteworthy that in the United States during the early period, AIDS was concentrated in those cities where large numbers of high-risk individuals lived. In New York 58 percent were heroin addicts and had antibodies demonstrating previous exposure to the AIDS virus. In San Fran-

cisco, 49 percent of the homosexual population was sero-positive (Chen, 1987: 183). During the same period, in sub-Saharan Africa, AIDS appeared to be concentrated in newborns and among adults of both sexes in urban areas. Heterosexual and mother-to-child transmission, as already indicated, were the predominant modes of transmission.

The fact of the rapid growth of mother-to-infant transmission of HIV/AIDS through pregnancy, child-bearing and breast feeding, traditionally considered a woman's sacred duty in African societies, poses a serious threat to the natural order of African kinship and marriage and thus to the normal growth and development of entire lineage, clan or ethnic communities doomed to see not only the older generations of fathers and mothers condemned to death or long term disability but large numbers of their new generations sons and daughters, nephews and nieces equally condemned to premature or early death, thus undermining or totally destroying any hope for inter-generational cultural and social continuity, not to mention the negative effects on potential economic growth and development required for the alleviation of an objective and grinding poverty in rural and urban Africa.

#### **'Trade'-Routes of Transmission**

In sub-Saharan Africa as elsewhere, the four routes of HIV/AIDS transmission are as follows: (a) sexual intercourse; (b) blood products; (c) needles and skin cuts; and (d) mother-to-unborn or newborn child. HIV has been isolated from blood semen, vaginal and cervical secretions, saliva, tears, breast milk and urine. A preponderant majority of transmission is through sexual intercourse (vaginal, oral, and anal). In adults, the latency period from infection to clinical disease varies from six months to five or more years.

Within five years, it is estimated that 10-30 percent of infected persons will develop AIDS, while another 20-50 percent will suffer milder AIDS related symptoms. That is, at best 70 percent and at worst only 20 percent of infected persons will remain completely healthy five years after infection. It cannot be over emphasized that AIDS is lethal, and living with AIDS can be emotionally and psychologically devastating. Without adequate and diligent anti-retroviral treatment, it is estimated that 50 percent of AIDS seropositives die within 19 months and 90 percent within five years. In children, the latency period is even shorter and clinical diagnosis and death come earlier (Chen, 1987).

#### **AIDS Epidemic in Historical Perspective**

The sheer scope of The HIV/AIDS crisis in sub-Saharan Africa defies historic and cultural imagination. The genocidal devastation and the biological and cultural consequences of what WHO has called "the worst epidemic in centuries" (*Financial Times*, May 12, 2004:4) begs description. The ugly statistics are simply numbing. An estimated 34 million to 46 million people world-wide are infected with HIV/AIDS, the vast majority in sub-Saharan Africa. By the end of 2003 over 15 million people had died, 20 percent of them were children. There were close to 29 million Africans living with HIV/AIDS, over half of them women between 15 and 49.

The HIV/AIDS epidemic could not have hit the crisis-ridden sub-region of Africa at a worse period in postcolonial African history. Since independence, Africans have been struggling with only limited and uneven success against civil war, low life expectancy, poor and inadequate medical services, poor diet, hunger, starvation and malnutrition and lately obe-

sity and related health problems; a high birth rate and equally high infant mortality rate, a high rate of unemployment, especially among the youth, a low real income per capital (a majority living on less than one U.S. dollar a day), inadequate social and physical infrastructure, high rate of illiteracy, low levels of technology development, and, in short, low levels of human development. HIV/AIDS pandemic has simply and tragically compounded Africa's endemic human development crisis.

It is noteworthy that in January 2000 the United Nations Security Council (UNSC), considering rightly the HIV/AIDS epidemic as a global *security* issue, held a debate on the epidemic. This was the first ever debate on a health development-related question by UNSC and the first of several high-level AIDS-related meetings held at intervals throughout 2000 and 2001 by various regional governments and heads of state (Kelly and Bain, 2005:3).

Thus at a gathering in Abuja, the federal capital of Nigeria, the Abuja Declaration of April 2001 stated that the epidemic of HIV/AIDS, tuberculosis and other related infectious diseases, through their potential to undermine development, social cohesion, political stability and food security, constituted not only a major health crises but the greatest global threat to the survival and life expectancy of the peoples of Africa.

The significance of the Abuja Declaration is that it was accompanied by a framework or a program of action for controlling the spread of HIV/AIDS and mechanisms for monitoring how the plan was to be implemented in African countries.

The various regional meetings on HIV/AIDS culminated in the June 2001 UN General Assembly Special Session (UNGASS) on HIV/AIDS crisis with intensified action and increased resources.

A practical result of the UNGASS was the establishment of the Global Fund to deal with AIDS, Tuberculosis, and Malaria (GFATM), a promising, significant, innovative and importantly independent partnership between the public and the private sector, bringing together government, business, non-governmental organizations (NGO) and other stakeholders in civil society to address the challenge posed by the pandemic. The basic objectives of GFATM are to increase global resources to fight the “big three” life-threatening diseases, direct these resources where they are most needed and ensure that they are used effectively (Kelly and Bain, 2003:4). The continuing, unabated spread of HIV/AIDS world-wide but more particularly in sub-Saharan Africa, has made such intensified political intervention and public-private partnership critical.

Already, the government (public sector) and business (private sector) partnership to fight HIV/AIDS, is yielding beneficial results in South Africa.

In December 2004, the International Finance Corporation launched a guide for mining firms on how to respond to the disease. In late November 2004, the South African Business Coalition on HIV and AIDS published a survey of over 1,000 firms on the impact of AIDS. Among mining houses, 60 percent said the disease was hurting profits and productivity. Almost 50 percent of all financial firms and manufacturers said the same. Sick workers and those retiring early or those who die on the job all make doing business more expensive, especially in South Africa (and other African countries) where the supply of healthy, skilled alternative workers is limited. Rehiring, retraining and tackling low morale are costly. Thus, the global mining giant, Anglo-American, today creates a health profile for every one of its 135,000 southern African workers.

All employees are offered regular HIV tests, counseling, and, if needed, anti-retroviral drugs to keep them healthy and productive. Under a scheme launched in 2002, some 2,300 people now get drug treatment that costs the firm \$245.00 (U.S.) a month per patient. Hundreds of lives have been saved. Workers’ families are offered testing and treatment, too. The program is now expanding from the workplace to clinics in towns and villages near mines in partnership with LoveLife, an AIDS charity (*The Economist*, December 4, 2004:68).

In the countries of tropical Africa deeply ravaged by The HIV/AIDS epidemic, the resulting reduction of average life expectancy speaks loudly and eloquently. In Botswana, one of the few politically stable and economically successful countries in tropical Africa, life expectancy is 39 years, down from 61 just seven years ago (1996); in Namibia, 33 years down from 70, and in South Africa, 38 down from 68, all countries which had made substantial progress in living standards in the past few decades.

The HIV/AIDS epidemic has also had a drastic and equally damaging effect on the youth of sub-Saharan Africa. Indeed, there is hardly an aspect of tropical African society and culture in which the epidemic has not wreaked some havoc. Yet if one were to name one social group that has been adversely affected the most by HIV/AIDS, it would be the youth and children on whom Africa’s future depends. In the countries of eastern, central, and southern Africa in particular, there are thousands, if not millions, of young children growing up without one or both parents because they have died from HIV/AIDS-related diseases.

According to a report released at the end of 2003 by UNICEF, 11 million children under the age of 15 in Africa have lost one or both parents to HIV/AIDS. It is estimated that by the end of the decade

(2010) that number is likely to have climbed to 20 million. In a dozen countries in the sub-region of Lesotho, Swaziland, Botswana, Zimbabwe, Mozambique, Zambia, Namibia, Malawi, Rwanda, South Africa, Central Africa Republic, and Burundi, between 15 and 25 percent of children will be orphans. Carol Bellamy, the executive director of UNICEF, warns, "They [orphans] are a crisis that is massive, that is growing, that is long term and unless governments and the international community intervene, we are creating an explosive situation (Geoff Dyer, 'Africa Fighting AIDS/HIV', *Financial Times*, Friday, January 23, 2004:29).

The countries with the highest number of AIDS orphans are Botswana, Lesotho, Swaziland (all former British High-Commissioned Territories) and Zimbabwe. Of those orphans, 50 percent are between 10 and 14 years old, while 35 percent are between five and nine. What is more, young people are also the most likely to become HIV/AIDS positive according to the UNICEF report. In one study, half of the new infections were in the 15-24 age group. Young women appear to be particularly at risk, partly because of the pressure they face in some sub-Saharan African countries to have sex (mostly unprotected) early with their peers as well as older men, who believe that having sex with nubile teenage girls is a prophylactic against contracting HIV/AIDS.

The social and cultural consequences for the future health and well being, not to mention the survival, of the well-celebrated African extended family and lineage organization on which the integrity of indigenous African cultures depend are even more ominous. A World Bank report in 2003 also warned of the potential economic effects of the rise of HIV/AIDS orphans. Focusing on South Africa, which has an estimated 5 million HIV/positive

citizens (the highest number in the world for any one country) except India and where 600 people a day die of AIDS-related diseases, it is argued that the absence of parents in so many families would severely damage the process of passing on knowledge and culture to future generations as well as lead to lower school attendance rates. The World Bank report particularly stressed the damage to the country's human capital, which, if unchecked, could lead to "economic collapse" within four generations (*Financial Times*, Friday, November 21, 2003:6).

With respect to education, it has been suggested that improved educational access is one area where African governments, with the assistance of the international community, can help reduce the social impact of HIV/AIDS. Sub-Saharan African countries are among those with lowest primary school enrollment (*The Economist Pocket World in Figures*, 2004 Edition, 2004:74).

UNICEF argues strongly for the abolition of all fees for basic education (universal fee-free compulsory education) to make it easier for children from orphan families to attend. It also argues that public policy should be directed at supporting extended families which have traditionally provided safety-net/social security for their members and which are most likely to pick up and shoulder the burden from HIV/AIDS deaths. The death of a parent or parents not only means that grandparents and uncles and aunts, brothers and sisters, and cousins often have to look after children but it also puts other financial pressures on extended families. A study in four provinces in South Africa of the households which had suffered AIDS-related deaths found that one-third of the annual income was spent on funerals alone. What is particularly disturbing is that many of tropical Africa's worst affected HIV/AIDS countries, unlike South Africa which has relatively better social

services, only had modest networks of social provision and healthcare delivery even before being hit by the HIV/AIDS epidemic.

Again, it is estimated that about 40 percent of tropical Africa's population living in countries where the prevalence of HIV sero-positivity remains substantial, more than one-third of the population at risk will be infants potentially exposed by peri-natal transmission. AIDS could increase childhood and overall mortality in central Africa by at least 20 percent and even higher in other regions, especially southern Africa.

*The World Health Report, 2004* indicates that the percentage of HIV prevalence among 15-49 year olds in leading countries in sub-Saharan Africa is as follows: Botswana, about 38 percent; South Africa, about 20 percent; Malawi, about 15 percent; Kenya, about 12 percent; Tanzania, about 8 percent; Uganda, about 5 percent; Nigeria and Chad, about 4 percent each. The lowest is Senegal, 1-2 percent (*The Economist*, May 15, 2003:78). The actual incidence and rates of spread of HIV/AIDS among all demographic groups may never be known until it is too late. This is because HIV/AIDS surveys in tropical Africa tend to be of special population sub-groups, namely pregnant women in hospitals or clinics; women and children using hospitals and clinics mostly in urban areas; patients attending sexually transmitted disease clinics; and samples of female prostitutes or sex workers. Large areas of the countryside where a majority of Africans live are yet to be systematically surveyed for HIV/AIDS infection.

The explosive character of HIV/AIDS in sub-Saharan Africa suggests that a whole host of interrelated factors geographical, historical, cultural, economic, and social—may be facilitating transmission. It is noteworthy that in an interview Brigitte Syamalevwe, a Zambian educator and mother of 11 children who was diag-

nosed HIV positive in 1991 and a passionate UN volunteer AIDS activist, points out correctly, "The illiteracy rate and the growing poverty problems on the continent are certainly aggravating the issue of AIDS in Africa. The issue is now multidimensional. It is now a development issue." She goes on to explain that "when the South African President, Thabo Mbeki stressed the fact that HIV does not cause AIDS, his message was misinterpreted, or rather he missed the point slightly. ...Mbeki's stand, I suppose, was the belief that the continent of Africa has several depressing factors, all playing different parts in the spread of the disease. The ultimate immune deficiency syndrome and the resulting problems are only a manifestation of the many problems, malnutrition, hunger, starvation, and numerous disease on the African continent" (Bernard Otabil, West Africa 11-17 June, 2001:12). Brigitte Syamlaevwe's holistic approach to the AIDS epidemic in tropical Africa brilliantly echoes a point made more than a generation ago by George H.T. Kimble in his assessment of the status of health and wellbeing of tropical African populations in the colonial period.

George Kimble observes that "lacking a balanced diet and adequate protection against cold and damp and living in ignorance of the elementary principles of sanitation and out of reach of hospitals, doctors and drugstores....For him sickness is the norm; it starts at birth ... and continues until death. And he is a very lucky African who is not sick of more than one thing" (1960:33). Kimble goes on to indicate that diseases affect the African more or less permanently and make it difficult, if not impossible, for him to go on supporting himself for the better part of his life, which, depending on the disease, may mean a few months or many years; (b) sicknesses that allow him to go on supporting himself, but with impaired vitality, but for less than the customary span of

life; and (c) sicknesses that occur epidemically whenever there is a favorable concurrence of organic and inorganic factors.

In the first group, (a) belong to the following: malaria, trypanosomiasis (sleeping sickness), bilharziasis, leprosy, tuberculosis and a number of deficiency diseases. Some of these are known to be opportunistic diseases of HIV/AIDS. In the second group, (b) comes a number of other worm infections (ascariasis) yaws in its tertiary or late forms, various intestinal disorders; pneumonia, ulcers and venereal diseases (gonorrhoea, syphilis, and other sexually transmitted diseases (STDs)); in the third group, (c) belong plague, rickettsial diseases (typhus), yellow fever, smallpox, influenza, meningitis, and the *epidemic* explosions of such endemic diseases as malaria and trypanosomiasis (Kimble, 1960:35).

Malaria has long been a chief threat to the health as well as life throughout tropical Africa. It can be fatal, especially among children – malaria kills more than one million people a year across the world, 90 percent of them, Africans and the majority are children (*Financial Times*, April 24, April 25, 2004:4). What is particularly disturbing about malaria is its indirect effects in undermining health, thereby rendering its victims susceptible to other infections.

Malaria is a debilitating disease for which no traditional African pharmacopoeia has a cure; in chronic forms, malaria gives rise to loss of appetite and weight, low irregular fever, general weakness and anemia of varying severity, the symptoms of which can mimic HIV/AIDS. What is more, malaria costs African countries an estimated \$12 billion a year in lost GDP and consumes about 40 percent of the continent's health care spending (*Financial Times* April 24, and 25, 2004:4). All this suggests that an assault on HIV/AIDS in tropical Africa, its prevention, arrest of

its spread, its control and containment; absolutely demands, in addition to a stepped up AIDS awareness, education in both rural and urban Africa, by governments and non-governmental organizations and AIDS activists, universally available accessible and affordable cocktails of anti-retroviral drugs, and a holistic approach that includes the following: better employment opportunities and a living wage that raises the average standard of living, improving the diet and nutrition of the average African, and better sanitation and public health along with a development strategy that succeeds in lifting the ordinary African, particularly the African woman, out of abject poverty in the shortest possible time.

Along with an ongoing AIDS strategy focusing on awareness, prevention and nutrition, the South African government, in August 1993, launched an ambitious operational plan on an anti-retroviral treatment program “as a matter of urgency” (*Financial Times* Tuesday, November 20, 2003:6). The program called for at least one “service point” offering anti-retrovirals (ARV's) in each of South Africa's 53 health districts by the end of its first year. Within five years, it aims to provide all South Africans who require comprehensive HIV/AIDS care and treatment “equitable access to the program within their municipal area.” South Africa's Department of Health estimates that more than 50,000 people will receive ARVs in the first year alone. The number will increase to more than 1 million by 2007 (*Financial Times*, Wednesday, January 21, 2004:11). Senegal with perhaps the lowest rate of HIV sero-positivity in tropical Africa, has also enacted a similar nationwide HIV/AIDS treatment program. The examples of Senegal and South Africa (with the largest pool of HIV/AIDS positive people) are worth emulating by all African countries.



### AIDS, Culture and the Supernatural

As already noted, parallels have been drawn between AIDS and the catastrophic epidemics of human history: the Black Death plague of 14<sup>th</sup> century Europe, measles, smallpox, syphilis following the post-Columbian discoveries of the New World; and cholera, typhoid and influenza in the 19<sup>th</sup> and 20<sup>th</sup> centuries that killed thousands of people world-wide. Historically, epidemics have usually accompanied natural disasters or have occurred at times of socio-political turmoil, particularly civil wars, revolutions, large-scale population movements and periods of rapid social change. But it has been well argued that the AIDS pandemic of the late 20<sup>th</sup> century differs from historical health crises in several crucial respects. Notable features specific to AIDS are 1) life long infection, long latency periods, and, more importantly, automatic transmission; 2) partly due to improvements in world transport and communication-air, road, rail, transoceanic-the AIDS pandemic has demonstrated unprecedented rapidity and breadth in spreading internationally. Whereas it took each of the cholera pandemics nearly 20 years to sweep across Europe, it took only half a decade for AIDS to spread to over 100 countries world wide. The nature of contemporary society with its cosmopolitan values and emphasis on mass international tourism, clearly has contributed to the global export and import of HIV/AIDS (Chen, 1987). It has become evident that a major hidden cause of AIDS, especially in the countries of eastern, central and southern Africa, with high rates of HIV seropositivity, is the persistence of the colonial tradition of international wage-labor migration, a migrant labor system which has led to the development of widespread prostitution along truck stops near mines and plantation to cater to the sexual needs of migrant workers away from home in

distant countries. Migrant miners, truck drivers and prostitutes are what World Bank and other development agencies refer to as “groups with high risk behavior” with respect to HIV. It is not uncommon for bar girls and local prostitutes servicing migrant workers and truck drivers to have sex with twenty or more different men every week (Helen Epstein, *The New York Review of Books*. Vol. XLIXL, Nov. 8, May, 2002:43-49; Owusu, 1999:340-343).

Other notable characteristics of AIDS, in contradistinction to contemporary and past epidemic diseases, include the fact that it is no respecter of persons, attacking rich and poor, healthy and unhealthy, young and old, the high and low, men and women, with equal viciousness. It is also transmitted primarily through sexual contact, -a very private act surrounded by social taboos which makes its open and frank discussion and social acceptance often difficult.

Any sexually transmitted disease is unequivocally “a bad thing”- immoral, evil, and shameful. People do not want to think about or talk about sex in polite society. Yet sex is a basic element in the biological (mammalian) and cultural nature of man.

The Western theory that HIV/AIDS perhaps originated from black Africa is countered by the popular view among urban Africans that AIDS is a new, fatal and incurable disease which spread from Western societies where homosexuality (which to the conservative African mind is an abomination and unnatural act) is widely practiced and tolerated. The conservative African view is that AIDS is caused by engagement in abnormal sex, or, more commonly, by bewitchment or ancestral wrath. Others see HIV/AIDS as chronic gonorrhea transmitted through illicit sexual intercourse. Still others believe that HIV/AIDS is curable by means

of divination, spirit mediumship of herbal medicine.

The Yoruba people of southwestern Nigeria believe that HIV/AIDS is an acute form of gonorrhoea, which can result from a curse put on a married woman who is unfaithful to her husband or a man who engages in illicit sex with married women. The disease is thus seen as a supernatural punishment for immoral sexual behavior. Similar views concerning AIDS exist in many parts of sub-Saharan Africa. This is not surprising. It is the case that typically traditional African society tends to moralize about “bad” things like pre-marital sex or sex with a girl before her puberty rites, which are thus tabooed, and the penalty for infraction, in the past, could be death.

This leads to a situation in which an infected person, once diagnosed with HIV positive finds it difficult to disclose his or her HIV status because of the shame it brings to him/herself and to members of the extended family and lineage. The result is that kin groups tend to stigmatize and ostracize a kinsman or woman living with AIDS. In Ghana, the conservative Christian view of what causes AIDS is similar to the traditional perception that HIV/AIDS is a manifestation of the anger of God or ancestors against sexual laxity and promiscuity. Increasingly, many radio preachers and televangelists in the country attack people living with HIV/AIDS as deserving of their punishment. Some believe that the global spread of HIV/AIDS has an apocalyptic message, a sign of the approaching end of the world, while for others see AIDS as ‘*bonsam yare*’ – disease of the devil (Sackey, 2001).

### **Feminization of AIDS: Fact and Fiction**

The change in the pattern of AIDS transmission, making women in Africa more vulnerable than men needs to be explained. As to the factors contributing to the higher rates of AIDS infection

among women, Nnamdi-Okagbue (1998) has observed that the female. In sub-Saharan Africa experienced economic decline and widespread poverty, driving many women into sex-work, a high-risk occupation, must be mentioned, as well as rape and other forms of sexual abuse associated with civil war and refugeeism, especially in eastern and central Africa, which has forced women to engage in unprotected sex. A more detailed discussion of the historical, social structural and cultural factors that put Africans in general and African women in particular at risk of HIV/AIDS infection will be presented later in the paper. It is relevant to be reminded at this point that four routes of the transmission of HIV/AIDS have been identified.

In addition to supernatural explanations of the causes and spread of HIV/AIDS, a number of African feminist scholars have identified several traditional and customary practices, which they believe are major contributory factors to the high rates of AIDS infection in tropical Africa, especially among women. First, they argue that the patriarchal nature of African society forces women to submit without question to sexual advances (they assume are unwelcome or inappropriate) by husbands and lovers, who often insist on having unprotected sex (that is, avoiding the use of a condom, with the saying that one cannot enjoy sweets with the wrappers on).

There is no doubt that in sub-Saharan Africa, according to UNAIDS, three women are infected for every two men, and that by the end of 2003, the number of women aged 15-24, living with HIV in Africa was two and a half times higher than the one for men of the same age set. It is also true that no matter how they are infected-- by a vicious and violent rapist or by a loved one (husband or boyfriend), women in many African societies bear a disproportionate share of the burden of

HIV/AIDS, for instance, many women, even when they themselves are sick, must care for family members with AIDS. In some rural areas of Zimbabwe, according to Matambanadzo, caregivers may have to collect as many as 24 buckets of water, walking up to eight miles a day, just to wash laundry soiled by the diarrhea and vomit of the sick person. But when the women themselves become sick, there is no one to care for them. They are labeled as the ones who gave their husbands the disease. They are called witches (*Amnesty Now* 2004:10).

The view that across sub-Saharan Africa one of the principal causes of the spread of HIV/AIDS from male to female bloodstreams is how little say women have in the matter, that women have no right or power to say “no” to sexual advances they do not want, and that male chauvinism or patriarchy is largely to blame can be misleading. Suffice it to point out that in a study by T. Preter Omari, a Ghanaian sociologist, on the role expectations in the courtship situation in Ghana, he concluded that “[T]he Ghanaian woman is no less independent than the male [and this] holds true in the realm of adolescent love” (Omari, 1965:153). What is true of Ghana is certainly the case in many other West African societies.

Heterosexual intercourse, the norm in African societies, is, as a rule, consensual in most African societies and based on complex, often nuanced and subtle culturally understood seductive negotiations relying heavily on language and looks between the sexes in which men and women can and do take the initiative and see themselves as active participants. As Peter Omari stresses in his study of role expectations in the courtship situation in Ghana, the young Ghanaian woman “is liable to take an active role when actually presented with the situation, rather than a passive one” (Omari, 1965:133). Another study by Gustav Jahoda which explored

the changing Ghanaian attitude and behavior toward love and marriage based on content analysis of letters to the advice column of a West African newspaper clearly supports Omari’s findings (Jahoda, 1965:143-158).

Moreover, it is interesting to note that in Muslim North Africa and the Middle East (not to mention Muslim Senegal), patriarchy, in the sense of arranged marriages by male family heard, female chastity (purity from unlawful sexual intercourse), that marriage can be polygamous (a man can have up to four wives at a time) while women must confine their sexual favors to their husbands only and to one at a time, and divorce initiated by a woman is discouraged and difficult to obtain, but easier to obtain when initiated by a man, seems to have contributed to very low prevalence of HIV seropositivity in those societies. Conservative sexual values of premarital teen abstinence and fidelity to one’s spouses or lovers do clearly prevent the spread of HIV/AIDS. In other words, patriarchy alone cannot be a major cause of the spread of HIV/AIDS in sub-Saharan Africa. The view that men tend to contract HIV/AIDS because of things they do, while women are more likely to contract it because of things that have been done to them – by men, needs to be re-examined (*The Economist*, November 27th, 2004: 82).

In contemporary Africa, many rural and urban women, irrespective of age or economic status, engage in what may be called *sexual entrepreneurship* – calculated sexually risky behavior- for material or monetary and immaterial (non-monetary) gain and profit, for example, a chance for marriage or overseas travel. Modern conditions (globalization and international tourism) may have simply exacerbated a tendency which may have existed in some African societies for generations. For instance, in his study of kin-

ship and marriage among the Lozi of Northern Rhodesia (Zambia) and the Zulu of Natal (South Africa) Max Gluckman reports that among the Lozi, men and women were promiscuous and marriage unstable. Women looked at marriage ties as loose. Seduction, adultery and abduction of wives were common (Gluckman, 1950:180). In contrast, Gluckman notes that the Zulu of Natal imposed strict laws of chastity with severe sanctions. If an unmarried girl became pregnant by a young man of the warrior age set, both they and their families were liable to be killed, unless the girl was hurriedly married to a man whose regiment had the king's permission to marry. Adultery too was severely punished with death, or flogging with thorny branches or cacti were thrust into the woman's vagina (Gluckman, 1950:180; see also Kenyatta, 1938, on the Gikuyu of Kenya).

In addition, the strong desire of African men and women to have children to fulfill lineage obligations. "Motherhood" defines "womanhood" as "fatherhood" defines "manhood" and compounds the problem of the spread of HIV/AIDS.

Not surprisingly, the sexual behavior of the African youth, particularly African girls, has become a focus in the fight against HIV/AIDS. In a number of countries, including Uganda and South Africa, governments are promoting female sexual abstinence (chastity) before or outside marriage as a primary means of combating the pandemic. In Uganda, government billboards proclaim "Saving yourself for marriage is the right thing to do." "Beware of sugar daddies" warn posters in schools. They depict a heavy-set man giving flowers and sweets to seduce a frail girl through the tinted window of a Mercedes-Benz.

For young women and disadvantaged and vulnerable young girls, including those orphaned by AIDS or internally displaced by civil wars, and political and

economic refugees-in many parts of Africa, sex has for generations been a way out of extreme poverty, overcrowded and uncaring homes, and uncertain future. The problem is complicated by the pressures of consumerist capitalist culture and the material goods on offer.

In Uganda, the government of President Yoweri Museveni, once a leader in promoting condom use in the war on HIV/AIDS, under pressure from the Bush administration, which champions abstinence and monogamy (in the true spirit of evangelical Christianity) to prevent HIV/AIDS and which gives the Ugandan government eight million dollars (\$8 million) each year for the abstinence program, has shifted to please the Bush administration.

Indeed, a member of parliament in Museveni's government Mr. Sulaiman Madada, is promoting for what it is worth, chastity scholarships for to qualified young girls, hoping the program would reduce the incidence of AIDS in his district and help turn poor and desperate young women away from sexual arrangements – what I have called sexual entrepreneurship can ruin their lives. Applicants would be examined to prove they were virgins.

In colonial Africa, missionaries from the Christian West had always preached to polygamous Africa that marriage should be monogamous and permanent and that physical love should not occur outside such an injunction (consistent with Victorian ethics and morality) was of course considered by Africans as unAfrican, even though in pre-colonial and colonial African, it was much more common to find such a rule of chastity, where it existed, applied unilaterally to females, often as a precaution against childbearing before marriage rather than as a moral requirement. Accordingly, most Ugandans, south Africans or Ghanaians expect women to have sex only with their husbands and to

one at a time, whereas men are allowed more variety.

Critics of the female chastity/abstinence program argue that such a program is discriminatory as there is no equivalent test for boys or men and that testing for virginity can be traumatizing and could stigmatize girls who have been raped. They also point out that virginity tests may be inaccurate and that girls who fail may be ostracized and also that women may be forcibly tested (infringing their human rights) as a form of moral policing (*Guardian Weekly*, October 14-20, 2005:33).

There is a long list of traditional African cultural practices which some scholars claim facilitate the spread of HIV/AIDS. Heading the list is female circumcision, or the cutting or altering of female genitalia as part of traditional puberty rites, the rites of passage from childhood to womanhood. Althus (1997) indicates that at least 28 countries in sub-Saharan Africa and northeast Africa practice some form of female genital cutting. In these countries, female genital cutting is found among all classes, educational levels and religious backgrounds—animist, Christian and Muslim—in both rural and urban areas. Clitoridectomy accounts for up to 80 percent of all cases of female genital cutting. Al-Krenamwi and Wiesel-Lev (1999) point out that most traditional “surgeons” of female circumcision are without health training in the use of anesthesia or do not sterilize their surgical instruments, which include razor blades, glass, kitchen knives, sharp rocks, scissors, and scalpels which may be contaminated.

The second group of cultural practices that may facilitate the spread of HIV/AIDS include the levirate—the marriage of a widow to her deceased husband’s brother, and other forms of wife inheritance and wife-sharing. These may be high risk behaviors (Afuekwe, 1992). The Alor community of Igbo, Nigeria

practice “*Nkuchi Nwanyĩ*”. The practice involves a dead man’s wife being inherited by either his senior brother or kinsman appointed to inherit the property of the deceased. Given the asymptomatic nature and the long latency period of HIV/AIDS, if the deceased is HIV positive without knowing it, the wife may have AIDS and transmit it to the new husband, who in turn may pass it on to his numerous wives. It must, however, be pointed out that any form of sexual sharing above all, the sharing of the sexual services of prostitutes, in some cases like that of Agatha of Nairobi’s Majengo slum (Kenya) who may service up to 40 clients a day, poses even more serious potential danger (*World Press Review*, February, 2004:16-17).

Other ethnographic examples of woman-sharing include the following: among the Tshokwe of the Democratic Republic of the Congo (Zaire), a wife is shared sexually with the husband’s intimate friends (or age-set mates, as occurs elsewhere in East Africa). Here a bridegroom selects one intimate friend of his to have sexual intercourse with his wife whenever he is away. Such a Tshokwe wife is not accused of adultery when she sleeps with the husband’s surrogate (Beya, 1992). Beya also states that in Bakete clan in the Democratic Republic of the Congo, a girl must be completely prepared for marriage by first having the ‘practical skills’ with a man other than her prospective groom. Among some Tiv communities in Nigeria, a wife may sleep with a guest as a mark of hospitality.

The third group of cultural practices in traditional Africa that may contribute to the spread of HIV/AIDS consists of those that involve skin incision (face, body) for cosmetic, medicinal or social identity purposes as well as body, ear, nose, and lip piercing (Uwe, Ekuri, and Asuquo, 2004).

Be that as it may, the fact is that there are over 30 million Africans who are HIV

positive, and we have to be realistic enough to recognize that these cultural practices, mostly in relatively isolated parts of rural Africa, cannot by themselves account for the exponential rise in HIV positivity in Africa. As already noted, there are four confirmed primary routes of HIV transmission: sexual intercourse; blood products; needles and skin cuts and mother to unborn or newborn child. Though the bulk of transmission is through sexual intercourse, it cannot be overemphasized that the comparative efficiency of the various routes – male-to-male, male-to-female, and female-to-male is yet to be established. What cannot be denied is that abject poverty is not only contributing to HIV infection, because poor people are less healthy, and poor women are more likely to engage in commercial sex work, it is also preventing people living with AIDS from staying alive longer, as most cannot afford a balanced diet and ARV drugs.

**Conclusion: What can, and needs to be done?**

Clearly, the habitual use of condoms, abstinence, or avoidance of casual sex, that is taking the ABC message seriously, can reverse as the Ugandan and Zambian cases show in spite of the rapid rise of new cases of infection. In the final analysis, only rapid, people-centered development that raises the standard of living of the people at the bottom, that is, development that gives most Africans access to better nutrition, education, better sanitation and social security, can help halt the scourge of HIV/AIDS.

As experience demonstrates, the challenge of HIV/AIDS in sub-Saharan Africa is that most prevention programs are slow in reducing the transmission of the virus, given the poverty and severe social and physical infrastructural limitations and constraints of the region. Thus, millions of

HIV/AIDS sufferers in tropical Africa who need anti-retroviral drugs are yet to receive proper treatment. This is, of course, very costly and requires long term budgetary commitments by national governments and the international community, to make adequate funds available for anti-retroviral treatment and care. This is critical, for the available therapy cannot wipe out the virus within the body, the AIDS patient never ceases to be an infected person. The virus remains dormant as long as the infected person adheres scrupulously to required treatment regime, allowing the AIDS sufferer to lead a reasonably normal and useful life.

African countries saddled by debt and poverty and the international community must be prepared for long term commitment to provide funds and drugs and for interventions extending across several generations. But given the poor record of Western promises of pledges of aid to Africa, when despite ostensible good intentions or good will, more often than not, aid promised or pledged has not been delivered or, when delivered has arrived too late, the future of HIV/AIDS in Africa seems rather bleak (Owusu, 2004).

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# The Political Economy of HIV/AIDS

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## Abstract

This theoretical and interdisciplinary paper is an historical, political, economic and sociological analysis concerning the origin, development, and effects of HIV/AIDS in Africa and elsewhere. Though an etiological and phylogenetic analysis would have been more appropriate for this approach, the culturally, sociologically and economically emphasized interpretive conclusion is an honest admission of the ignorance that imperial creators of knowledge impose on researchers, scientists, policy makers, thinkers, and society in order to rationalize, control, predict, and theorize about laboratory experiments which need not to have existed in the first place and whose results ratify the mission and motives of the drugs industry and scientific and political establishment.

## HIV/AIDS Related Theories of Political Economy

Currently, “only two structures of approximately 20 or 30 proteins of HIV-1 have been determined and non from the related viruses HIV-2, HTLV-1, HTLV-11 and SIV?...” (<http://www.scienceblog.com/community> and Duesberg, 1996). The atomic structures of HIV and SIV related retroviruses may provide new knowledge on the functions of many virus components that are necessary for the development of new vaccines, therapies and diagnostics. Although some scientists such as Carter and McKenzie believe that structural biology is the biotechnological linchpin for research in HIV/AIDS, other scientific disciplines such as chemistry, advanced x-ray crystallography and physics should be used to search for the cure of the modern plague which is also extremely pandemic. This introductory note advocates the use of interdisciplinary scientific disciplines to search for the permanent cure and elimination of “death.” The implications of such scientific inability to provide viable

results for human survival and longevity are being discussed pessimistically in the context of modern and contemporary discourses of history, sociology, and political economy.

The term “political economy” is derived from politics and economics. Economics is acting in certain ways. Politics is a platform from which action takes place. Economics rationalizes what is done and why. Politics is a context for doing and acting. Sometimes economics is about an existing activity excluding market institutions, though such exclusion may not fully define the term without the latter. Economically, market institutions tend to satisfy human wants better than any others that are known and thereby making them more dominant than politics, which is subordinate to them – economics. Politics means “who gets, what, when, and how” (Lasswell, 1936). It is “the struggle for power” (Morgenthau, 1948). Politics is “the art and science of government” and “the socialization of conflict” (Schattschneider, 1960). Politics is “the authoritative allocation of values” (Easton, 1953). Evidently, it is “pure conflict” (Schmitt, 1976) and “the concilia-

tion of conflicting interests through public policy” (Crick, 1962; and Caporaso and Levine, 1997, p. 8). For instance, after the 2004 presidential elections in the USA, we witnessed how morality, i.e., values, militarism and ideas about economic rationality, were explained to defeat intellectual elitism and the afflicted voices of hope and humility. Through the struggle for power, in which conflict was socialized, the winning regime was authoritatively authorized to allocate values or resources through the conciliation of a variety of interests in the realm of political economy.

In real life there are many major theoretical approaches to the study and application of political economy whose diverse views influence organization theory and political practice and vice versa. The theoretical approaches have a variety of assumptions, stage actors, and different explanatory, interpretive and inferential issues. Political economy is a structure of national and international dependence in terms of division of labor. The system is held together by exchange contracts among legally independent property owners (the market economy). These property owners have property rights, which the political system legally protects (Sagini, 2001). Specifically, seven theories of political economy are highlighted.

First, classical economists associate the term “political economy” with the unlimited but satisfied wants that exist in a world of scarcity and competition. To satisfy people’s wants, society is depoliticized because politics is eroded with the rising dominance of the autonomous and self-interested primitive capitalists who dominate Third World economic and political markets. The state defines how production and distribution of the wealth among classes is to be conducted. The economy is mercantilist in character. Second, Marxists argue that politics and economics can be connected by using

revolutionary activity to transform political and economic structure, social democratic politics and the Marxian state model, whose radicalism is anti-competitive market, anti-democracy and anti-free enterprise. Their production goals are based on satisfying needs rather than wants. Planning is centralized and production and distribution are collectivized. The theory emphasizes partial rather than holistic inclusion of the state. The state coercively emerges to resolve the irreconcilable contradictions in society, which the pre-capitalist and capitalist classes fail to deal with. This theory contributed to the collapse of the Soviet Union largely due to the latter’s lack of creativity and destruction of competitive genius. Marxism is a living intellectual reservoir that exists only as a radical school of thought and critique of the organizing principle of the capitalist system and its liberal, sociological, conservative and competitive values including those of the market. Evidently there is inevitable and considerable tension between economics and politics in both classical Marxism and modern capitalism. In Marxism, the tension is contradictory, irreconcilable and eventually destructive of itself and its political economy.

Third, the end of the classical period was epitomized by the classical and Marxian models, which were replaced by the neoclassical economic theory of marginalism during the 1870s. Neoclassical economic theory of laissez faire was a shift from the fascination with class categories to the concern with individualism through which the individual selfishly sought productive utility in the areas of consumption and profit maximization. The individual’s self-seeking behavior is manifested in both perfect and imperfect competitive settings of the market. In itself, individualism has been viewed as a form of liberal political philosophy where the individual has “a commitment to personal initiative,

self-sufficiency, and material accumulation. This principle upholds the superiority of private-enterprise economic system and includes the idea of the individual as the foundation of society” (Pettersson, 2000, p.4). Within neoclassical political economy, politics becomes deterministic when market failure prevails. In other words, in such an arena self-seeking, particularly that of the state, can enter non-market institutional and organizational domains in order to “provide public goods, correct externalities, and solve collective action problems through coercion” (Caporaso and Levine, 1997, p. 219). Within the neoclassical economic realm, market economics lacks the full potential for productive exploitation. As a result, economics fails to reconcile the relationships between wants and means. Such failure caused the Great Depression of the 1930s when FDR used New Deal and Keynesianism to involve political leadership in the circular flow including the securing of incomes and investment to challenge the failed creativity of specialization and capital markets. In other words, human needs and wants cannot be satisfied under neoclassical economic theory unless creative and bold transformational leadership introduces regulatory measures that become the checks which balance the viability of neoclassical economic theory of the market-driven society.

Fourth, neoclassical economic ideas, in the form of rational self-interest, have been extended into the political arena. Rational self-interest is used to analyze politics. “Neoclassical political economy, with its focus on the state’s role in market failure, offers a way to complete the liberal project in one direction” (p. 220). In other words, rationality is used to analyze the market in order to enhance the political economy and uplift the state’s interest and stake in it.

Currently the Clinton Foundation has been working with the governments of South Africa, Mozambique, Tanzania and Rwanda. These countries are likely to possess 1/3 of all Africa’s AIDS cases. The same foundation has worked with the Caribbean nations of Haiti, the Dominican Republic, the Bahamas, Jamaica and Eastern Caribbean states. These nations account for 95% of the AIDS cases in this region, which is also second highest infected region in the world. Lately, the Clinton Foundation also has begun work in China. Other organizations that are members of the Clinton Foundation include Columbia University Institute, Harvard Medical School Division of AIDS, Health Alliance International at the University of Washington, Medecins Sans Frontieres, Pangaea Global AIDS Alliance, Partners in Health, PharmAccess International, University Research Corporation (Magaziner, 2004) and Brown University Medical School. These organizations share the experiences and results concerning the HIV/AIDS scourge. The Presidents’ Foundation has donated ten million dollars.

The suppliers with which the Clinton HIV/AIDS Initiative and Care Consortium deals with are Aspen Pharmacare Holdings Ltd., Cipla, Ranbaxy Laboratories Ltd., Hetero, and Matrix Laboratories Ltd. The Pharmaceutical companies involved include Bayer Diagnostics, Beckman Coulter, Inc., Becton, Dickinson and Company, BioMerieux and Roche Diagnostics. The donor governments, which give money directly to the recipient nations are those of Canada, Ireland, Norway, Sweden, and the U.K. Later, the Clinton Consortium plans to get support from more countries. In consonance with the theories of political economy, some of the strongest pharmaceutical industries, which are dominated by the conservative economic and political elite, are rationally opposed to President Clinton’s effort for

economic, globalization and exploitative reasons.

In his book *Disease and Democracy: The Industrialized World Faces AIDS*, Peter Baldwin uses a comparative approach to discuss the politics of public health issues in advanced Western countries. He paradoxically argues that while nations such as the U.S., Sweden and others undertook a variety of interventionist strategies to combat the disease both at home and abroad, France and Germany employed a laissez faire attitude about the suffering and dying millions. Although the two European nations were largely less involved for ideological reasons, the reality of their behavior is better explained in the light of historical and colonial experience in which the “path dependence” model was reinforced. The author vividly demonstrates that public debates on the pandemic were highly politicized. In France, Switzerland and the United Kingdom, policy on AIDS was removed from public opinion and political discourse. Surprisingly enough, knowledge about the economic, psychological, social and medical costs of the disease was utilized to galvanize society to willingly and legitimately integrate the Western gay community into its social and cultural institutions.

The last three theories of political economy are power-centered, state-centered and justice-centered. The power centered theory sees relations of power and domination in the market to be existing between the market and the state and within the state itself. Economic agents who include firms and pressure groups may challenge the state by voting and lobbying over the political process, economic agencies and consumers. Since power is almost everywhere within the political and nonpolitical spheres of the state, to address the state’s interest and the interest of citizens, policy analysis, including the one on HIV/AIDS, should be

more focused rather than being broad and generalized. In the metropolises, since HIV/AIDS resides within the province of marginalized groups, HIV/AIDS policy can be brief and highly generalized. That is why the problem is not a major issue in Western political campaigns. State-centered theories of central political institutions can define politics decisively. Since politics is what the state does in and with society, this may involve the “regulation of the economy and economic actors, the effect of the economic actors on the state policy, distributional effects of policy on economic resources, and traditional macroeconomic policy along Keynesian lines” (p.220). Finally, the justice-centered approach concentrates on fairness and rights instead of concentrating on individualistic efficiency. Justice is not an historical accident; it is politically, legally, and morally definitive state policy for reconstructive economic and political practice. In the light of such an understanding of political economy, including the HIV/AIDS policy, the problem may or may not be rationalized through a political process for sound economic planning and distribution (Grosh, 1999). All these theories, or most of them, place emphasis in market and state domination over the individual, who is also self-centered and rational enough to maximize certain choices for personal rather than societal gain. Globalization, which is a form of neocolonialism, means capital crossover, raw materials, brain drain and currency flows tend to weaken the economic, social and cultural social fabric of Third World peoples more than that of the systems of the people of Japan, Western Europe and the Anglo-American world where the HIV/AIDS pandemic is less highly pronounced (see Table 1:1).

Tables 1 and 2 show that HIV/AIDS significantly increased in all the nine or ten regions of the world during the last three years. Currently, the Sub-Saharan

**Table 1 AIDS /Living and Dying with HIV**

Region	Living With HIV/AIDS	Newly Infected in 2000	Deaths in 2000
Sub-Saharan Africa	25,300,000	3,800,000	2,400,000
South and Southeast Asia	5,800,000	780,000	470,000
Latin America	1,400,000	150,000	50,000
North America	920,000	45,000	20,000
Eastern Europe and Central Asia	700,000	250,000	14,000
East Asia and Pacific	640,000	130,000	25,000
Western Europe	540,000	30,000	7,000
North Africa and Middle East	400,000	80,000	24,000
Caribbean	390,000	60,000	32,000
Australia and New Zealand	15,000	500	500
<b>TOTAL :</b>	<b>36.1 Million</b>	<b>5.3 Million</b>	<b>3.0 Million</b>

Source: Rachel Zimmerman and Michael Waldholz, *The Wall Street Journal*, The U.N. Plots a War on AIDS, 2001.

**HIV/ AIDS World Statistics for 2004- Table 2**

Region	People Living with HIV	New Infections 2004	AIDS Deaths 2004	Adult Prevalence %
Sub-Saharan Africa	25.4 million	3.1 million	2.3 million	7.40%
Asia	8.2 million	1.2 million	540,000	0.40%
Latin American	1.7 million	240,000	95,000	0.60%
North American & Western & Central Europe	1.6 million	64,000	23,000	0.40%
Eastern Europe & Central Asia	1.4 million	210,000	60,000	0.80%
Middle-East & North Africa	540,000	92,000	28,000	0.30%
Caribbean	440,000	53,000	36,000	2.30%
Oceania	35,000	5,000	700	0.20%
<b>Total</b>	<b>39.4 million</b>	<b>4.9 million</b>	<b>3.1 million</b>	<b>1.10%</b>

Source: [www.unaids.org](http://www.unaids.org) Joint United Nations Programme on HIV/AIDS (UnAids) 2005.

African region leads the world with the highest cases of HIV/AIDS seroprevalence. The region has over 10 % of the world's population. Of nearly 40 million infected, 60% are Sub-Saharan inhabitants while 40% live in other regions of the world. In 2006, more than 65 million have been infected with HIV and more than 25 million have died while 15 million children are orphans ([www.unaids.org](http://www.unaids.org)). Some sub regions have higher concentrations of HIV infection than others. In East Africa, Uganda reduced its HIV/AIDS prevalence because it used technologically-advocated prevention measures that were financed by the United States. However, U.S. strategies that encourage abstinence are neither popular nor effective in the region. In Southern Africa, 10-12.6 million people are infected and most of them are women. All over Africa, the 15-24 years olds show that for every 36 women living with the disease, 10 young men remain to be their counterparts as both groups struggle for survival ([www.unaids.org](http://www.unaids.org) 2005). Transmission is largely through heterosexuality.

The African region and all other regions should counteract the disease by planning strategically. Strategic planning should be conducted by establishing the mission of development, the goals to be addressed, and the priorities to be tackled. The region should empower leadership which implements the priorities. Governments should create partnerships for treatment and mobilize resources to be used as the capacity for treatments, tracking, monitoring and evaluation. They should unblock existing constraints by employing better "procurement, tendering, staff costs, simplification of procedures" (p.3).

In populous Southeast Asia, national HIV infection cases are small compared to those of the Sub-Saharan African region. The disease has spread to all the 31 provinces of China where selling blood

plasma, paid sexual favors and injecting drug use are common. In Japan, men who have sex with other men tend to transmit the virus to female sex partners. The empowerment of leadership and the forging of partnerships can be scaled up to target injecting drug users and sex workers in order to prevent the escalation of the disease. In Oceania, the Caribbean and Western Europe, the HIV/AIDS concentrations are found in people of African descent. While transmission in New Zealand continues to be associated with sexual intercourse between men, and unlike Latin America, transmission is largely heterosexual in the Caribbean particularly in Haiti, Jamaica and the Dominican Republic. In Cuba, the Communist government's policy of quarantining and the universal free access to antiretroviral therapy have made infection rates almost non-existent. In terms of care and treatment, the Caribbean region places emphasis on strong and better governance that utilizes resources cost-effectively to strengthen health care systems. Monitoring and evaluation systems that use strategic information to enhance cooperation are encouraged. Leadership should be empowered by using the strategic planning tactics, information sharing, involvement and partnership building. The money from Global Fund and the World Bank is used to promote care, treatment and prevention strategies.

In North America, AIDS is among the three highest causes of death in the African American community in which 25-54 year old men and 35-44 year old women are mainly the victims. Of the U.S. women affected, 72 % are African Americans. The medium of transmission comprises injecting drug use, sex between men and heterosexuality that is characterized by undisclosed risk behaviors. However, in Canada unsafe sex between men, injecting drug use and unsafe heterosexuality are not uncommon. Between 1/4

and 1/3 of African Americans in America are poor people. Most HIV/AIDS victims are poor. Such kind of victimization of African-Americans is exacerbated by “their low incomes, high incarceration rates, particularly for men; injecting drug use, and unprotected sex in prison institutions” (<http://www.unaids.org> 2005).

In North Africa and the Middle East, the medium of transmission includes paid sex, sex between men and injecting drug use. Sudan has the highest HIV/AIDS infection rate that is predominantly transmitted via heterosexuality. In Eastern Europe and Central Asia, the number of HIV/AIDS cases has increased nine times in ten years. Ukraine and the Russian Federation are the leaders in this pandemic in which 80 % of the infections are found among people who are less than 30 years old. The strategies employed to confront the pandemic include “fostering partnership forums, supporting emerging organizations of people living with HIV, facilitating access to financial resources, generating and for harmonized monitoring-and-evaluation systems.” Though antiretroviral medication is rather expensive, the strategies of better treatment and perestroika-openness (Sagini, 2001) are in demand to eradicate taboos and denials that challenge prevention efforts.

The Southeast Asian region has a variety of AIDS only epidemics second to the pandemic experience of the Sub-Saharan African continent. In Latin America the HIV/AIDS pandemic is most prevalent in large cities, particularly in Brazil, Argentina, Mexico, Guatemala and Honduras. In this region 1/3 of the AIDS cases are in Brazil. Cities are centers of localized epidemics. Preventive measures include the “empowerment of leadership, strategic planning, information sharing, and partnership involvement of people living with HIV, and mobilizing of resources”

(<http://www.unaids.org/en/geographical+area/by+region/latin+america.asp> 2005).

### **History of HIV/AIDS Pandemic**

The way in which governments (states) react in terms of making policy decisions regarding HIV/AIDS depends on which political economic policy in planning for local, national, regional or international development is dominant. In addition, technology advancement, the cultural terrain of the society and how each country is affected by the structure and architecture of international political economy that is hierarchically stratified and universally hegemonic (Smith and White, 1992 and Wallerstein, 1980) become the building blocks for decision making about such policy-related issues.

Historically, the HIV/AIDS disease may have existed in the U.S. particularly in laboratories where it was used in experiments that were managed by eugenic and racist thinkers and scientists such as Bertrand Russell, Earl Traub and Joseph J. Kinyoun. Between 1878 and 1950, the HIV virus, which is a man-made “syndrome” rather than a natural disease (Duesberg, 1996), was used to perform experiments on goats, cats, monkeys, sheep, horses, birds and humans including gays and African Americans. During the last 30 years, the disease has explosively and progressively become a pandemic, particularly in societies that are relatively closed, technologically challenged, poverty ridden, and characterized by sensitively high birth rates and cultural traditions that disregard common sense and preventive scientific methods. Over the years the United States government has made it its policy to eliminate the “undesirable, the unsuspecting and nonessentials.” During the 1970s, U.S. and Russian governments may have secretly conspired to use the HIV virus as a form of biological germ-warfare to control world

population particularly in Africa and, subsequently, elsewhere ([aobie@mercury.oktax.state.ok.us](mailto:aobie@mercury.oktax.state.ok.us) and [http://content.sciencewise.com/res...47-11DA-A71F-004F4E05317F}\\_215.htm](http://content.sciencewise.com/res...47-11DA-A71F-004F4E05317F}_215.htm)). The long political history of covert and unethical medical experimentation on humans, particularly African Americans and Manhattan gays, is both interesting and questionable (p.2). The use of the “super germ or synthetic biological agents that is refractory to the immunological and therapeutic processes” (p.5) upon which the medical and scientific professions depend on to prevent infectious disease could be developed in the future and be militarily employed to reinforce potential military technological superiority. In light of this argument,

It is difficult if not impossible, to determine the truth about global biological warfare capabilities and their possible effects on world health. The American taxpayer is kept ignorant about U.S. chemical and bio-warfare programs. Scientists involved in bio-warfare research are sworn to secrecy and silence. Thus, “classified” and “top secret” medical experimentation continues to be promoted by powerful government agencies, such as the CIA, the CDC, the Department of Defense, the military, and other institutions. (Cantwell, [http://content.scincewise.com/res...47-11D4-A71F-004F4E05317F}\\_215.htm](http://content.scincewise.com/res...47-11D4-A71F-004F4E05317F}_215.htm))

Evidently, the long history of government policy on Los Alamos laboratory and other experiments and the progressively evolutionary and explosive consequences of those experiments in terms of their pandemic effects should bring to rest the shallow, uninformed and distorting debates concerning the green-monkey, the gay-plague and the African-origin theories that are largely elements of media propaganda that cover up “our evil and my epic genius.”

Dr. Wolf Szmunes, Polish Jew and Soviet-trained world expert in Hepatitis-B who is now a U.S. citizen, Dr. Robert Gallo, foremost expert on AIDS at the CDC, Dr. Donald M. MacArthur, spokesman for the U.S. Department of Defense, and a large number of experts in HIV/AIDS and AIDS-related disease experts agree that there is an “ominous link between cancer and AIDS, between animal experimentation and the genetic engineering of viruses, between biological warfare technology and drug companies, between genetic experiments and AIDS, and between vaccine programs and the contamination of the nation’s blood” (<http://content.sciencewise.com/res...s/Reporter/HIVorigin/wfdigest.htm>).

If scientists maintain a flow chart, which informs them about the results and effects of the experiments and if these experiments have accidentally backfired due to the fact that they have caused what is truly bio-warfare terrorism, which started with MK-NAOMI to Manhattan experiments and now the worldwide pandemic, don’t we have the freedom and rights to question the role of bad science? Shouldn’t political, scientific, medical, and legal leaders everywhere unite to use forensic science and sue individuals, firms, institutions and governments for this shocking news? Wasn’t President Mbeki of South Africa right when he raised this issue at the beginning of the 21<sup>st</sup> century?

The disease spreads through “unprotected sex needle sharing, donating blood or other tissues and infected mothers” at delivery (<http://healthmba.com/hiv-test.html>). All HIVS are parasitic and virulent retroviruses characterized by rapid and toxic or poisonous severity. They are malignant because they cause the disease AIDS. SIVS are benign. HIVS are retroviruses, while AIDS is the disease they cause in their hosts, humans or animals. Phylogenetically, in other



words, based on their origins, a variety of theories that explain their origin and development display dubious scientific validity because the theorists ignore laboratory experiments that have been carried out for over 100 years and put emphasis on the current symptoms, effects, similarities, and regency of the disease which has evolved as a result of the globalization project and its geostrategic and structural interests. The man-made theory, the out-of-Africa theory, the chimpanzee to man theory, the vaccines theory, the hepatitis theory, the polio theory and the germ warfare theory ([http://content.sciencew...er/HIV\\_origin/wfoc.htm](http://content.sciencew...er/HIV_origin/wfoc.htm)) have been used to advance new knowledge, introduce controversial distortions, and compare results, all of which are largely man made and prescribe culturally biased conclusions regarding the origin and development of HIV/AIDS.

Three scientists from the Universities of Michigan, Maryland and Massachusetts (Mindell, Shultz and Ewald) respectively wrote an article on the phylogenetic evolution of the HIV/AIDS pandemic ([http://content.sciencewise.com/res...97-11D4-A71F-004F4E05317F}\\_356.htm](http://content.sciencewise.com/res...97-11D4-A71F-004F4E05317F}_356.htm)). The thesis and conclusions of this phylogenetic tree are paraphrased and discussed. The AIDS pandemic is a new problem for humans, but it is not clear whether the human immunodeficiency virus (HIV) giving rise to AIDS is also new to humans. Either (1) HIV has recently infected humans, in which case we have a new virus and a new disease, or (2) HIV infected humans long ago (being mild and/or restricted in range until recently), in which case we have an old virus and a new disease. There are precedents for each scenario among known viruses causing diseases (Shope and Evans, 1993). The new virus and old virus scenarios have profoundly different implications for understanding the mechanisms of HIV propagation and the etiology of

AIDS, for combining AIDS, and, potentially, for efforts to prevent future epidemics. The terms “new” and “old” are ambiguous beyond denoting relative age so for purposes of this article we consider a new virus one that has infected its host species within the past 50 years or so.

The first view, that HIV has only recently contacted humans, entails recent cross-species transmission of a simian immunodeficiency virus (SIV) from one or more nonhuman primates, and represents the current conventional wisdom (Dietrich et al., 1989; Doolittle, 1989; Allan et al., 1991, Fox, 1992; Myers et al., 1992, 1993; Hirsch et al., 1993; Temin, 1993; Myers and Korber, 1994). However, some have suggested that certain rural African populations of humans may have been infected with an immunodeficiency virus for many decades, centuries, or even millennia (Montagnier, 1985; Hahn, 1990; McClure, 1990); Ewald (1991, 1994) and have described an evolutionary model in which virulent strains are placed at a selective advantage by higher rates of sexual partner change.

Understanding HIV origins is of general interest to systematists as well. Viruses evolve by descent with modification like any other group of organisms, and systematizers will become increasingly involved in attempts to understand their complex histories as more of their DNA sequences become available. Systematists working on viruses need to consider distinctive features of viral evolution, including extremely high rates of molecular sequence evolution, subsequent high levels of within-population sequence variability (variously described as yielding species swarms or quasispecies), evolutionary rates that vary depending on the species of host and type of cell infected, potential for recombination when representatives of different viral lineages infect the same host cell, and potential biases in the sampling of host species.

The objectives of these scientists were to (1) assess the evidence used in support of the “new virus” hypothesis, (2) present their own phylogenetic analyses of representative viral taxa, (3) estimate the most-parsimonious evolution of the character “virus host” in the study taxa, and (4) comment on methodological issues in the systematics of viruses. Although it is not possible to reject either hypothesis, they concluded that any consensus favoring the “new virus” hypothesis was not justified on the basis of current evidence and that the “old virus” hypothesis remained a viable but scientifically dubious alternative.

Evidence currently available does not support the popular view (the “new virus” hypothesis) that HIVs have recently colonized humans and that PIVs in humans are recent descendants from one or another of the PIV lineages known from nonhumans. “Phylogenetic trees show only sister relationships for extant taxa, not ancestor-descendant relationships for extant taxa.” Use of the phylogenetic hypothesis and a parsimony criterion to estimate the smallest number of host species shifts (that is, to diagnose changes in the character “viral host”) indicates humans to be the ancestral host species for a clade including SIV cpz from chimpanzee and for a clade including SIV sms from sooty mangabeys. The three scientists specifically do not claim that the latter analysis resolves the issue of ancestral host, however, in light of potential sampling biases. Their point is to show that current evidence does not support the “new virus” hypothesis. Support for the “new virus” hypothesis then devolves to unjustified assumptions that pre-1959 human blood samples testing negative for PIV presence successfully represent all human populations and demes potentially harboring PIVs, and that new viruses are virulent and old viruses are mild. Small human populations with dormant PIVs may readily have been

missed by limited sampling, and the assumption that new viruses are virulent and old viruses are mild ignores the ability of natural selection to affect an increase, a decrease or stasis in virulence over time. Even if the latter assumption were valid, inferred newness of PIV infection of humans is contradicted by discovery of non-cytopathic HIV2uc1 and relatively low virulence (longer latency and asymptomatic periods) of PIV2s in rural human populations having relatively low rates of sexual contact among individuals.

Retroviral evolution challenges systematists with a variety of distinctive and potentially confounding “features, including (1) extremely fast rates of molecular sequence evolution (due to short generation times, large numbers of progeny, and low fidelity replication), (2) evolutionary rate heterogeneity within and among virus sequences (due to potential host specific and cell-type specific rate differences and variable use of three different replication enzymes having variable error rates), and (3) potential for genetic recombination among different lineages infecting the same cell, complicating character homology determinations. Improved understanding of these features and greater sampling of primate host species will enhance future studies of immunodeficiency virus phylogeny and may entail revision of current hypotheses of relationship” (p. 12).

During the 1980s and 1990s, the major challenge for the HIV/AIDS establishment was to search for the cause(s) of AIDS disease. With the influence of governments, major organizations in the U.S., Europe and Japan, created bureaucratic structures and complex physical and scientific infrastructure for funding, R and D, treatment and prevention policies and procedures. Their political, scientific and economic strategies were largely guided by extrinsic rather than intrinsic motives. In the U.S., the race to study the cause(s)

of AIDS became the focus of the National Institute of Health (NIH), the Center for Disease Control (CDC), the Food and Drug Administration (FDA), the National Institute on Drug Abuse (NIDA), all other divisions of the federal Department of Health and Human Services, and of all researchers and scientists who secured federal grants and contracts. Because these strategies and efforts were and are guided by market-driven extrinsic factors protected and controlled by the policy elite and the drug industrial establishment, scientific and creative voices of dissent are tolerantly intolerable in terms of their contributions to the search for the cure. This could be the reason why more than “100,000 AIDS experts, particularly eminent medical doctors, virologists, immunologists, cancer researchers, pharmacologists...Nobel Laureates” (Duesberg, 1996, 9) have been unable to find the cause and cure for AIDS. Although HIV virus appears to cause AIDS, the same scientific establishment which made that discovery has not succeeded in preventing deaths caused by AIDS. Given the scenario, and as the “research establishment becomes more centralized, bureaucratized, and fraught with commercial conflicts of interest, each episode achieves more monstrous proportions” (p. 10). Moreover, the same scientific community which is researching for the cause and cure of AIDS may be directed to the causes via “inappropriate experimental designs and very short follow-up times” (p. 334).

Scientific critics and dissenters of the AIDS establishment (bureaucrats, pro-AIDS scientific community, scientific AZT, DDC and DDI popularizers, organizations, drug manufacturers and distributors and journalists can mobilize their forces to censor dissidents’ work in professional literature and silence or alienate the critics regardless of the validity of their discoveries and contributions. Since “a scientist’s career depends heavily on

peer-reviewed grant money, peer-reviewed opportunities to publish in scientific journals, and invitations to conferences” (p. 396) such vulnerabilities can “ostracize,” alienate, and silence creative genius and dissent due largely to the group think of the AIDS and drug establishment.

During the 1960s, many people heard about the availability of psychedelic drugs, which nonconformists, rock stars, war protestors, sex gurus, and intellectuals preyed on. With the extrinsic motivation and commercialization-driven policies, those who use cocaine, nitrite inhalants, amphetamines, heroine, LSD, marijuana, PCP and a variety of psychoactive drugs have collectively generated new disease epidemics unparalleled in human history. Since AIDS is incurable but “host-tamable,” it may be “caused by long-term consumption of the above mentioned recreational drugs and by AZT and its analogs. Hemophilia-AIDS, transfusion-AIDS, and the extremely rare AIDS cases of the general population reflect the normal incidence of AIDS – defining diseases in these groups plus AZT induced incidence of these diseases under a new name” (p. 411). If each of these recreational drugs is toxic, then AIDS may have many causes. Since scientists, for obvious reasons, have not and, under the current climate will not, examine a multicausal hypothesis, the cure for AIDS is made more illusive, obscure and distant. The AIDS establishment should disestablish its command science and explain why an agent is a plausible cause of one or all of the thirty fatal AIDS diseases that are AIDS-related.

Why is there no AIDS cure? There are three main reasons; first, the scientific AIDS establishment’s enthusiastic acceptance that the “virus-AIDS hypothesis is not based on its scientific rigor or its fruits” (p. 595). Instead, it is based on the universal administration and respect for

germ theory, which globally and psychologically enhances the geopolitical and imperial power of the state and its military industrial complex. Second, though funding for the AIDS establishment is humongous, there is limited scientific expertise on the subject in question. Third, worldwide ignorance of the poor masses who are vulnerable, or those who get sick and die or struggle for survival results in a lack of scientific information concerning the cause(s) of AIDS and how, when, where and why it is transmitted, how it can be prevented and why people are vulnerable.

Both in the U.S. and elsewhere in the developed world, “new medical treatments have turned AIDS from a death sentence into a chronic illness for most people infected with HIV virus. While no cure for AIDS yet exists, most HIV positive people can live productive lives, raising families and contributing to society” (Magaziner, 2004: 28) even though “the future...is not nearly so hopeful for the tens of millions of men, women, and children living with the disease in the developing world”. AIDS “includes 25 previously known diseases and two clinically and epidemiologically very different AIDS epidemics, one in America and Europe, the other in Africa” (Duesberg, 1996, 510) and elsewhere. The American European epidemic is characterized by the “male homosexual epidemic, the intravenous drug user epidemic, the hemophilia epidemic, and the transfusion recipient epidemic” (p. 510). The American and European AIDS can be sub-epidemicly described as the homosexual Kaposi sarcoma (Selik et al., 1987) drug-user induced tuberculosis; cocaine related pneumonia and tuberculosis; hemophiliacs who suffer from opportunistic fungal and viral pneumonia and Kaposi sarcoma (Evatt, 1984 and Koerper, 1989); transfusion cases with pneumonia; hemophiliac wives with pneumonia; babies with de-

mentia (Center for Disease Control, 1992b); and users of cytotoxic DNA chain terminator AZT who develop anemia, lewipenia and nausea. According to Greenfield, OU professor (2005), representatives from all American racial and ethnic groups have AIDS. These patients are middle class, urban, rural, elderly people and minority populations.

During the 1980s, and compared with American and European AIDS cases, only 0.3% of Americans out of 6 million world HIV positive cases were identified as carriers. In other words, although very few Africans were AIDS-infected twenty years ago, now Africa leads the world in HIV/AIDS pandemic. Table 1 illustrates that phenomenon. African HIV/AIDS includes common diseases such as tuberculosis, diarrhea, chronic fever, weight loss, pneumonia and other neurological diseases (Hishida et al., 1992). It is difficult but not impossible to provide a classic definition of African HIV/AIDS (Gilks, 1991) particularly when serious cases of malnutrition, Ebola, parasitic infections and poor sanitary conditions are prevalent causes of death. Sixty percent of the HIV/AIDS infected persons in sub-Saharan Africa are women. Polygamy, sexual coercion and violence against women contribute to their distress. Girls are sexually exploited by old people who pressure them for sexual promiscuity in exchange for food, clothing and school tuition (Marton, 2004).

Volberding invented Zidovidine (AZT) an antiviral drug. “AZT blocks DNA production, not only in human T-cells or retroviruses, but also in any bacteria that might exist in the body...it can act as an indiscriminate antibiotic, killing opportunistic infections while destroying the immune system. Even Burroughs Welcome...billed the drug as an antibacterial” (Duesberg, 1996, 321). The drug destroys the pancreas, bodily nerves, T-cells and bone marrow largely because of

its extreme toxicity. It seriously contributes to collateral damage.

Jerome Horwitz developed Dideoxycytidine (ddc) in the 1960s. It is marketed by Hoffman-La Roche and is used in combination with AZT. It also terminates the production of DNA as AZT does. The effects of Nevirapine, (which prevents mother-to child transmission and is used in poor countries), is not clearly known yet. Didanosine (ddi) is manufactured by Thailand after the Thai government prevented Bristol-Myers Squibb a U.S.-based pharmaceutical company, from Thailand has expanded its treatment program by producing a single pill that contains the medicines stavudine, lamivudine and nevirapine – a combination recommended by the WHO. These drugs appear to be effective. Third World countries should buy anti AIDS drugs from Thailand.

Robert Gallo, M.D., Director of the Institute of Human Virology and professor of microbiology and immunology at the University of Maryland, gave a presentation on *HIV/AIDS Research: The Light and the Dark* at the Oklahoma Medical Research Foundation in Oklahoma City on March 8, 2006. During the 1980s and 1990s, his research helped physicians develop HIV therapies that prolong people's lives. In 1996, Dr. Gallo discovered "chemokine" a natural compound that blocks the HIV virus to stop the progress of AIDS. As an internationally known scientist and a decorated member of the National Academy of Sciences and the Institute of Medicine, he believes that HIV has become a chronically treatable illness rather than a death sentence. However, Dr. Gallo knows that "we must continue to make significant advances in developing new therapies because of drug resistance to some of the present therapies and drug toxicity" (*The Oklahoman*, February 24, 2006: 3). He also asserts in *Lancet* (2005, 366:1894 – 98) that although

most of the scientific community is pessimistic about the cure of AIDS, he is optimistic because the "rational pathways toward development of an effective vaccine" are available. Dr. Gallo concluded that the three major therapeutic advances that have been increasingly helpful in treatment and care for the HIV/AIDS victims have been the 1984 blood test, the 1986 anti-viral treatment which came with the AZT and the 1995 Highly Active Antiretroviral Therapy (HAART), which has made people live longer and have healthier lives.

On February 6, 2006, the 13<sup>th</sup> Conference on Retroviruses and Opportunistic Infections was held in Denver to discuss the prospects of new experimental drugs. First, Manufacturer Panacos reported that PA-457 prevents the virus from sending infectious materials into the blood stream. This drug is a maturation inhibitor. Second, Pfiser Global Research scientists have identified and designed UK-201844 to prevent the virus from fusing with other cells at the beginning of the infection process. As a result, Trimeris scientists have received positive results concerning the cell entry or fusion inhibition. Also, new drugs such as TRI-1144 and TRI-999 seem to "be 100 to 150 times more potent than Trimeris first generation fusion inhibitor, Fuzeon, in fighting HIV infection." The dosage lasts for one week.

### **The Political Economy of HIV/AIDS**

We live in a world of 6.4 billion people, which grew last year by nearly 76 million. Nearly three billion (2 in 5) people struggle to survive on less than \$2 a day. More than 1 billion people lack safe drinking water, and 2.4 billion are without basic sanitation. More than 800 million people are chronically undernourished, 2 billion lack food security, and the fertility rate (child bearing age) group is 78 million annually. Half of the world's original

forest cover has been cleared, and another 30 percent is degraded. By 2030, 60 percent of the world's population will be urban. Currently 15-24 year olds competing for jobs are 1 billion and 137 million women want to delay their next birth or avoid another, yet more than 350 million couples lack access to a full range of family planning services. Three billion young people will enter their reproductive years within this generation. Today, about 65 million people have HIV/AIDS and most of these are in Africa (see table 1). AIDS, like malaria and tuberculosis, kills 6 million people yearly in the Third World (*The Population Institute*, 2004).

In the context of the structure of global political economy Bratton, Mattes, and Boadi (2005) have written *Public Opinion, Democracy and Market Reform*. The authors concluded that support for democracy in Africa is wide but shallow. Africans find themselves trapped between the state and the market. Beyond multi-party elections, people want clean and accountable government. They like economic structural adjustment only if it is accompanied by an effective state, the availability and provision of jobs and an equitable society. These attitudes originate and are constrained and informed by social structure and cultural values that are a product of rational experience and contextual and collective cultural wisdom. How do these demographics and people's expectations about governance inform international organizations such as the World Bank?

Structural adjustment in Africa is national economic reform programs undertaken by countries in return for assistance from the World Bank and other international donor institutions. Numerous countries in Africa began to experience difficulty meeting their financial obligations during the 1970s. By the early 1980s most African countries were receiving loans from international financial institu-

tions that were subject to conditions on borrowers' national economic policies. The conditions that accompanied these loans were known collectively as structural adjustment policies (SAPs). The lending agencies responsible for devising SAPs included the World Bank, the International Monetary Fund (IMF) and bilateral agencies such as the United States Agency for International Development and European aid agencies.

The history of SAPs is more controversial in Africa, possibly than anywhere else. The results have been disappointing. Critics portray SAPs as a failure, foisted on Africa by heartless and exploitative outsiders. Other critics have complained that theorists unfamiliar with African problems designed policies that are poorly suited to African conditions. Defenders claim that incomplete and incoherent implementation of SAPs often accounted for their disappointing results. They emphasize the benefits of these policies, not the failings. If anything, the benefits are enjoyed by international organizations and NGOs rather than by the Third World peoples who have less competence to rationalize the incompleteness and incoherence of the SAPs.

The increase in oil prices of the mid-1970s caused problems for African oil importers in their balance of payments (in a given country, total money received in export earnings and financial assistance, less total money spent on imports and external debt). When oil prices increased, many countries found that the money they received in export earnings and aid funding was insufficient to cover the cost of oil imports. Many countries met their increased need for foreign exchange by borrowing funds rather than by curtailing other imports or increasing exports. As a result they were unable to adjust to the new scarcity of foreign exchange.

Meanwhile, they increased their foreign debts and worsened their long-term

balance of payments problems. In the future, they would have to pay not only for oil imports but also for the interest on debt. Although Blair initiated G8 Prime Minister Conference, resulted in debt relief initiatives and funding programs, the historically practiced repatriation of capital strategies are likely to be imposed on these debt relief overtures in order to perpetuate the status-quo – the irony of African economic problematic. A number of commodity booms in the mid-1970s temporarily generated increased foreign exchange earnings for some African countries. Prices of coffee, cocoa, tea, and phosphates were all high, and the boom encouraged more borrowing and less saving. Banks were willing to loan to African countries because of the countries' high export earnings at the time and because the banks needed to find ways to invest the petrodollars on deposit from the oil exporters. However, the recession in the early 1980s caused commodity prices to collapse as global demand dropped. High interest rates imposed by the Federal Reserve Bank to fight inflation in the United States caused real interest rates to rise to highs that were unforeseen when African countries negotiated their external loans. By the early 1980s many African countries facing potential bankruptcy turned to the World Bank, IMF, and bilateral agencies for assistance. In addition, geopolitical and technological conditions that contributed to the collapse and dissolution of the U.S.S.R. encouraged Western nations to invest in Eastern Europe, Asia and Latin America to the detriment of the African region which became less "bankable."

Assistance included additional lending, some grants, and some debt forgiveness. Lenders required acceptance of conditions intended to promote short-term stabilization, generally combining devaluation of the local currency with government financial austerity. They also

required policy changes aimed to increase growth over medium to long term periods. Currency devaluation was expected to improve the balance of payments because it would make imports more expensive and hence reduce demand for them, while it would make and hence increase the supply of foreign exchange. Financial austerity measures required governments to reduce expenditures or increase taxes or both. This was supposed to reduce monetary growth and, hence, inflation. Inflation contributed to currency overvaluation by making domestic prices rise faster than international prices. Inflation increased demand for imports and reduced supply of exports. Reducing inflation was essential to regaining balance of payments equilibrium. Since devaluation itself spurred inflation by increasing the prices of imported goods, it needed to be combined with austerity measures to keep overvaluation from recurring. Such an economic climate could not and does not enable these countries to buy expensive drugs which the pharmaceutical industry and the drug establishment controls.

### **Politico-Economic and Cultural Interpretation**

AIDS poses a threat to the survival of millions, especially in the Third World where health and social infrastructures weakened by prolonged economic crises cannot bear the heavy burden of this new disease. Ninety percent of the more than 40 million people who had contracted HIV/AIDS by 1998 lived in less developed countries; more than two-thirds of the total, some 35 million, were Africans. Nearly half of those infected were female.

Sexual transmission of HIV/AIDS between heterosexual partners predominates in Africa. Adolescent girls are especially biologically and socially vulnerable to sexual infection by older men, and up to six times more girls are infected than boys

of the same age. As in poverty-stricken United States, both urban and rural areas, AIDS is the leading cause of death in youth and young adults in Africa. Because of a lack of funding in Africa, effective screening of the blood supply, transfusions for victims of acute malaria, hemorrhage in childbirth, or traffic accidents carry a significant risk of HIV infection. Since over half of infected Africans are females of childbearing age, many children – about 10 percent of the total number of those infected – acquire HIV in the womb, at birth, or during breast feeding. Countries with intravenous drug use can expect that shared syringes will become an additional source of HIV infection.

The period between infection with HIV and the onset of disease of symptoms is lengthy and varies among individuals, apparently depending on their genetic makeup and the makeup of the virus. The viral strain predominant in high-prevalence areas of eastern and southern Africa, HIV-1 type E, is readily transmissible in heterosexual intercourse and accounts for an estimated 80 to 90 percent of infections. In addition, an untreated sexually transmitted disease (STD) such as syphilis or gonorrhea increases the likelihood of sexual transmission of HIV. Most Africans do not have access to effective antibiotic treatment for STDs. Together, these facts help to explain high rates of HIV transmission. The so-called opportunistic infections that characterize AIDS include tuberculosis, pneumonia, and severe diarrhea, forms of cancer, blindness, and brain disorders. Effective treatment is costly and inaccessible to the poor majority in Africa.

Since people who carry the virus appear to be, and feel healthy for some years, and since HIV testing is not widely available in Africa, most people who are infected do not know it. Therefore, most do not protect sexual partners from infection. A major challenge for prevention is

to encourage people to accept the possibility that they may have been infected and, in that case, use condoms regularly except when conception is desired to decrease the risk of transmission. Another major challenge is to persuade or empower youth to delay sexual activity, use condoms, and avoid sexual promiscuity.

The prolonged disease process is extremely painful in its later stages, and the sick require extensive care. Much of the burden of care falls upon women, who may be sick themselves and without resources. Ninety percent of deaths occur among adults aged 20 to 49 years, the prime working years, more than half of those infected are 15 to 24 years old. HIV and AIDS exacerbate tuberculosis, a leading cause of death for young African women. More African children now die from AIDS than from malaria or measles, formerly the major killers.

In the United States, before new disease-delaying drugs became available in 1985, about half of those infected with HIV developed AIDS symptoms within ten years. Expensive new drug combinations can suppress viral replication and delay disease onset, but the rapidly mutating virus develops drug resistance. To date, no person with HIV has recovered a healthy immune system.

Most may be expected to progress to AIDS eventually. In Africa, where sophisticated drugs and medical monitoring are not widely available, death generally occurs within two years following the onset of AIDS. Neither a cure nor effective vaccines are likely to emerge in the near future, and if they do become available, most people's access will be blocked by inability to pay, especially in poor regions such as Africa. Despite price reductions offered by pharmaceutical companies seeking African subjects for vaccine and drug testing, the poor or middle classes will not generally be able to afford these drugs.



Because public health authorities largely perceived AIDS as an urban phenomenon, they believed that the majority of Africans lived in “traditional” rural areas and hence would be spared. Many social scientists, however, saw the coming catastrophe: first, few people anywhere have only a single lifetime sex partner, and rural areas are neither isolated nor unchanging. Second, even if condoms can be made available very cheap and on a regular basis, a variety of stigmatized political, social, and cultural obstacles discourage their use. Third, harsh economic conditions have divided families, increased disparities in wealth and power and changed behavioral standards in both rural and urban areas. These economic hardships have fueled the epidemic by increasing the number of vulnerable youths and young adults.

Since the mid-1970s, increasing millions of Africans have lived in abject poverty, their survival precarious, deprived of hope for the future. The deepening economic crisis and structural adjustment programs of the 1980s fell hardest on the poor. Peasant incomes and wages declined sharply and governments were forced to greatly reduce funding for public services, including education and health care. Dwindling government jobs and deindustrialization raised unemployment levels. Wars and military occupation brought civilian deaths, rapes and mass population displacements. These conditions set the stage for sex with multiple partners and led to ever more widespread dissemination of HIV.

Poor people’s survival strategies include migration in search of paid work, carrying goods long distances to urban markets, smuggling and trading sex for food and shelter. Mines, plantations, trading towns, fishing camps and ports attract job seekers in large numbers. Most are youths and men who come without their families; girls, divorced women, and wid-

ows also provide low-cost migrant labor and are vulnerable to sexual exploitation. Workers’ camps are visited by girls and women who arrive on paydays, often traveling long distances. Poor women have few income-earning opportunities that pay as well as sex. Often they must support dependents as well as provide for themselves. Poverty and pervasive gender inequality make it especially difficult for girls and women to avoid unsafe sex – even within marriage. Sexual violence – on the rise with deteriorating social conditions – further increases the risk of contracting HIV.

Some cultures stigmatize diseases associated with AIDS such as tuberculosis, dementia, sexually transmitted diseases (STDs), and skin rashes. Because it is sexually transmitted and incurable, some may blame AIDS on moral transgressions and unseen forces; a woman is often blamed for a man’s infection.

AIDS often provokes fear and hostility toward the afflicted. Husbands may abandon wives. Families unable to hide the nature of the illness may find themselves isolated. AIDS orphans may be shunned and left to roam the streets, where they are particularly vulnerable to HIV infection. With many people falling sick and others overworked and demoralized by so much death around them, the impact on all economic activities in the affected areas is severe. AIDS particularly disrupts seasonally labor-intensive agriculture, food processing and family life. Blaming others allows people to deny risk and avoid taking realistic steps to protect themselves and others. Where people believe that AIDS is caused by women or by unseen forces, scapegoating, witch hunts, and social unrest compound socioeconomic disruption and the misery of the poor.

Effective prevention involves enabling large numbers of people to change sexual practices that are widely consid-

ered to be natural and essential to health. Children are highly valued, and they may allow a woman to hold a steady partner and gain community respect. Condoms are not popular among men, many of whom employ a double standard to rationalize their relations with numerous, often younger, sex partners, while they strictly control their wives' sexuality. Condoms have been widely stigmatized by being associated with prostitutes and STDs.

In many countries, powerful interest groups have treated AIDS, like other STDs, as a moral issue rather than a health issue. This makes it difficult for some governments to conduct rational prevention campaigns. Many adults believe that sex education and condoms will increase sexual activity (seen as immorality) among youth, although research carried out in numerous settings shows that access to condoms will lead wives to become unfaithful. Most wives who become infected, however, are infected by their husbands. In Uganda, Tanzania, and Senegal strong resistance to effective prevention by religious leaders and community elders continued into the early 1990s.

In sum, an epidemic such as AIDS is an essentially social process, shaped by political economy and culture. Today, several economic processes fuel the spread of the epidemic. These include a global economy that relegates Africa to production of a few agricultural and mineral exports and distorted domestic economies inherited from colonialism. These circumstances result in unfavorable terms of trade, massive foreign debt, landlessness, unemployment and widening disparities in wealth that are exacerbated by repressive politicians who siphon wealth from public funds. All of these processes, combined with the continued subordination of women, lead Africans to act out of desperation in ways that promote the spread of AIDS, while persistent

poverty leaves most Africans without access to effective treatment.

A major new center of HIV infection lies in South and Southeast Asia, home to well over 2.5 billion people. Despite its rapid industrial development, economic crises in Southeast and East Asia can be expected to increase the spread of the AIDS pandemic, which is already rampant in the sex "industry," and among the military among intravenous drug users. Within the United States, new infections are disproportionately concentrated among poor, especially the people of color, women, youth, and the elderly regardless of age, class, race and status, both in the rural and urban sectors, and homosexual environments.

### **Conclusion and Discussion**

The monolithic HIV/AIDS hypothesis limits the opportunity for more rigorous, scrupulous and penetrating scientific inquiry into the cause(s) of the AIDS disease. HIV causes the AIDS disease. AIDS is not caused by the AIDS virus. Of the new diseases which have been discovered such as hantavirus, Ebola virus, legionnaires disease, Lyme disease, chronic fatigue syndrome and toxic shock syndrome, HIV/AIDS has by comparison attained pandemic notoriety due largely to its resistance against the politico-economically orchestrated production of pharmaceutical and medical drugs. In other words, scientific utility is intimately related to economics, politics and policy making. In its arena, policy makers call on scientific experts to measure health problems as a basis for political negotiation that is in line with response strategies. Scientists acknowledge that their wisdom needs to be depended on in determining the nature and quality of policy. However, evidence shows that, if anything, the influence of science on politics and policy-making is quite "varied and sporadic." In

other words, instead of being the guardian and “eye” of politics, science is subordinated to political whims as it becomes the handmaid of politics. For instance, because science funding is limited and always insufficient, policy makers and their appointees choose between research proposals, indirectly selecting what knowledge is to be pursued and how. Most “science...is instituted and thus, designed, to answer questions of interest to policy makers that may not be of interest to pure science. Sometimes the political environment may demand conclusions from scientists ahead of sufficient science understanding of the relevant process” (Harrison and Brynes, 2004: 327). Such a situation creates a climate in which neither the scientists nor the policy elite have the grip on what they are really supposed to do by using pure science objectively in order to solve societal and civilizational problems of which the HIV/AIDS pandemic is a classic example.

Due largely to economics and politics in the developed world, HIV, which was invented in U.S. laboratories for eliminating the Manhattan gays and other unwanted, unsuspecting and nonessential victims, it accidentally backfired to spread into the heterosexual population which has been terrorized by it, particularly in the poorer communities of our global economy. The African, Eurasian, and Asian continents have become targets for the ill-intentioned pandemic. Although uninformed media experts and journalists have used many theories to explain the origin of the disease, the HIV/AIDS establishment related individuals are handmaidens of the policy makers who have apparently controlled the HIV/AIDS establishment for political and economic rather than of scientific and health gains for the human race.

The focus of local, national, and global strategic approaches to the monitoring, treatment and evaluation of

HIV/AIDS should encourage participation by all stakeholders. The approaches should be conducted comprehensively and realistically. The plans should be given adequate resources. The resources should be coordinated, implemented, monitored and evaluated by adequately trained scientific manpower, which relies on sustainable technical help. Monitoring and evaluating programs should strike a balance between the generation of valued and reliable tactical information for program managers. Managers should ensure that the use of public data banks does not create avenues for discrimination and stigmatization of people who are positive in human immunodeficiency virus.

Managers (coordinators) and strategic planners should ensure that national HIV/AIDS programs are monitored and evaluated to generate information, not only for use by donor agencies, but also for improving their implementation and treatment programs. Although the 2001 Declaration of Commitment on HIV/AIDS by 189 countries served as a benchmark for universal action, definite and specific deadlines should be used to put pressure on the countries to quicken diagnostic implementation and treatment programs. However, progress reports show a low response rate for certain indicators including concern for data quality. To minimize the prospects for the concern over data quality, local, national, and global implementation and treatment agencies should identify incentives and opportunities for collaboration rather than isolation and the provision of counseling, medical, and therapeutic services.

National strategic planners and program managers should secure data from different geographical areas within each country in order to plan for and monitor the adequacy of service delivery for the HIV/AIDS patients. They should ensure that patients have access to the services which exist. “An operational plan for

monitoring and evaluation with a detailed budget is an essential step moving from an indicator set to a functioning, monitoring and evaluation system” (Wilson, 2000, 101). Based on Uganda’s, Thailand’s, and Ghana’s experiences in monitoring and evaluation programs, data should be used to adjust national and local priorities, policies, and practices in order to improve the program. In particular, the Ghanaian model of treatment, monitoring and evaluation as illustrated by Wilson, is simple, strategically well coordinated and synergistically participatory.

Evidence based on a variety of sources has demonstrated that ineffective public health intervention can cost substantial amounts of money that could be used to advance more effective treatment, monitoring, curative and evaluation programs. All in all, it is necessary to proceed with the best available evidence in order to eliminate or minimize the suffering associated with the HIV/AIDS scourge. Ineffective national monitoring and evaluation systems geared toward generating data for the donor community can fail to gather basic information because the systems are exclusively unaccountable. In spite of the challenges associated with theoretical, methodological, economic, and political intricacies in the realm of the HIV AIDS pandemic, effective monitoring or implementation and evaluation systems could turn things around for the better.

The African continent, according to Nicolas Van de Walle, has experienced “the third decade of economic crisis and state decay.” Regardless of what global index is used to assess Africa’s viability, political repression, armed conflicts, perennial corruption, the brain drain, poverty, and lately the HIV/AIDS pandemic, have all contributed to the continent’s loss of its global competitiveness. It requires extraordinary ingenuity, in terms of the use of academic and policy relevant research

and a wisely coordinated multiplicity or sectoral engagements, to turn things around. Unlike in the developed societies where the poor, particularly women, ethnic minorities, illicit drug users, the homeless, and the mentally ill are frequently HIV/AIDS positive, their third world counterparts come from all classes, age groups and demographic groups. The disease kills them indiscriminately.

Based on the U.N. Conference on HIV/AIDS, in New York in 2001, seven out of ten people infected with HIV/AIDS are sub-Saharan Africans (Ayittey, 2001). Twenty-five million Africans are infected, and 90% of them don’t even know it. This year, the number of AIDS orphans will reach 15 million, a figure larger than the population of London. Africa has already lost 16 million people to AIDS –more than Africa has lost in all its wars. The World Bank estimates that \$5 billion a year is needed to combat the HIV/AIDS epidemic in Africa. The G8 suggests 10 billion in five years. The economic toll is no less hard to imagine. AIDS is decimating Africa’s labor force, killing the youngest, brightest and strongest at a disproportionate rate and further crippling its efforts at economic recovery and development.

In 2001, an impassioned appeal by U.N. Secretary General Kofi Annan called for the creation of a “global war chest” of \$7 billion to \$10 billion a year to battle AIDS. The Bush administration promised \$200 million, the British a matching sum, and the Canadians about one-third of that. One can never be sure how much of this was actually being raised and how much was merely the expression of good intentions. But, after bickering over the inclusion of words like “homosexuals” and “prostitutes,” the conference patched together an essentially rhetorical document calling on governments to reduce infection rates and protect those at risk.

Such gestures will not affect the spread of the disease in Africa. Nor will the constant clamor of AIDS activists who continue to target the pharmaceutical industry, accusing it of putting profits ahead of lives by refusing to lower the cost of drugs for poor African patients. Merck, Bristol-Myers, Squibb, Boehringer Ingelheim, GlaxoSmithKline, and Hoffmann-La Roche have offered to sell their AIDS drugs to poor nations at cost. Since "at cost" is still beyond the means of most Africans, activists are geared up to put more pressure on the industry for further price reductions, principally through a weakening of international intellectual property rights. This is the wrong approach for a disease which has no cure, or prevention.

Notwithstanding their noble intentions and concerns for AIDS suffers in Africa, activists have pushed this campaign into dangerous territory. The exclusive focus on drug prices has left a number of major players off the hook and consequently has the potential of exacerbating the epidemic. It's also ironic, since it is the pharmaceutical industry that is spending billions of dollars in R&D to find better treatments and one day, hopefully, a cure.

Let's take African leaders for an example. It is incomprehensible that they should continue to spend scarce resources on the procurement of arms to oppress their people and to prosecute senseless civil wars. Each year African governments spend more than \$8 billion on new weapons and the military. The South African government alone has just spent \$5.5 billion on new arms purchases. The 14 or so conflicts currently raging on the continent have created about 12 million refugees—more than half of the world's refugee population. The refugees, in turn, serve as easy targets for sexual predators and breeding grounds for the AIDS virus. West African peacekeeping soldiers fa-

thered some 25,000 children in Liberia. According to Teniola Olufemi, coordinator of the Ecomog Children Project, the Nigerian contingent accounted for 50% of the cases. In addition, the healthcare systems required to deliver and administer AIDS medicines have collapsed in many African countries as has the infrastructure of roads, electricity, water, communications and other basic requirements for an effective response to the epidemic. Besides, cultural taboos and outdated myths in polygamous societies are a major obstacle to detection and treatment.

Even African public health experts have themselves warned that unless public health systems are strengthened, the benefits of cheaper AIDS drugs could be undone by ineffective distribution or misuse, leading to the development of new strains of drug-resistant viruses. The South African government, for example, now admits that the health system must be upgraded before the drugs – even at lower prices – can be safely distributed in public hospitals. Finally, at a recent meeting on AIDS in Abuja, the Nigerian capital, an expert warned that there was great opportunity for corruption in selling and distribution of AIDS drugs. Other Nigerian experts say that studies have found that pills sold over the counter to the poor are often counterfeit or substandard. This kind of exploitation of the poor by the wealthy discourages many for whom the sophisticated industry and AIDS establishment do not speak. No wonder the cure remains dubious at best and hopeless at most. Germ warfare is a silent form of terrorism which wealthy nations have unintentionally imposed on the poor. It is a new form of class warfare whose purposive roots are sociologically and scientifically deterministic.

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## **Impediments in the War Against HIV/AIDS among the Rural and Urban Poor in Kenya**

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### **Abstract**

Kenya has declared war on the HIV/AIDS pandemic. But a victory in any war is often achieved when those managing the war possess unity of purpose, a common set of deeply cherished values and, above all, a *conscience* large enough to make them feel uncomfortable at the thought of deviating from those values. Kenya lacks such a *conscience*. This has undermined efforts to win the now much publicized war on HIV/AIDS pandemic just as it has done in many other countries in Africa today. This article, first, presents the situation of the HIV/AIDS pandemic in Kenya today, highlighting the measures the country has taken to wage war on the pandemic. Second, the paper attempts to show that the efforts to win the war are undermined by corrupt political leadership that lacks *a nation's conscience* to restrain leaders from committing economic crimes, resulting in reckless blunders and misappropriation of the very funds meant for the war on the HIV/AIDS pandemic. By analyzing the events that led to the loss of the nation's *conscience*, the paper then shows how this political leadership *without conscience* has now left the ordinary citizen in abject poverty despite the availability of immense wealth in the country. This in turn has not only created a fertile ground for the spread of HIV/AIDS but has also rendered the citizen unable to fight back the scourge. The paper then suggests that one way of winning the war on the pandemic is to direct more efforts toward the restoration of the nation's *conscience* by putting in place measures that would ensure the cultivation of a culture of transparency, accountability and good governance in Kenya.

### Introduction

Statistics available from the World Health Organization (WHO), together with those from the Ministry of Health (WHO, 2005; Republic of Kenya, Ministry of Health, 2005), paint a grim picture of Kenya as a low-income country, now almost devastated by the HIV/AIDS pandemic. Tables 1 and 2 below tell it all. The adult HIV prevalence rate was estimated at 9.6% in 2003. The country is experiencing a devastating impact on all sectors of the society. An estimated 820,000 to 1.7 million people are living with HIV/AIDS in Kenya. An estimated 1.5 million people have already died from AIDS since 1984 when the first case was reported in the country. More than 1.6 million children younger than 15 years

(3.7% of the total population of about 32.5 million) have been orphaned due to deaths from AIDS. Prevalence is still high but appears to be decreasing. The Ministry of Health reported an adult prevalence of 13.5% in 2001 and surveillance figures suggested that the prevalence had declined to 10.2% in 2002. It is now around 7% and continues to drop.

Major vulnerable and affected groups include AIDS orphans, pregnant women and rural populations living in areas with a high burden of disease. Girls and young women are particularly vulnerable to infections. Women aged 15-24 years are more than twice as likely to be infected as men of the same age. The prevalence of HIV is higher in urban than in rural areas and is about 15% higher among pregnant women.

### The Situation of HIV/AIDS Pandemic in Kenya Today

**TABLE 1. Demographic and Socioeconomic Data**

	Date	Estimate	Source
Total population (million)	2004	32.4	United Nations
Population Urban areas (%)	2003	38.8	United Nations
Life expectancy at birth (years)	2003	50	WHO
Gross domestic product per capital (US\$)	2002	388	IMF
Government budget spent on health care (%)	2002	10.2	WHO
Per capital expenditure on health (US\$)	2002	32	WHO
Human Development Index	2002	0.488	UNDP

Source: World Health Organization

**TABLE 2. HIV Indicators**

	Date	Estimate	Source
Adult prevalence of HIV-AIDS (15-49 Years)	2004	7.5%	Ministry of Health
Estimated number of people living with HIV-AIDS (0-49 Years)	Dec 2004	155,874	Ministry of Health
Reported number of people receiving antiretroviral therapy (15-49 Years)	June 2005	39,000	WHO/UNAIDS
Estimated total number needing anti-	June	233,831	Ministry of Health

retroviral therapy in 2004	2005		
HIV testing and counseling sites: number of sites	June 2005	600	Ministry of Health
HIV testing and counseling sites: number of people tested at all sites	June 2005	683,600	Ministry of Health
Prevalence of HIV among adults with tuberculosis	2004	60%	Ministry of Health

Source: World Health Organization

### HIV/AIDS Impact on Households

The AIDS epidemic is having a devastating effect on households: increased medical and health expenditure, funeral expenses, and decreased income (UN, *Impact of AIDS*, 2004). This has led to a loss of savings, assets and property in the affected households. Households contribute 51% of the total health financing (out-of-pocket is 45% of the total), and HIV/AIDS imposes significant additional costs (Republic of Kenya, Ministry of Health, *National Health Accounts*, 2004). This problem is magnified when the infected person is the breadwinner. Absenteeism from work due to poor health as the disease progresses affects household income. Consequently, affected households are poorer than they would be without HIV/AIDS. About 56% of the population in Kenya lives below the poverty line, subsisting on less than one dollar per person per day. HIV and AIDS and poverty deplete resources to invest in health and education of children, also depleting the country of human capital in both the present and the next generation.

HIV/AIDS has increased enormously the number of orphans in Kenya; estimation is about 1.6 million children in the year 2005. The situation of orphans in Kenya is pathetic. Some of these orphans are under the care of the older generation, who themselves are already weak and have low levels of income, if any. In other cases there are child-headed households because AIDS has wiped out all the adults

there! Such households cannot provide essential requirements, including education and health services. A report on the effect of HIV/AIDS on education in Kenya by the government of Kenya and UNICEF found that in all the districts surveyed respondents indicated that children in the affected households lacked basic needs (Government of Kenya and UNICEF, *Impact of HIV/AIDS on Education*, 2004). The recent rapid assessment by the Children's Department found these orphans and vulnerable children had priority needs that affected their growth, reduced access to basic education, and increased their risk of acquiring HIV infection due to lack of parental guidance and other socio-economic factors (Government of Kenya, Ministry of Home Affairs, *Rapid Assessment Analysis and Action Planning Process*; UNAIDS/UNICEF/USAID, *Children on the Brink*, 2004).

### Impact on industry and the business sector

The most critical factor in producing goods and services is labor, which generally takes the largest portion of the cost of production. The effect of HIV/AIDS has had a devastating effect on labor, upon which industry and business sector depend. According to the UN, the consequences of HIV/AIDS include increased absenteeism, decreased productivity, and reduced number of employees through death, with loss of accumulated skills and

declining morale (United Nations, *Impact of AIDS*, 2004). Businesses with health schemes incur increased medical costs. The declining productivity and increasing medical costs result in declining profits. A study funded by USAID under the AIDS Control and Prevention project found that the cost of HIV/AIDS per employee took a large portion of profits (United Nations, *Impact of AIDS*, 2004). A study on the effect of HIV/AIDS in labor productivity in Kenya provides evidence that HIV/AIDS indeed reduces the productivity of the labor force (United Nation, *ibid*).

### **Impact on Agriculture**

Although agriculture is the backbone of Kenya's economy, the impact of HIV and AIDS has lowered productivity in farming areas to dangerous levels due to illness, absenteeism, death and subsequent loss of farming skills. As a result, there is less land under cultivation, less labor-intensive crop production, less crop variety and less livestock production. Family members diverted their time from productive use to spend it in caring for the sick and attend funerals, which also contributes to loss of household income. This results in the decline in agricultural income, food production and increased food insecurity.

### **Impact on Education**

According to the Ministry of Education, the increased morbidity and mortality, absenteeism and attrition of teachers, the reduced number of school-aged children attending school, and poor performance in the classroom are some of the effects of HIV/AIDS on the education sector (Republic of Kenya, *Sessional Paper No. 1, 2005*). The number of orphans in schools has increased as parents die from HIV/AIDS. Without appropriate interven-

tions, these orphans will most likely drop out of school. Some children now stay at home to care for sick family members. Teachers are dying from HIV/AIDS. Others are too sick to work, thus denying the education sector of vital skilled human resources.

A report by the government of Kenya and UNICEF on impact of HIV/AIDS on education in Kenya also indicates that teachers' participation and performance in the learning process is adversely affected by chronic absenteeism due to HIV/AIDS infections (Government of Kenya and UNICEF, *Impact of HIV/AIDS on Education*, 2004). Yet, finding quick replacements for such teachers is not easy since it takes time to train them. The loss of trained and experienced teachers and interruption of teaching programs due to illness were noted as compromising the quality of education. The report also found that in both communities and households, resources available to support education were increasingly being diverted to meet HIV/AIDS-related needs. The HIV/AIDS pandemic has, therefore, undermined Kenya's achievements in literacy while increasing the dropout rates, the number of poorly educated children, and the number of working children, thereby delaying the implementation of the country's declared policy of "Education for All."

### **Impact on the Health Sector**

The effect of HIV/AIDS on the health sector has undermined Kenya's commitment to achieve the Millennium Development Goals. This is reflected in, among other things, the now increased demand for health services due to the HIV/AIDS infected persons. This has diverted more health resources to HIV/AIDS treatment, creating shortages to meet other health care needs. But the overall cost of AIDS care and treatment is out of reach for the

majority of families affected by HIV/AIDS, given widespread poverty and reduced household income. Fortunately, increased donor commitment for HIV/AIDS care and treatment has provided additional resources for drug procurement and other costs that have reduced the burden on both government and household resources. Current user fees for HIV care are a small fraction of their actual costs and are subsidized by the Ministry of Health and donor contributions, but they still represent a significant burden to individuals and families.

### **Impact on Economic Growth**

HIV/AIDS has slowed the economic growth because of its effect on labor and capital investment. The pandemic has slowed or reversed growth in labor supply since it affects mainly the most productive members of the population. It has also reduced the productivity of infected workers. The devastation to the economy becomes even worse when those dying of AIDS are skilled persons. Increased medical costs associated with HIV/AIDS reduce the level of domestic savings and investment that are crucial for capital formation. Furthermore, reduced income and increased poverty in the household decreases purchasing power of the household, leading to deficient demand for goods and services, thereby undermining economic growth.

As can be readily seen, the impact of HIV/AIDS is felt in all sectors of the economy, right from the household to the national level. HIV/AIDS depletes and weakens the labor forces, reduces productivity and household income, increases health and other costs to society, and diverts resources from national development. The control of this epidemic, therefore, is not only important for the health and well-being of Kenyans, but it is critical for the overall national development.

To combat this epidemic, the country needs to implement effective policies aimed at addressing the insidious effects of HIV/AIDS pandemic on all sectors of the economy.

### **Kenya Government Policy Response: War on HIV/AIDS Pandemic**

Faced with the kind of devastating impact described above, the Kenya government was forced to formulate and put in place appropriate policies to wage war on the HIV/AIDS pandemic. In 1999, Kenya declared HIV/AIDS a national disaster and public health emergency. In November of that year the government established the national AIDS Control Council to oversee all HIV/AIDS matters. The Council has developed the *Kenya National Health Sector HIV/AIDS Strategic Plan 2005-2010* (Republic of Kenya, Ministry of Health, 2005) whose overriding theme is social change to reduce HIV/AIDS and poverty. In March 2003, President Mwai Kibaki declared "Total War on AIDS" soon after assuming power. He mandated the National AIDS Control Council (NACC) to coordinate and manage the implementation of a multi-sectoral approach to the national HIV/AIDS program, to provide policy direction, and to mobilize resources.

In late 2004 the government instituted guidelines for HIV testing in clinical sites. Other supportive government policies include the *Sessional Paper No. 4 of 1997*, which provides a policy framework to guide all partners in Kenya's response to the challenges of HIV/AIDS (Republic of Kenya, 1997). Indications of other political commitment include a policy on condom use, *National Guidelines on Voluntary Counseling and Testing*, *Guidelines on National Home-based Care Programmes and Services*, *Guidelines on Blood Safety*, *Guidelines on Antiretroviral Therapy* and *Guidelines on Preventing*

*Mother-to-child Transmission.* (Republic of Kenya, Ministry of Health 2001). National treatment guidelines have already been developed, and a new policy on diagnostic testing and counseling has been recently finalized (Republic of Kenya, Ministry of Health, *AIDS in Kenya: Trends, Interventions and Impact*, 2005).

The National AIDS Control Council (NACC) and the National AIDS and STDs and Control Programme (NASCOP) handle the country's overall response to the HIV/AIDS pandemic. Significant progress has been made in preparing for institutionalizing care and treatment and has advanced plans to open 30 comprehensive care centers including all provincial hospitals, 15 high-volume district hospitals and support to six mission hospitals. The National Antiretroviral Therapy Task Force has developed a draft operational plan for treatment scale-up.

Kenya is also a beneficiary of the World Bank Multi-Country HIV/AIDS program for Africa with funding already approved of \$50 million (U.S.) over five years. WHO estimates that between \$ 277.3 million (U.S.) and \$336.5 million (U.S.) is required to scale up antiretroviral therapy to reach the WHO "3 by 5" (3 million people worldwide by 2005) treatment target of 110,000 people in 2005 in Kenya. Kenya submitted a successful round 2 proposal to the Global Fund to Fight AIDS, tuberculosis and malaria for total funding of \$129 million (U.S.) and two-year approved funding of \$36.7 million (U.S.). A portion of the funding from round 2 is proposed to be re-allocated to HIV/AIDS care and, specifically, to antiretroviral therapy. Funding disbursed so far totals \$26.5 million (U.S.).

Recognizing the global HIV/AIDS pandemic as one of the greatest health challenges of our time, President George W. Bush announced the Emergency Plan in 2003 – the largest international health initiative in history by one nation to ad-

dress a single disease (USAID, *Report of the Global Aids Epidemic*, 2004). Kenya is one of 15 focus countries of the Emergency Plan, which collectively represent at least 50 percent of HIV infections worldwide. Under the Emergency Plan, Kenya received nearly \$92.6 million in FY 2004 to support a comprehensive HIV/AIDS prevention, treatment and care program. In FY 2005, the U.S was expected to commit nearly \$145.5 million to support Kenya's fight against HIV/AIDS.

Admittedly, these are grand plans on the part of the government to respond decisively to the war on the HIV/AIDS pandemic. As can be seen, there are both local and international support for Kenya's declared policy to wage war on HIV/AIDS pandemic. If the policy as stated above could be fully implemented, the war on the pandemic could easily be won. But the situation on the ground paints a grim picture. Those charged with the responsibility of putting the policies into practice, the real lieutenants of the war, possess neither the *will* to fight nor the *conscience* to lead the nation on to the war. As will be shown, the success of this war is being undermined by a political leadership that has lost its *conscience*.

### What Is Conscience?

Although people such as economists, lawyers, soldiers, teachers and politicians are often acutely aware of the concept and the role that conscience plays in the practice of their professions, the concept seems to have attracted the attention of philosophers, psychologists and theologians far more than any other group of professionals.

For the purpose of this paper, only a summary of the views of these scholars, so neatly discussed in the *Encarta 98 Encyclopedia*, will be sufficient to get the meaning of conscience. According to this encyclopedia, the term *conscience* is gen-

erally taken to mean the *recognition and acceptance of a principle of conduct as binding*. Moral philosophers and theologians now regard conscience as the *inner sense of right and wrong in moral choices*. The term also refers to the satisfaction that follows right conduct and the dissatisfaction and remorse resulting from what is considered wrong conduct.

However, the concept has gone through some kind of metamorphosis with the passage of time. During the classical period, ethical theories often regarded conscience as a separate faculty of the mind that resides in the human soul. This notion first appeared in the works of the Greek philosopher Democritus, an older contemporary of Plato. Democritus is said to have used the Greek word *suneidesis* to refer to *consciousness* or awareness of wrongdoing. Then, the Roman philosopher Cicero translated *suneidesis* as *conscientia*, from which the now English *conscience* is derived. According to Cicero, *conscientia* is an inner voice that speaks with greater authority than any form of public approval. In his work *Tusculan Disputations*, Cicero used the metaphor of a bite (Latin *remorsus*, from which the English *remorse* is derived) to describe the feeling aroused by a troubled conscience.

Later, the apostle Saint Paul referred to *conscience* as the law written on the human heart (Romans 2:15). For Paul, scrupulous *conscience* brings not only illumination but also agony: it relentlessly exposes the inner battle that human beings must wage against their own impulses (Romans 7:15-20). Later on, the Fathers of the Church, led by Saint Augustine, maintained Paul's view that *conscience* is an inner witness to divine law, common to all human beings (Edwards, Paul, 1967: 200).

However, the Protestant reformers of the 16th century, led by the German theologian Martin Luther, felt that *conscience*

had been oppressed under the Roman Catholic system during the medieval period. He identified himself strongly with the sense of anguish described by Saint Paul and Saint Augustine over every action and impulse. While the medieval notion held that *conscience was a faculty a person possessed in his mind*, the Protestant reformers tended to view *conscience as a psychological organ, infallible and inviolate*. The French philosophers René Descartes and Michel de Montaigne also upheld these views (Hutchins, R. Maynard, 1952).

Whereas 18th-century philosophers Jean Jacques Rousseau and Immanuel Kant believed that *conscience* could provide a basis for deliberate, autonomous moral action, the 19th century philosophers widely disparaged *conscience*. In his work "*Annotations to Watson*," the English poet William Blake wrote, "*Conscience in those that have it is unequivocal*". The German poet Johann Wolfgang von Goethe portrayed his character Faust as laboring to purge himself of *conscience*. The Danish philosopher Søren Kierkegaard and Russian novelist Fyodor Dostoyevsky, seem to view *conscience* as being something obsessively inward which leads to deep despair.

But German philosopher Friedrich Nietzsche held that *conscience* merely imitates pre-existing values. He observes that from the earliest times in which groups established social customs or norms and enforced them through social sanctions, members of such groups who were tempted to violate these customs and norms could always feel the disapproval of their fellows and even "hear" in their own minds an *inner voice of protesting outcry*: "*No, no, please don't do that*" (Edwards, Paul, 1967:189).

This restraining influence of the mind upon the conduct of an individual became more explicit with the development of the science of psychology, although it had

long been expounded by the Greek philosopher Plato. During its initial stages, psychology held the view that the human mind is made of different faculties, each responsible for different capacities or abilities. These faculties were comprised of *reason*, which was thought of as the *rational* part of the mind; *emotion*, that was the passionate one; *volition*, which enables the individual to reach *decisions* and make *choices*, and the *moral* part, which operates through *feelings*. Scholars such as Shaftesbury and Francis Hutcheson, for example, held the view that the moral faculty would arouse feelings of repugnance in an individual if he attempted to do anything immoral which violated the customs and mores of his society and that the same faculty would arouse feelings of approval by the thought of acting virtuously (Edwards, 1967). Other scholars, however, have seen this moral-sense type of theory differently, although along the position that had been held by Plato. Samuel Clerk and Richard Price, for example, have thought that the moral faculty of the mind must be similar to reason or understanding since it enables the individual to distinguish between right and wrong. Joseph Butler has termed this faculty of the mind "*conscience*" (Edwards, Paul, 1967).

Of course, modern psychologists, particularly those belonging to the behaviorist school, do not see conscience as a mental faculty. Instead, they refer to it as "*learned modes of reaction to stimuli*" (Edwards, 1967: 190), a position that seems to have been alluded to by Friedrich Nietzsche, as has been mentioned above. According to this view, when a person has been trained or conditioned to respond to certain stimuli such as standard forms of conduct or ways of doing things which are widely and strongly approved, the person *tends to feel uncomfortable at the thought of deviating from those standard forms of conduct.*

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This paper adopts this modern psychological interpretation of conscience. The point of emphasis here is that *conscience* is *learned attribute*. It is "learned modes of reaction to stimuli." One has to "*learn*" in order to acquire these modes of reaction. Now, psychologists generally define *learning as a relatively permanent change in behavioral tendency resulting from reinforced practice* (Kimbler, 1961:114). To put it more simply, *learning is change in behavior due to practice* (Sills, 1968). The important point to note here is that the newly acquired mode of behavior can survive only if it is sustained by constant practice or reinforcement. So, *conscience* as a mode of behavior, once learned, is bound to die or disappear from a person's mind if it lacks sustenance from reinforced practice.

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#### Conscience in the "Good Old Days"

For those who still care to recall with nostalgia the "good old days" (now lost), memories are still fresh about the days when people in Kenya used to leave their homes unlocked and suffered no burglary. (This author used to leave his house door unlocked in the 1970s for the milkman to enter whenever he went out for a weekend, and the door would remain unlocked until he returned!). Memories are still fresh about the days when women could walk freely at any time of the day and night and fear no molestation, when children were safe under the care of an adult, *any adult*; days when a traveler could get a meal and a place to lodge from a total stranger; days when a deal was often sealed by the mere shake of the hands and a person's word was always the bond; days when there was dignity in honesty, hard work and thrift and when one was always respected for speaking the truth; days when elders, by their good counsel and decorum, inspired unqualified respect in those of the succeeding genera-



tion. The ordinary citizens now mourn this loss of their nation's conscience and long for its restoration.

During the pre-colonial era, indigenous education systems succeeded very well in the development and maintenance of conscience at the individual and community level. This is mainly because *education in those indigenous societies concentrated more in inculcating and perpetuating social values and the preservation of a stable system of social relations for communal advancement as opposed to imparting knowledge and skills oriented toward individual advancement.*

The inculcation of these social values and the maintenance of strong social cohesion was necessary for a number of reasons. *First*, the different ethnic groups lived in a predominantly subsistent economy, always relying on the vagaries of the weather that was completely beyond their control. *Secondly*, nature itself threatened the indigenous individual person with a variety of such devastating calamities as droughts, hailstones, lightning, floods, volcanoes, landslides and tremors. Nor were threats from nature the only ones. There were also threats caused by human conflict, such as war and raids, just to mention a few. All these made the life of an individual constantly balance on the edge of disaster and forced him to seek refuge in social cohesion and its reassuring communal responsibility for his safety and well-being, both materially and spiritually.

Therefore, for survival and security in threatening situations, for confidence in facing and tackling difficult problems in life, for guidance in situations of uncertainty, the individual turned to his kin-bound world of the family, the homestead, the lineage, the clan and the tribe. Insulated in this kind of social environment, the individual inevitably learned, acquired and cherished the kind of values that ensured communal responsibility for his

well-being. He acquired values that made him believe in communal life that was safer and more reassuring than a life of individual toil, adventure, initiative and accomplishment.

Now as long as the various ethnic communities remained relatively isolated and therefore undisturbed by outside influence, indigenous education continue to perpetuate a stable set of social values that ensure unthreatened social cohesion. Through the use of social sanctions, taboos and the threat of being ostracized, these communities were able to influence, regulate and direct the conduct of each of their individual members and ensured that certain vices such as corruption theft, murder, or human rights abuses were effectively kept in check. For reasons already indicated above, discipline, punishment or rewards were all dispensed within the guiding principle of collective responsibility. The well-being of an individual from the cradle to the grave, including his upbringing and his conduct, was the responsibility of every able bodied adult in the community or village rather than that of the nucleus family alone. Through this process, the individual's conduct was under constant surveillance, and the individual was always aware of it.

To reinforce and strengthen this process, elaborate myths and beliefs regulated almost every aspect of individual and community actions and were backed by supernatural sanctions. Myths regulated not only the individual's interaction with his social environment but also his interaction with the physical environment, such as the use and preservation of natural resources. Certain plants and animals, for example, were regarded as either sacred or extremely useful to the well-being of humanity and were therefore treated with reverence. Hunting, for example, was done never as a sport to satisfy man's craving for destructive indulgence but as a

necessity to provide food for the family. And even then, whenever such hunting became necessary, the myth associated with the manner of killing the animal was always elaborate. For example, a Hottentot or Pigmy hunter ensured that he apologized to the antelope before he would aim his arrow at it and shoot it dead, uttering words to the effect that it was not really his wish to kill the animal but that it was because his family needed food and the antelope's meat was that delicious food!

Traditions of indigenous ethnic societies succeeded in instilling these social values because every effort was made to ensure the maintenance of a strong bond of social cohesion where everyone lived a shared life. As Hord and Scot Lee (1995) have elaborately put it, the guiding principle always was "*I am because we are.*" More often than not, *individuals maintain a strong bond of social cohesion only if they share a common set of values they all cherish and which regulate their lives.* If a member attempts to deviate from these values, the inner voice of *conscience* often prickles and he/she *feels uncomfortable*. The amount of discomfort and remorse that individuals experience whenever they attempt to violate existing societal values may serve both as a proof and as a measure of the extent to which individuals have developed the voice of *conscience* in their minds. The greater the feelings of discomfort and remorse an individual experiences in violating the commonly held values, the stronger and more compelling the voice of *conscience* the individual may be said to have developed. Indigenous communities succeeded in developing this strong *conscience* among their members by their success in inculcating a strong common set of values and a code of conduct by which everyone lived.

### **Factors that Influenced Loss of Conscience in Kenya and Perhaps Elsewhere in Africa**

#### ***Colonial Influence***

The coming of the colonial era with its foreign system of education, religion, commerce and industry introduced new and completely opposite values from those of the indigenous societies. The values that had been responsible for maintenance of communal cohesion fell victim and were completely undermined by these new systems. These colonial consequences inevitably arose for a variety of reasons. In the first place, colonialism necessitated the movement and migration of people away from their cohesively interwoven ethnic communities and made them interact with those from other cultures, some of whose values and norms were at variance with those of one's community. An individual's conduct was no longer under the watchful eye of fellow members of his ethnic community and, therefore, he/she could not feel duty-bound to conform to those widely accepted ethnic standards of doing things since, as no one from "back home" was around to raise eyebrows if the individual's conduct deviated from the ethnic norm.

Perhaps the most devastating blow of the colonial institutions on the indigenous value systems was the freedom it granted to the individual as an independent entity, completely eclipsing the old systems where one's individuality and identity are "swallowed up" in the individuality and identity of the whole social group. The colonial system of education enabled the individual to acquire scientific knowledge and understanding not only of the world around him but also of the anatomy and physiology of his own body. This knowledge that became power dispelled old myths and beliefs that had created and perpetuated fear, forcing the individual to cling to his fellow men for assurance,

support and security. Until then, the insecurity caused by the fear of the unknown had created the need for continued social cohesion. The newly acquired knowledge and understanding wiped out this fear and with it went the need for continued strong social cohesion, freeing the individual from the yoke of group protection and affording him the opportunity and the confidence that he needed to stand on his own.

With this freedom came the accompanying and inevitable personal responsibility. An individual was now his own master, carrying on his shoulders all the responsibility for both his well being as well as his suffering. His welfare was no longer the concern of his community. He carried his own cross. Punishment for his vices and reward for his virtuous conduct were no longer perceived as a community affair where an individual always rejoiced and/or suffered as a member of the group. He now faced the world alone. And when The HIV/AIDS plague came and complicated that world further, the individual, particularly in the urban areas, had to face it alone! Given his/her economic status, this made the condition even more precarious.

***Lack of Political Will after Independence: "The Spirit is Willing but the Body is Weak"***

At independence, the citizens hoped that the newly established nation state would step in and fill the gap left by the disintegration of the indigenous cultures. The new government was expected then, as now, to provide the necessary assurance, security, transparency and accountability if the individual citizen was to succeed in facing the world alone and enjoy the newly acquired socio-political and economic freedom, particularly in the urban areas. The government never provided these prerequisites. By the early

1970s, contrary to expectations political leadership in independent Kenya had begun to show a downward trend in the concern for the well being of its ordinary citizens. How? By systematically *resisting genuine efforts to initiate and nurture a culture of transparency and accountability* in the provision of goods and services in all sectors of the economy when the leadership knew very well that these are the two vital qualities, the possession of which any government builds a firm foundation upon which a nation's conscience rests.

It all began with a section of the recommendations of the Ndegwa Commission Report of 1974 that advocated the establishment of the *Ombudsman*, the watchdog office that would have ensured that transparency and accountability were nurtured and practiced in the public service (*Government of Kenya: 1970-71*). The Commission was fully aware of the danger of public servants, particularly those in high places, abusing their powers to further their private interests, especially where these interests conflicted with public duty. So, the Commission's Report recommended putting in place very firm safeguards against such a danger in the form of a watchdog. The Report advised:

*To deal with the danger that fear and favour may operate behind the wall of official secrecy, and with the danger that powers may be abused, we have no hesitation in recommending as a matter of urgency the creation of Kenyan equivalent of the "Ombudsman or Parliamentary Commissioner, which has now been established in many countries of the world. ... The essential feature of this proposal is that there should be a highly qualified and authoritative institution, with powers of access to all official files and powers to question all public servants and any member of the public which can receive and investigate any bona fide allegation that an abuse of power or improper use of office has occurred. This must be coupled*

*with an obligation to make a public report on such allegations, and if necessary to refer such reports to proper quarters ... for action. (pp. 23-24)*

In recommending such safeguards, the Commission's Report was not only advocating protection of the public from the possible danger of the tyranny of the State upon its citizens, but it was also advocating protection of the public servants from unjustifiable criticisms that might be leveled against them by treacherous citizens who may be bent upon smearing the good name of the State or of any of its public servants. As the Report rightly put it,

*We would like to emphasize that this proposal is not merely designed to safeguard the public from abuse of power. It is also important to protect the public services from false allegations. What is needed in such cases is the existence of a routine system of impartial inquiry such as we are recommending. (p. 24)*

Admittedly, these were noble ideas. But those charged with the important responsibility to see that these recommendations were implemented lived up to their reputation. Being the very public servants whom the Commission's Report allowed to engage in private business, they conveniently selected those sections of the Report that suited and promoted their private interests and deliberately "killed", through constitutional means, any recommendations that would question these private interests. How?

When the Commission's Report was brought to the National Assembly for acceptance and implementation, the section on the establishment of the watch-dog institution of the *Ombudsman* was **conveniently rejected** by the leaders whose private interests it definitely would have

*kept under surveillance (Sessional Paper No.10: 1974).* Despite its recognition of the need for greater accountability and openness among public officials and, therefore, the need for the office of the *Ombudsman*, the government vehemently and shamelessly argued against it in the National Assembly as follows:

*the Government considers that the office is unnecessary in a parliamentary democracy where the maxim that the State can do no wrong no longer holds true by reason of the fact that the Government and Government Servants can be sued and prosecuted in civil matters. A citizen injured by an abuse of office by public servants can also have the matter raised in Parliament by means of Parliamentary Question. Furthermore, it is feared that the "Ombudsman" might be misused by unscrupulous elements in the society for witch-hunting and undue victimization. The Government does not, therefore, accept this proposal at this time (p.17).*

Now, in the absence of such an office it would be extremely unfortunate should the State machinery happen to fall into the hands of unscrupulous leadership. The citizens would hardly escape, let alone be saved, from undue victimization by State officials in cases where the citizens question their activities. When State apparatus happens to be in the hands of such unscrupulous officials, the tyranny of the State may at times escalate to such ridiculous proportions that it knows no bounds, not even the recognition and respect for parliamentary immunity enjoyed by the people's representatives.

Indeed, this seems to be precisely what happened soon after rejecting the Ndegwa Commission recommendation on the establishment of the "*Ombudsman*." Around that time, powerful but selfish officials without any conscience at all found themselves in control of the State machinery. In the absence of the watch-dog institution whose establishment they

had rejected earlier, and taking advantage of the then aging president Mzee Jomo Kenyatta, these officials became increasingly intolerant to any criticism leveled against their official conduct. Perhaps two examples may suffice here to illustrate this point.

In 1975, barely a year after the government had rejected the establishment of the watchdog office of the *Ombudsman*, arguing that there was no need for its existence since any *citizen injured by an abuse of office by public servants can also have the matter raised in Parliament by means of Parliamentary Question*, the late Mr. George Anyona, the then honorable member of Parliament for Kitutu East, questioned in Parliament what the public felt was misuse of power and abuse of office by some State officials concerning the cancellation of the contract with a Canadian firm for the supply of rail wagons. Anyona tabled papers to substantiate his claims. Now, instead of the State is feeling guilty that it had been "caught with its pants down", it turned round and accused Anyona of being in possession of classified government material and unashamedly threw the honorable member of parliament into detention (*The Weekly Review*, May 16, 1977:4).

If the country had heeded the recommendation of the Ndegwa Commission and had instituted a well established office of the *Ombudsman* and if the office had been allowed to do its job, there would not have arisen the need for The Hon. Anyona to question in Parliament the conduct of the State officials in the cancellation of the Canadian firm contract. The *Ombudsman* would have identified the misuse and the abuse of power for private gain by these State officials and stopped it at its onset. This in turn would have saved the people of Kitutu East the agony of watching helplessly as their Member of Parliament was being thrown into detention for heroically representing the citizens of this

country in questioning the illegal activities of those who held the reigns of power.

The second example illustrates even more graphically the extent to which the tyranny of the State could stretch when State apparatus is controlled by unscrupulous officials in the absence of the *Ombudsman*. When there was disclosure in the National Assembly that the then Attorney General, Mr. Joseph Kamere, and the then Minister for Labor, Mr. Titus Mbathi, were at the centre of alleged corruption in the then infamous loan dealings with the Bank of Baroda (*ibid.*, p. 4), the Attorney General was so embarrassed that eight months later he was driven to a make desperate attempt to introduce a Bill in Parliament aimed at ***making a law that would restrain anyone from unlawfully exposing such evil dealings!***

Unfortunately, the embarrassment had seemingly taken its toll. He was unable to figure out how to frame the Bill well. In the process, he fumbled with the Bill so badly that he had to be forced to withdraw it. To save the government further embarrassment, Kamere had to be relieved of his duties as the Attorney General. See? By refusing to implement the recommendation to create the office of the *Ombudsman*, the State not only supported those in power to practice tyranny against its own citizens, but, what was worse, it also opened a wide avenue for them to practice all sorts of corruption and other evils behind the walls of official secrecy.

However, despite its effort to kill the establishment of this important office in 1974, the Government found itself in an awkward position when, four years later, it convened a National Leaders Conference at the Kenya Institute of Administration (K.I.A.). The Conference was held from 17th to 19th January, 1978. The government fell short of admitting that it had made a grave mistake in rejecting the Ndegwa Commission recommendation concerning the establishment of the office

of the *Ombudsman*. All the leaders present agreed and lamented that corruption in high places was rampant. They suggested that one way of eradicating it and of providing the machinery for the public to register their complaints without fear of undue victimization was the creation of the office of the *Ombudsman* (Republic of Kenya: *Second National Leaders Conference, January 17th-19th, 1978.*) The Conference clearly resolved

*That corruption is strongly condemned and that legal proceedings should be instituted against those who practice it and in addition an office should be established through which members of the public and leaders alike can get redress for wrongs done against them to ensure efficiency of Government administrative practices. (p36)*

**The spirit was** there, present and always **willing, but the body was too weak** to make any move. Yet the need for the establishment of the *Ombudsman* in Kenya kept rising. Nearly ten years after The Ndegwa Commission, the heat from the burning spirit again ignited the fire in yet another Report, this time headed by S.N. Waruhiu (Republic of Kenya *The Report on the Civil Service Review Committee:1980*). The *Waruhiu Report* stressed that the watchdog office should be set up: "We are persuaded that there is still a case for the creation of the *Ombudsman* and we suggest that the Government considers and determines whether this is the right time for the establishment of the office of the *Ombudsman*" (p.23).

Like the Ndegwa Commission Report, the *Waruhiu Report* also devoted a whole chapter to the need to establish this office. The Ndegwa Commission had clearly stated that the **absence of such an office at any one moment** meant not only that a person in a powerful office would easily abuse his powers but that such a person (and this was even worse) always

depended on his own self-criticism and evaluation in whatever he did.

*Immunity to outside evaluation and criticism, while making it possible for the public servant to pursue his duty without interruptions, also makes it possible for him to neglect his work, or even abuse his office. Perhaps even more importantly, immunity to outside criticism means that the Civil Service is entirely dependent on self-criticism for the continuing reform and improvement of its development capability. History gives little grounds for optimism that any social institution will exhibit this quality of constant self-renewal if it is not subjected to effective pressure from outside to do so (p.133).*

The *Waruhiu Report* made a strong case for the establishment of the office of the *Ombudsman*. It gave extremely convincing reasons why there was need for this office. Explaining that *Ombudsman* is an old Swedish word meaning a person who acts and speaks on behalf of someone else, the Report said that the word has now been internationally adapted to mean

*the special institution for the protection of the rights of the citizen against abuse of power, error and neglect by authorities. The basic idea behind the creation of the Ombudsman is that the courts and administrative agencies would be less inclined to disregard or abuse or misuse the laws. The rights of the people would be better safe-guarded if the activities of the authorities were watched by a people's tribunal which is independent of the Government (p.134).*

The Report said that the main duties of the *Ombudsman* would be to protect the individual citizen against the tyranny of the State, "against injustice arising from misconduct, error of judgment, abuse of office or encroachment by people in authority." What was more, the Report recommended that the *Ombudsman* should recommend "prosecution of a public offi-

cer who has committed a fault or neglected his duty" (p.11).

But when the *Report* was tabled before Parliament for acceptance and implementation, the Government rejected it (*Sessional Paper No.10:1980*). Recalling its earlier stand when the Ndegwa Commission had recommended that the office be established, the Government maintained that

*Waruhiu Committee has suggested the revival of setting up the Office of the Ombudsman which had been proposed by the 1970-71 Ndegwa Commission. The Government rejected the establishment of this office in the Sessional Paper No. 5 of 1974 on the grounds that such an office might be misused by unscrupulous elements for witch-hunting and undue victimization. The Government still maintains the same views and accordingly rejects the establishment of the office of the Ombudsman (p.11).*

Now the government's rejection to implement this recommendation was rather shocking and, in fact, reflected once again a somewhat childish ambivalence. It should not be forgotten that this was the same government which, at the *Second Leaders Conference* held at K.I.A. barely two years earlier, had passed a strong resolution that the office of the *Ombudsman* be established. It is not clear why these same leaders could turn round to reject the very office they themselves had resolved to set up. Were they merely paying lip-service to the K.I.A. Second Leaders Conference, only to find themselves later caught with their pants down by the Waruhiu Commission Report, or is this yet another glaring example of a *willing spirit* in a miserably *weak body* politic?

The government's ambivalence again resurfaced at the *Third National Leaders Conference* held again at K.I.A. on 21-22 July, 1980. After rejecting the Waruhiu's recommendation concerning the *Om-*

*budsman*, the leaders again complained of "indiscipline, malpractices, and divisive politics" (*ibid*, p.18), the very evils which the office of the *Ombudsman* was required to prevent. After discussing how these evils were affecting the nation, the leaders in the Conference

*felt that there was an urgent need for a code of ethics. This was felt necessary in order to encourage and maintain discipline in our society, particularly among leaders. The need for a clear document setting out such a code for all leaders, whether in politics, public or private sector, was desirable. In this respect, it was suggested, and the delegates agreed to request His Excellency the President to appoint a committee to draft such a code for consideration by the party and the Government. Once approved, knowledge of, respect for and living by the code would be prerequisites for any person aspiring to a position of leadership (The Weekly Review, pp. 10-11).*

How this code of conduct would function without the existence of the watchdog office was not made clear. And even then, the committee to draft such a code was never appointed until after the coup attempt of August 1, 1982, when the President appointed Mr. Gecaga to chair such a committee. Anyone can now see that, had the recommendation in the Ndegwa Commission Report been heeded, there would probably not have arisen later the need for the appointment of the Gecaga Committee to draft the code of conduct. The existence of the code of conduct was not going to do the job that the *Ombudsman* was supposed to do. Kenya still needed the services of the *Ombudsman* over and above the existence of the code of conduct that the Gecaga Committee had suggested.

That notwithstanding, the need for a watchdog office grew stronger and stronger as public morality of those holding high offices sank lower and lower

with the passage of time. Enjoying the protection and the convenience of hiding and *operating behind the walls of official secrecy*, these shameless government officials (with no conscience) threw the virtues of transparency and accountability out the window. The Goldenburg scandal, which involved top government officials in the Moi administration, is a classic example of crimes that can be committed *behind the walls of official secrecy*. The scandal, now popularly known as “The Golden Affair,” is the subject of a judicial commission of inquiry (Republic of Kenya: *The Kenya Gazette, Special Issue, 24<sup>th</sup> February, 2003*). The Commission was appointed “to inquire into allegations of irregular payments of export compensations to Goldenberg International Limited, ... and into payments made by the Central Bank of Kenya to the Exchange Bank Limited in respect of fictitious foreign exchange claims” (ibid. p.1).

Headed by the judge of the High Court of Kenya, Justice Samuel E.O. Bosire, the Commission is expected to establish, among other allegations,

*the circumstances and grounds upon which the compensation was claimed and paid to Goldenberg International Limited...the actual amount of export compensation paid...,including but not limited to Ksh. 5.8 billion, and whether any of the said amount was paid to third parties and if so, the identity of such third parties and the amount paid to them (p.1).*

Unlike those in the Moi administration, the scandals in the Kibaki administration have become even more shocking. Kibaki’s Government of National Rainbow Coalition (Narc) came to power on the firm promise to anxious voters that it **shall wage war on corruption**. Yet, before it could reach even halfway through its expected five-year period in office, the

Kibaki administration is already staggering under the cripplingly heavy weight of its own scandals, as voters open-mouthedly gape in utter disbelief as to whether this truly is the government they overwhelmingly brought to power. Two of these scandals may illustrate the magnitude. First, there is the embarrassing Anglo-Leasing scam in which top government officials fleeced the treasury Ksh 4 billion for non-existent Criminal Investigation Department (CID) forensic laboratories. Then the chilling HIV/AIDS funds scandal (now dubbed “Robbing the Dying”) in which top government officials are reported to have gone into a looting and feasting frenzy on HIV/AIDS funds entrusted to them for proper administration while millions of patients continue suffering without treatment (Kenya Government, Efficiency Monitoring Unit: *Report on the Financial Management Audit of the National Aids Control Council, 2005.*).

All this is happening when the Narc administration is privileged with the best means and ways to wage and win the war on graft, using, among others, its newly established formidable weapons of *Kenya Anti-Corruption Commission (KACC)* and the *Anti-Corruption and Economic Crimes Act (ACECA)*. Despite having these lethal arsenals at its disposal, however, the Kibaki administration has largely remained a sorry case of a **willing spirit** in Kenya’s miserably **weak body** politic, as now clearly evidenced by its weakness to deal firmly with the Anglo-Leasing scam looters and other corrupt senior officials within its ranks.

But, just as Karl Marx observed long ago, such scam never escapes the effect of historical dialectics and inevitably culminates in creating for itself a strong antithesis – in this case, it is the agitation by the citizens for transparency and accountability. That is what seems to have happened two years ago. Parliament once again



found itself faced with yet another motion seeking the establishment of the watchdog office of *the Ombudsman* nearly thirty years since the government first **resisted** its establishment. *The spirit is willing* (it has been doing so since the Ndegwa Commission in 1974 as evidenced by the recent enactment of KACC and ACECA), *but the body politic is still weak, very miserably weak*, as the above-mentioned scandals clearly prove.

### **The Cost of Losing a Nation's Conscience**

Perhaps a detailed presentation of the transactions in the two major scandals mentioned above could suffice to illustrate the magnitude of the economic crimes and loss to the country when political leadership lacks national conscience. The diversion of resources through rip-offs by the Goldenberg and Anglo-leasing, besides creating sudden and extreme income inequalities, causes massive human deprivations. That is why 2.5 million Kenyans are now faced with famine (*The Standard*, January 18, 2006) while, as was seen earlier, 400,000 have no access to antiretroviral treatment.

The loss of the nation's conscience is best illustrated in the Goldenberg Scandal of the Moi administration. While Kenyans are still counting the cost, it is said that in one transaction alone, some KShs.13.5 billion (\$180 million) was ferreted from Central Bank of Kenya. According to some accounts, as much as Kshs.70 billion was looted in three years (Maina Kiai, *Poverty and the Struggle for Human Rights in Kenya*, UNESCO, Nairobi, May 9, 2005). ***This huge sum of money "is equivalent to what the country requires to finance free health care for all people in Kenya for one and a half years" (p.4) only if the political leadership had a conscience.***

The CID forensic labs deal in the Anglo-leasing scam of the Kibaki administration that had declared "zero tolerance to corruption" and involved contract amounts of Kshs.4 billion. This enormous figure, Kiai observes, "is more than the Kenya Roads Boards used (Kshs. 3.42 billion) in FY 2002/03 to put gravelling on 282km of roads, put pavement reconstruction on 20km of bitumen roads, re-seal and re-carpet 151km of roads." (*ibid.* p.4)

Leaders with no conscience never blink when they wallow in the midst of conspicuous waste. Between September 2003 and February 2004, Kiai reveals, the High Court of Kenya, the very institution expected to uphold the conscience of the nation, itself unblinkingly purchased a fleet of 13 sleek Mercedes Benz E200k at a cost of Kshs.82.5 million. ***These funds could easily enable more than 10,000 orphans of AIDS victims to go through 8 years of schooling comfortably, only if political leadership had any conscience!***

Nor is the High Court the only one with a craving for buying limousines in the poverty-stricken and AIDS-ravaged country with 2.5 million citizen already staggering under starvation. That honor goes to Ministers and Permanent Secretaries. In their first act of business after the December 2002 election, Kenya Parliamentarians voted to give themselves each a grant of Kshs.3.3 million to buy vehicles for their use, on top of salary and allowance increases that total about Kshs.600,000 per MP. The total cost of the grants for these new vehicles is Kshs.732 million over 5 years. ***This money could provide anti-retroviral drugs for 20,000 people for one full year, only if political leadership had any conscience!***

The Centre for Governance and Development, in a landmark report analyzing the reports of the Controller and Auditor General, states that the government of

Kenya lost Kshs.475 billion from 1991 to 1997. These funds – for which there was not discernable accountability are twice the annual revenue collection by the Government! ***It was enough to repay Kenya's external debt of about Kshs.350 billion, and build all the roads that Minister for Roads says he needs (Kshs.90 billion), and still give the Minister for Health the Kshs.40 billion needed to start the Free Health Care project, only if political leadership had any conscience!***

### **Implications on War Against HIV/AIDS Pandemic**

Faced with the kind of scenario described above, the individual in present day Kenya exerts personal efforts to improve his lot. In practical terms, he finds himself constantly in cut-throat competition with his fellowmen for scarce resources. The new capitalist system of commerce and industry pits brother against brother in this never-ending competition for the artificially-made scarce resources which the Kenyan capitalist system adopted at independence. We unto him should HIV/AIDS strike in the midst of this unfair competition because it will nearly always catch him off guard and cripplingly disadvantaged: no social security, no medical insurance, no secure employment and, sadly, no one to turn to!

Interestingly, the apparent “scarce” resources now being fought for happen to be the very same resources that proved abundant enough for everyone in the egalitarian indigenous community in the pre-colonial era. All essential resources were held in common and the welfare of one individual was the concern and the responsibility of everyone in the community. No one slept hungry when others had something to spare (Nyerere: *Man and Development*, 1974). Today 3,000,000 Kenyans, most of them school children, are starving to death when the rich are

throwing the unfinished meals into the dustbin. At that time, cooperation rather than competition was the key in social relations. Today, it is competition. The modern formal system of education, with its devastating testing methods, is elaborately designed to encourage competition. The new competitive values are not only aspects of modernization, but they are also responsible for contradictory change which is the science of post-modernism.

When an individual finds himself constantly competing against his fellow men for resources artificially made scarce by a capitalistic economic system such as the one now in operation, he inevitably develops a morality quite different from that of individuals who constantly shared the available resources and who cooperated to achieve a shared goal in an egalitarian community, long ago killed by colonialism. While the **conscience** of an individual in a cooperating group would ***prickle him at the thought of deviating from group values*** of co-operation, the individual in a competitive, capitalistic system ***will feel no discomfort*** at all if the destruction of his brother's business would shoot up his profits!

In any competition for scarce resources, the end justifies the means, and the winner always takes it all, with no love lost between him and the loser. Ever since the introduction of capitalism as the way to steer economic growth in Kenya, the country has witnessed the dreaded growth of materialistic culture and its attendant loss of the once cherished values that used to enhance social responsibility.

Nowadays, a person's worth is what he ***has***, not what he ***is*** as an individual. People are now described in terms of what they possess so that the usual answer to a question such as “Who is this person?” is often given as this is the owner of such and such a company, or such and such a house, or such and such a car, not his real

name Kamau or Smith or Otieno or Patel or Monyenye!

Under such material culture, the citizens now clamor for material well being, for that is now the measure of the **new** but perverted "*conscience*." Those who are perceived wrongly or rightly as having "made it" in present day Kenya all possess this **new** "*conscience*." Unfortunately for the youth of this country, **these people have now become the role models to be emulated**. More often than not what they possess has been ill gotten. The beneficiaries of the Goldenburg Scandal in Kenya, which is now the subject of a judicial commission of inquiry, is a glaring classic example. But since society regards them as role models, their morality becomes the measure, the yardstick, the right one to be emulated! Hence, their *conscience*, Kenya's **new** "*conscience*," the inner voice of materialism, **encourages them to go for more rather than prickle them to feel moral discomfort and refrain from doing so**.

In such circumstances of this **perverted** "*conscience*," the poor are driven into accepting that the end justifies the means, and it is not hard to imagine the devastating and chilling consequences: At the extreme, the urban poor, in a desperate attempt to survive, avail themselves of exploitation. Here is an opportunity for an almost "symbiotic" existence between the "haves" and the "have nots." The filthy rich can now satisfy their base appetites, the drug traffickers target the children of the rich, the desperately needy schoolgirl now surrenders her tender body to the marauding sugar daddies, the beautiful job-seeking girl is blackmailed into accepting sex with a prospective employer, the poor twilight girl plays the sex role of a bitch for a rich man's dog! What matters is to have what one needs, not how one gets it.

In this perverted lifestyle, the "have nots" are always more vulnerable to

HIV/AIDS than the "haves" The vulnerability is compounded further by the misconceptions and persistent false indigenous beliefs about the causes and treatment of HIV/AIDS despite efforts now exerted toward educating the public about it. The false beliefs have led to the now too frequent incidents in which some of the desperate HIV/AIDS victims rape children as young as three years and/or chop off their genitals to use in making medicinal concoctions, falsely believed to cure HIV/AIDS infections!

In a country that lacks a nation's **conscience**, individualism has occupied centre stage and has led to the incidents described above. If this state of affairs is not reversed, then it is hard to see how Kenyans will ever stop to reflect upon the plight of the hungry packing boy, or the thirsty twilight girl, or the sickly begging cripple, or the hungry orphaned child, all of whom are now roaming in the urban streets and, sadly, whose numbers are increasing at an alarming rate.

These are the sad realities that must be boldly faced by anyone truly concerned with the efforts towards the **restoration of true national conscience** that is so vital now in the war on HIV/AIDS pandemic.

### Suggestions for the Way Forward

There are a number of possible options open for anyone genuinely concerned and willing to restore the nation's **conscience** in the war on HIV/AIDS in Kenya and elsewhere. In the first place, the war can be won only by fighters who are truly committed to win, not those half-hearted civic and political decision makers, some of whom are even benefiting from the existence of HIV/AIDS pandemic.

This is particularly important in the case of leaders charged with the responsi-

bility to wage war on the pandemic. For example, if leaders in charge of the funds already set aside for the war on the pandemic do not feel guilty (have no *conscience* to prickle them) when they misappropriate the funds, it is highly unlikely that the war on HIV/AIDS will be won. At the time of writing this work, a top executive in charge of HIV/AIDS funds in Kenya was serving a prison sentence for misappropriation of such funds that were under her administration. There are many other examples of such unscrupulous officials still holding high public offices, without any *conscience* at all to prickle them as they bleed their country's economy to death. Those involved in the *Goldenburg* and the *Anglo Leasing* scandals are only the tip of the iceberg. They show the extent to which the loss of the nation's *conscience* has sucked this country dry.

It would appear that the selection process through which the jailed official mentioned above got the appointment was not watertight enough to prevent persons of this type of character and conduct from ascending to important positions such as these, which, as can now be admitted, need individuals of *conscience* and high integrity.

Perhaps one of the many ways of restoring the nation's lost *conscience* would be to put in place mechanisms in which all those holding important public offices are made to undergo some kind of a stringent vetting process to ensure that candidates of dubious and questionable character and conduct do not occupy important public positions. The vetting should be a continuous and compulsory exercise.

As for ordinary citizens, the most important resource they need is basic civic education. After all, at Independence, the Kenya Government actually declared *war on ignorance* as one of the *three* most dreaded enemies that had to be fought, the other two being *poverty* and *disease*. Ref-

erence has already been made as to how *ignorance* of the cure for HIV/AIDS leads to raping children and chopping off their genitals for use in making concoctions falsely believed to cure the disease. Since education involves the acquisition of knowledge and understanding, it is the one single weapon which would enable the citizens to participate effectively in the war on HIV/AIDS. The provision of this civic education is the responsibility of the government. It has the obligation to design an urgent civic education program as a short term measure to quickly *sensitize the citizenry* countrywide and in all sectors of the economy on the importance and advantages of understanding not only the nature of the HIV/AIDS pandemic but also the urgent need for the restoration of the nation's *conscience* that is so crucial in the war on the pandemic. As the analysis in the preceding sections has shown, the root cause of loss of the nation's *conscience* is lack of will power to fight the evils of corruption in the government by implementing the policies. *Sensitization of the citizenry* should aim at empowering them to force those in power to implement the policies aimed at ensuring transparency, accountability and good governance since these are the pillars upon which the *restoration* of the nation's *conscience* will have to rest.

Then, as a long-term strategy to restore the nation's *conscience*, the country's national education system should be designed so as *to incorporate the teaching of integrity, transparency and accountability as an important component of the school curriculum*. The teaching of this component, if successfully done, would hopefully lay the foundation for the restoration of the nation's lost *conscience*. It should be made a compulsory and examinable subject at every tier in the country's education system. This is particularly important now that the government is planning to give every child in Kenya a

minimum of twelve years of education (Government of Kenya: *Sessional Paper No.1, 2005*). This strategy, together with the fact that schools countrywide are now teaching and sensitizing children on measures to take to avoid HIV/AIDS infection, would certainly go a long way to win the declared war on HIV/AIDS pandemic.

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# **Transformational Leadership Role in Creative Awareness of HIV/AIDS Infection in Minority Populations: A Theoretical Study**

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## **Abstract**

This article is a theoretical analysis of the role of transformational leadership in making policy concerning HIV/AIDS in minority populations in the United States. Theoretically, effective leadership uses a variety of strategies that are appropriate for such situations (Kotter, 1985; Yukl, 1989). Burns (1978) described leadership as a process of interrelationships in which leaders influence followers and are influenced in turn to modify their behavior as they encounter responsiveness or resistance. Today's transformational leaders who exercise power in an arrogant, manipulative, and domineering manner are likely to endanger resistance arising from social sensitivity and empathy required for understanding the need for HIV/AIDS awareness. This study examines the role of transformational leader's responsibility to raise HIV/AIDS awareness of the racial and minority populations in the United States. African Americans and Hispanics constitute 61 percent of the more than 830,000 cases of AIDS reported to the U.S. Center for Disease Control and Prevention (CDC) since the epidemic began in 1981. The CDC (2002) reported that African Americans make up 41 percent of all AIDS cases reported in the United States, yet they comprise only 12 percent of the population. Hispanics represent 19 percent of all AIDS cases and are approximately 13 percent of the U. S. population. An investigation concerning this kind of disparity should be the goal of future research, which should employ empirical rather than theoretical methodology for further verification.

**Background of the Problem**

The hallmark of any institution lies in the quality of its leadership (Conger 1989). Conger and Kanungo (1998) suggest that followers' attributions of charismatic qualities to a leader are jointly determined by the leader's behavior, skill and specific aspects of the situation. It is no surprise that in today's complex society, visionary institutional leadership will influence awareness concerning HIV/AIDS infections in minority populations. The Human Sciences Research Council of South Africa (HSRC, 2004) reported that the creation of knowledge management requires a nimbleness of decision-making that in turn requires new ways of managing information. Early in his 2002 tenure, USAID Administrator Andrew Natsios identified combating the HIV/AIDS pandemic as "top agency priority" and mandated a stepped-up, more focused approach to combating HIV/AIDS with a new operations plan entitled "War on AIDS." The plan mandated stand-alone HIV/AIDS strategies and more extensive reporting for "priority countries." The number of priority countries was increased from 19 to 23. One of the factors which facilitated the rapid spread of HIV in Ukraine was the high level of stigma and discrimination faced by the marginalized population which has been the focus of the epidemic. No nation can escape the effects of HIV/AIDS. In today's increasingly integrated world, if heavily infected nations are allowed to disintegrate, the economic, political and strategic consequences will be felt far beyond their borders (Magaziner, 2004).

The HIV epidemic in the United States is a composite of multiple, unevenly distributed epidemics in different regions and among different population

groups. There continues to be knowledge gaps in racial and ethnic communities about how HIV, the virus that causes AIDS, is spread. Based on CDC's observations, the epidemiologic profile suggests that the risk of becoming infected with HIV is reported to be by men who have sex with men (MSM), injection drug users (IDU), persons at high risk for HIV infection through heterosexual contact, women, children, adolescents and young adults, racial/ethnic minorities and other populations.

Despite the success and availability of drug therapies that have cut the death rate of AIDS in the U.S., the epidemic continues to gain strength in some groups such as women and minorities and in some areas such as urban and poor neighborhoods and in rural areas of the southeastern U. S. African Americans and Hispanics constitute 61 percent of the more than 830,000 cases of AIDS reported to the U.S. Centers for Disease Control and Prevention (CDC) since the epidemic began in 1981. The CDC (2002) reported that African Americans make up 41 percent of all AIDS cases reported in the United States, yet they comprise only 12 percent of the population. Hispanics represent 19 percent of all AIDS cases and are approximately 13 percent of the U. S. population. The latest statistics on AIDS and HIV in the USA were published in December 2004 by the CDC. Tables 1-4 present a visually graphic representation of the seriousness of number affected by this disease. Below, the CDC HIV/AIDS Surveillance Report 2003 (Vol. 15) shows facts that create several important problems for the transformational leaders. Such visual material is important because the transformational leaders' perceptions may affect responses to the CDC observations.



**Table 1. Estimated HIV Diagnoses by Race/Ethnicity and Year**

Race/Ethnicity	Year of Diagnosis			
	2000	2001	2002	2003
<b>White, not Hispanic</b>	9,962	9,803	10,214	10,322
<b>Black, not Hispanic</b>	16,257	16,042	16,216	16,165
<b>Hispanic</b>	4,340	4,560	4,833	4,963
<b>Asian/Pacific Islander</b>	177	162	187	273
<b>American Indian/Alaska Native</b>	178	164	185	188

In 2002, in response to the trends in the HIV/AIDS epidemic and the mandates of reauthorization, HRSA concentrated its efforts on improving and expanding access to quality health care for high risk and hard-to-serve populations. This was achieved through the development of an ongoing relationship with clinical sites and their providers, identifying and closing gaps in care, identifying minority

providers in under-served communities, identifying HIV cases and bringing patients into care early, and disseminating information and resources on HIV/AIDS to minority providers in the U.S. This work was accomplished through the participation of The National Minority AIDS Education and Training Center headquartered at Howard University. The center was founded in 1999 (CDC MMWR, April 18, 2003).

**Table 2. Estimated AIDS Diagnoses by Race/Ethnicity and Year**

Race/Ethnicity	Year of diagnosis					All Years
	1999	2000	2001	2002	2003	
<b>White, not Hispanic</b>	12,626	12,047	11,620	11,960	12,222	376,834
<b>Black, not Hispanic</b>	19,960	20,312	20,291	20,476	21,304	368,169
<b>Hispanic</b>	8,141	8,233	8,204	8,021	8,757	172,993
<b>Asian/Pacific Islander</b>	369	373	409	452	497	7,166
<b>American Indian/Alaska Native</b>	162	186	179	196	196	3,026

**Table 3. Estimated Adult and Adolescent Males living with AIDS by Race/Ethnicity and Exposure Category End of 2003**

Race/Ethnicity	Exposure category					Total*
	Male-to-male sexual contact	Injection drug use	Male-to-male sexual contact and injection drug use	Heterosexual contact	Other	
White, not Hispanic	96,563	13,594	11,269	5,040	1,943	128,409
Black, not Hispanic	50,842	35,335	8,649	20,111	1,660	116,598
Hispanic	32,063	18,606	4,003	7,637	623	62,931
Asian/Pacific Islander	2,329	304	146	349	81	3,210
American Indian/Alaska Native	675	201	186	81	20	1,162

\* Because totals are calculated independently of the subpopulations, the values in each column may not sum exactly to the figure in the Total column.

**Table 4. Estimated Adult and Adolescent Females Living with AIDS by Race/Ethnicity and Exposure Category End of 2003**

Race/ethnicity	Exposure category			Total*
	Injection drug use	Heterosexual contact	Other	
White, not Hispanic	7,054	9,963	547	17,565
Black, not Hispanic	17,797	34,025	1,397	53,219
Hispanic	5,546	10,894	400	16,839
Asian/Pacific Islander	98	449	53	600
American Indian/Alaska Native	132	182	11	325

\* Because totals are calculated independently of the subpopulations, the values in each column may not sum exactly to the figure in the Total column.

Sources: Tables 1-4. The next data are due December 2005.

• Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report 2003, (Vol. 15)*.

The draft Epidemiologic Profile of Oklahoma (1998) reported that urban areas have the largest number of cases and the largest proportion of cases by percentage and rate per 100,000 populations in Oklahoma. Numerically, more whites have been diagnosed and reported with HIV/Aids. However, proportionally, blacks have experienced rates of HIV and AIDS 2 to 2 ½ times greater than rates observed in whites; hence the impact has become more substantial within black communities.

With the sheer number and per 100,000 of sexually transmitted diseases

diagnosed each year in Oklahomans age 15-25, these individuals, of all racial/ethnic groups and gender, have placed themselves at risk of becoming HIV infected through unprotected sexual contact. Although these ages have not been the bulk of cases reported with either HIV or AIDS, Oklahoma could encounter a large increase. Somehow more of these teens and young adults have to understand that by having unprotected sex they are placing themselves at risk for not only HIV but also other STDS and unplanned pregnancies.

**Figure 1. Oklahoma Reported HIV and AIDS Summary Statistics, Cumulative as of 12/31/2004**

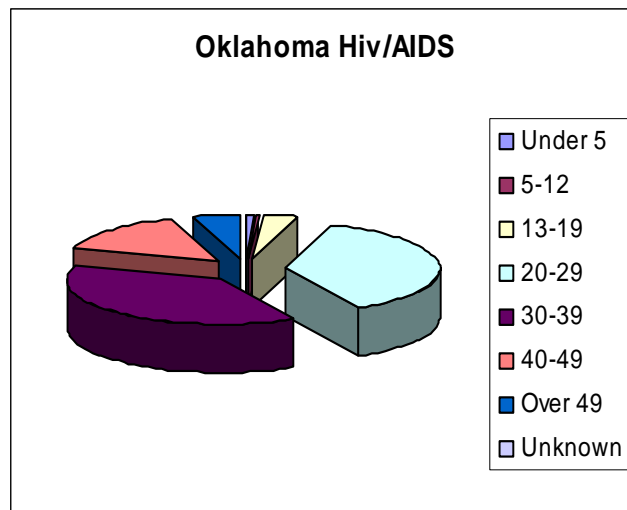


Figure 1 is a reflection from Oklahoma Reported HIV/Aids for age groups of under 5 through over 49 out of Oklahoma's 3,145,585 total population. The state is divided into 77 counties, and of

the states population, 51% are female and 49% are male. The 1990 racial distribution was estimated as follows: White (81%), American Indian (8%), Black (7%), Asian/ Pacific Islander (1%) and

Hispanic (3%). *The Draft Epidemiologic* (1998) reported that in Oklahoma, males, American Indians, black and white, ages 25-44, HIV was the leading cause of death during years 1994 - 1996. In females, HIV was never the leading cause of death; however, in blacks 25-34 it was the second leading cause of death.

The estimated HIV infections prevalence based on Aids OIs in Oklahoma by gender among all adults and adolescents living with HIV infection, including those diagnosed with AIDS, was estimated for males 3,080 – 3,920 and females 360 – 480 persons. Prevalence refers to currently infected persons. Infections among persons in Oklahoma who have died are not included in the estimates.

The majority of adolescents and young adults reported as HIV/AIDS positive are male and white; most of these are MSM, but almost ¼ injected drugs. Although transmission of HIV results from certain high-risk behaviors and is not the consequence of one's racial or ethnic group, racial and ethnic minorities have been disproportionately affected by the HIV epidemic. For example, HIV seroprevalence among men who have sex with men, injection drug users, and high-risk heterosexuals is now higher among blacks than among other racial/ethnic groups (Oklahoma, 2004).

Every reportable STD, including HIV/AIDS, has disproportionately affected black communities across the state. Nowadays, HIV/AIDS rates per 100,000 populations are 3 to 8 times greater in blacks as compared to whites. STD rates are 6 (Chlamydia) to 80 (early syphilis) times greater in black adolescents/young adults as compared to white adolescents/young adults. "We're seeing an ever increasing number of new HIV infections each year. The largest growing sectors include heterosexuals and minorities," said Gene Voskuhl M.D., a clinician and professor of infectious diseases at the

University of Oklahoma Health Science Center. "The largest population continues to be men who have unprotected sex with another man." "Males account for 84 percent of people infected with HIV in Oklahoma, while females comprise only 16 percent, according to recent statistics. Among races, whites make up two-thirds of Oklahoma's HIV-positive population. African-American account for 23 percent; American Indians, 6 percent; and Hispanics, 5 percent. State statistics point to brighter news for state's youth and teen populations. Children make up 1 percent of those with AIDS. Teens account for 4 percent of those who are HIV-positive and 1 percent of those with AIDS" (*The Oklahoman*, February 24, 2006: 3). "First, HIV testing is available in every county health department. Anyone who has had unprotected sex with multiple partners, has a history of sexually transmitted diseases, has used intravenous drugs or is a gay male should be tested. And second, we need to be teaching our teenagers and young adults safer sex practices" (Gene Voskuhl, M.D., 2006).

### Statement of the Problem

Most people know that HIV can be spread in several ways: from mother to child at birth; via unprotected sex with an infected person; or by sharing needles with someone who is infected. The AIDS pandemic has become a complex global crisis which continues to worsen. At the same time, the world is responding more effectively than ever before with increased political commitment and greater allocations in domestic resources. The transforming leadership can play a key role with regard to the process by which leaders appeal to minorities' values and emotions and poor neighborhoods in urban and rural areas in an attempt to raise their consciousness about HIV/AIDS and to mobilize energy and resources in those

areas that are priorities for care, treatment and program administration. The process by which leaders appeal to followers' values and emotions is a central feature in current theories of transformational and visionary leadership in organizations (Bass, 1985, 1996; Bennis and Nanus, 1985; Sahkin and Fulmer, 1988; Tichy, and Devanna, 1986). All of these theories describe leadership as a process of influencing commitment to shared objectives by empowering followers to accomplish them. The Human Sciences Research Council (2004) reported that leadership must advocate a vision that is highly, from the status quo, but still within the latitude of acceptance by the follower. It could be argued that transformational leadership is the chameleon-like strategy for leaders who appeal to minorities' values, emotions, and poor neighborhoods in urban and rural areas in an attempt to raise their consciousness about HIV/AIDS. The chameleon is uncompromisingly focused on its course. As it sticks to its course, it scans its opportunities. When necessary, it changes its color. When it moves, it takes one step at a time.

Politicians are transformational leaders, and in addition to receiving passive epidemiologic profiles and reports from surveillance epidemiologists, they understand that the AIDS pandemic has become a complex global crisis which continues to worsen. The U.S. Department of Commerce distributes published and unpublished data for large areas such as census regions, states, metropolitan areas, counties, cities, and small areas down to the size of a city block (DOC, 1993). In addition to providing a regional snapshot of the entire population, census data are used as the principal source of denominator data for calculating HIV/AIDS incidence rates (the number of cases per 100,000 people).

Solutions can be found from a variety of providers, laboratories, private physi-

cians, inpatient hospitalizations, outpatient care, death registries, HIV Counseling and Testing sites, etc., of HIV/AIDS infections in minority populations. County health departments and all personnel of programs are transformational leaders who provide support services and have a responsibility of encouraging the provider to report when they first encounter a new positive case in their practice. In many regions, data from certain analysis cannot be presented because of small numbers of HIV infection or AIDS cases in the minority communities. Reporting small numbers of cases may lead to a breach of confidentiality and to the inadvertent disclosure of a person's identity. Showing data with small numbers may be acceptable only if there is no risk of such inadvertent disclosure.

### **Purpose of the Study**

The purpose of this study is to emphasize the importance of the transformational leadership role as a strategic tactic in creating awareness of HIV/AIDS infections in minority populations. Theoretically, transformational leadership can be effective in a variety of ways that are appropriate for certain situations. Burns (1978) suggests that as far as transformational leadership is concerned, the followers feel trust, admiration, loyalty, and respect for the leader, and they are more motivated to do more than they originally expected to do. Transformational leadership recognizes that prevention efforts, while very important, are insufficient and that prevention cannot fully work without treatment. Magaziner (2004) reports that many people will not seek voluntary counseling and testing if they are simply going to be told that they are HIV positive and that nothing can be done about it. Education and prevention will not significantly reduce transmission rates unless care and treatment accompany them.

Without adequate treatment, we will continue to face a situation in which millions of infected individuals are unaware of their HIV positive status and its implications for their families and communities. Generally, transformational leadership is viewed as value-added performance beyond basic expectations in what has been called the *augmentation effect* (Waldman, Bass, & Yammarino, 1990). Burns (1978) described leadership as a process of interrelationships in which leaders influence followers and are influenced in turn to modify their behavior as they meet responsiveness or resistance. According to Bass (2002), the leader transforms and motivates followers by (1) making them more aware of the importance of task outcomes, (2) including them to transcend their own self-interest for the sake of the organization or team, and (3) activating their higher-order needs.

### Literature Review

Leadership is one of the most observed and least understood social phenomena. Over the last 80 years, researcher methodological preferences and conceptions of the study of leadership have included a variety of classical approaches. Those approaches include the trait approach, behavior approach, power-influence approach, and the situational approach.

Stogdill (1948) and Mann (1959) suggested that the trait approach emphasizes the personal attributes of leaders and made the assumption that some people are naturally endowed leaders over others. Yukl's (1994) behavior approach emphasizes what leaders and managers do on the job and the relationship of behavior to managerial effectiveness. The power-influence approach taken by some researchers (French & Raven, 1960; Katz & Kahn, 1978; and Kotter, 1985) examines leadership effectiveness in terms of the

amount and type of power possessed by a leader and the exercise of that power. Finally, researchers such as Blake and Mouton (1964) used the situational approach to classify leadership behavior that facilitates the nature of managerial work and to compare the behaviors of effective and ineffective leaders.

Leadership researchers seem to have defined leadership according to their individual viewpoints and the aspect of leadership of most interest to them. Harder (2001) reported, "Various researchers have defined leadership in many different ways" (p.16). Stogdill (1948, p. 259) also observed that there might be as many definitions of leadership as there are researchers. For example, Stogdill (p. 35) defined leadership as "the process of influencing group activities toward goal setting and goal achievement." Durbin (1951, p. 5) stated, "Leadership is the exercise of authority and the making of decision." Terry (1954, p. 228) viewed leadership as "the activity of influencing people to strive willingly for group objectives." Davis' (1972, p. 124) definition stated, "It's the ability to persuade others to seek defined objectives enthusiastically." Haimann and Scott (1974, p. 349) defined leadership as a "process by which people are directed, guided, and influenced in choosing and achieving goals" Roach and Behling (1984, p. 46) believed that the process of influencing the activities of an organized group toward goal achievement is leadership. Stoner, Freeman, and Gilbert (1995, p. 470) defined it as "the process of directing and influencing the task-related activities of group members." More recently, Bass and Avolio (2000) have defined leadership in terms of the leader's ability to influence others; pointing out that the leader's style is either transactional or transformational. This will be the definition used for leadership throughout this study. The underlying

theory for this type of definition of leadership comes from Weber and Burns.

### **Transformational Leadership Theory**

The theoretical perspective of Burns' (1978) opinion that leadership is characterized as either transactional or transformational is based on the work of two scholars: Weber and Downton. Weber's (1947, 1968) concept of charismatic leadership of the bureaucracy, which is rooted in a sociological perspective, introduced the charismatic authority (*charisma*, from the early Christian concept of "the gift of grace"), where the leader was obeyed by virtue of the follower's personal trust and belief in the leader's powers or revelations. Weber postulated three pure types of legitimate authority i.e., socially acceptable authority: (a) rational-legal authority, which rested on legality, or the "right of those elevated to authority...to issue commands"; (b) traditional authority, which rested on a belief "in the sanctity of immemorial traditions and the legitimacy of the status of those exercising authority under them"; and (c) charismatic authority, which was based on "devotion to the specific and exceptional sanctity, heroism, or exemplary character of an individual person" (Wren, 1994, p.195). The point of Weber's transformational piece is presented in the sense of an affiliation and intense feeling of admiration and respect from the followers, who find the leader's vision to be quite appealing. The concept of transformational leadership was derived from Downton's political science writings.

Based on these writings, Burns (1978) advanced the thought and created his theory of transformational leaders. Burns (1978) described transformational leaders as those who obtain support by inspiring followers to identify with a vision that reaches beyond their own immediate self-interests. For example, Magazi-

ner (2004) reported that building the capacity for effective care and treatment programs in resource-poor settings poses a number of interrelated challenges. Governments need to set a national protocol and organize and train extensive networks of doctors and nurses at the local and national levels. They need to procure high quality drugs at affordable prices, ensure that they can be stored and distributed securely and efficiently, and outfit laboratories with equipment and supplies needed for diagnostic testing. They need to train health care workers who can educate patients about their treatment regimens and monitor their compliance. They need to recruit personnel who can properly administer the programs. Above all, establishing effective long-term programs requires strong and sustained political will and management systems that can oversee program implementation.

The Clinton HIV/AIDS Initiative supporters worked with governments to develop and implement operational business plans for large-scale comprehensive prevention and care treatment programs. The Clinton foundation also works with a number of international organizations such as the World Bank and the Global Fund to Fight AIDS as well as many donor nations including Canada, the United Kingdom and France. The foundation utilized the services of over 100 people, most of whom have volunteered their time or had their time volunteered for them by their companies and organizations. The volunteers include medical experts and business and management experts who can manage the leadership problems in developing countries in order to implement the initiative. To complement the leadership and health care volunteers, partnerships have been made with a number of leading institutions in HIV/AIDS care and treatment, which provide clinical expertise as care partners (Magaziner, 2004).

Bass (1985a, 1985b) presented a new approach to leadership transitions focused on shared values and follower development called values leadership, visionary leadership, or transformational leadership. His transformational leadership occurs when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of inspiration and morality. The leader is compelling and his or her charismatic personal qualities inspire others to support the leader's vision. Bass and Avolio (2000) suggested that transformational leadership identifies the importance of visioning, promoting shared values, shaping culture, role modeling, teaching, trusting, and empowering. Bass suggested that practicing transformational leadership would inspire followers to exert extra effort, to become self-led leaders, and to enhance their commitment to the common purpose.

Bass and Avolio (2000) described transformational leadership as augmenting leadership in terms of its impact on performance. Transformational leadership differs in terms of goals, skills, values, and competences. Leadership focuses on the development of the individual member and the importance of a transcendental purpose, the singleness of purpose, the dominance of an idea that inspires one to add enthusiastically his or her contribution to the whole. The appeals of the transformational leadership are interspersed with the balance of establishing expectations and satisfying agreed-upon contracts.

### **Findings Using the Transformational Leadership Theory**

In transformational leadership, findings support the concept that participative leadership, when balanced, can serve the needs of the follower (Kanter, 1979). Integrity and credibility earn the respect and trust of followers (Bennis & Nanus,

1985). Managers and leaders who possess the attributes of honesty, competence, vision, and inspiration have credibility (Kouzes & Posner, 1995). Charismatic leadership behaviors and attributes as rated by the leader, his or her subordinates, or independent observers are associated with effective follower performance and positive follower attitudes (Barling, Weber, & Kelloway, 1996; Bass & Avolio, 2000; Hater & Bass, 1988; Howell & Frost, 1989; Lowe, Kroeck, & Sivasubramanian, 1996; Podsakoff, Mackenzie, Moorman, & Fetter, 1990; Yammarino et al., 1998). Other researchers have associated transformational leadership with the follower's willingness to expend extra effort (Bass, 1985a; Bass, Waldman, Avolio, & Bebb, 1987; Lowe et al., 1996; Seltzer & Bass, 1990; Singer, 1985; Yammarino and Bass, 1990a, 1990b) and with the follower's satisfaction (Avolio, Yammarino, & Bass, 1991; Bass, 1985a; Hater & Bass; Seltzer & Bass; Singer; Yammarino & Bass, 1990a, 1990b; Yammarino & Dubinsky, 1994). One way to organize these findings is to focus around the organizational settings in which they were done. One of the key areas presented in the literature review is related to health care organizations.

The concept of transformational leadership in organizations encourages an increased effort in treating HIV/AIDS patients which is more complicated than simply dispensing pills. AIDS requires trained doctors, nurses, laboratory technicians, and community health workers. AIDS care also demands adequate systems for patient information, drug distribution, laboratory testing, and community outreach and counseling. In the clinical social work area, health care organizations have emphasized leadership characteristics and behavior as critical areas for social workers (Ezell, Menefee, & Patti, 1989; Gummer, 1997; Hansenfeld & Schmid, 1988; Jansson and Simmons,



1986; Malka, 1989; Wernet & Austin, 1991). Other researchers have expanded social worker training with transformational leadership practice in the clinical schools of social work (Bargal & Schmid, 1989; Brilliant, 1986; Malka, 1989; Patti, 1987).

Relevant literature informative to social work examines transformational leadership in teams and organizations (Bass, 1985a, 1985b; Bass & Avolio, 1994; Bennis & Nanus, 1985; Gummer, 1997). New strands of research in the health care organizational field have focused on transformational leadership (Bass, 1985a, 1985b) and related concepts of charismatic (Conger & Kanungo, 1988) and inspirational leadership (Bennis & Nanus, 1985) as well.

Gellis (2001) provided key research in the social work field of clinical health care organizations defining two types of leadership processes—transactional and transformational leadership—within social work practice. His model tested a sample of 187 clinical social workers employed in 26 hospitals. The results indicated that only one transactional factor and five transformational factors were significantly correlated with the leader outcomes of effectiveness, satisfaction, and extra effort. Such encouragement of innovation is thought to be associated with higher levels of job satisfaction. Gellis reported that the main findings of the study were the four transformational items used to measure satisfaction of organizational outcomes effectiveness: (a) meeting the job-related needs of social workers, (b) representing social work needs to higher level managers, (c) contributing to organizational effectiveness, and (d) performance by the leader's work group. Gellis' research showed that the extra effort scaled reflected the extent to which social workers worked beyond what was expected as a result of the leadership. Gellis found two transformational items used to measure

leader satisfaction reflected social workers' general satisfaction with the leader.

Bass and Avolio (2002) reported that many theories or concepts may have an impact on nursing and health care and other organizations. These theories can enable leaders in these areas to become real transformational leaders that manage people and processes effectively.

### **Summary**

This literature review has attempted to present information about articles, books, and journals that support Burns's (1978) and Bass's (1985) proposed transformational leadership theories. Theoretically, effective leadership uses a variety of strategies that are appropriate for situations (Kotter, 1985; Yukl, 1989). Burns (1978) described leadership as a process of inter-relationships in which leaders influence followers and are influenced to modify their behavior as they meet responsiveness or resistance. Today's transformational leaders who exercise power in an arrogant, manipulative and domineering manner are likely to endanger resistance to the social sensitivity and empathy required for understanding the need for HIV/AIDS awareness.

For example; five years after leaving office, Bill Clinton has shown AIDS activists the leadership they wanted to see during his presidency. They say he is using his celebrity clout and fund-raising prowess to fight AIDS around the globe as never before. He has negotiated deals with several major pharmaceutical companies to supply AIDS drugs at discounted prices to the Third World. He has sent policy experts to help countries deal with the outbreak. And he has steered hundreds of millions in private donations and contributions from governments to AIDS-stricken parts of the world — especially Africa, where the disease is rampant — for treatment and public education.

HIV/AIDS infections in the minority populations reflects a common cultural basis toward leadership in explaining HIV/AIDS awareness in terms of the rational actions of people, as opposed to uncontrollable natural forces, or actions of minorities that spread HIV/AIDS infections and contribute to the general decline of society. Looking at where people live, especially those who have sought and received HIV testing, it is important in that this doesn't represent everyone who is at risk or infected. Theoretically, effective leadership uses a variety of tactics that are appropriate for situations (Kotter, 1985; Yukl, 1989), and a myriad of reasons can contribute to why someone does not seek testing, including the level of understanding about risk behaviors, cultural/gender sensitivity of prevention messages, availability of testing sites, fear of

the results, confidentiality concerns, socioeconomic factors that may contribute to accessing health care in general, and lack of family or peer support. Future research of this theoretical study should be conducted as an empirical inquiry.

The literature examined leadership in a variety of classical and contemporary approaches that included the trait approach, behavior approach, power-influence approach, and the situational approach and how leadership researchers seem to have defined leadership according to their individual viewpoint and the aspect of leadership that interested them. Finally, the literature review attempted to extend the transformational leadership theory of the followers' willingness to expend extra effort in a variety of organizations that are inspired by transformational leaders.

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## *Research Note*

### **Legal Issues Impacting Individuals with HIV/AIDS**

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#### **Abstract**

Acquired Immune Deficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV) was first reported in the United States in 1981. Since that time, however, AIDS has quickly grown to become a major pandemic not just in the United States but globally as well. This epidemic has brought with it a multitude of legal issues and dilemmas for individuals with HIV/AIDS. For example, individuals with HIV/AIDS have been discriminated against, fired from their jobs, denied access to health care and life saving medications, excluded from schools, isolated socially and have had their privacy invaded. Fortunately, however, individuals with HIV/AIDS, like other individuals with a disability, are not without recourse. The United States has several laws in place to protect the rights of such individuals. Examples of these laws include Americans with Disabilities Act (ADA), Occupational Safety and Health Act (OSHA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), Family Medical Leave Act (FMLA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Fair Housing Amendments Act (FHAA), and Architectural Barriers Act (ABA). It is important to educate the individuals with HIV/AIDS about their legal rights under these laws. Additionally, it is important to educate individuals with HIV/AIDS about certain necessary legal documents such as the Last Will and Testament, Living Will, Guardianship and Custody, Powers of Attorney, Advanced Medical Directive, and Do Not Resuscitate Order that should be in place so that the rights and wishes of the individuals with HIV/AIDS are legally protected.

Acquired Immune Deficiency Syndrome (AIDS), which is caused by the Human Immunodeficiency Virus (HIV), was first reported in the United States in 1981. Since that time, however, AIDS has fast become a major epidemic not just in the United States but globally as well.

According to the World Health Organization, there were an estimated 37.2 million adults and 2.2 million children living with HIV/AIDS worldwide at the end of 2004 (1). It is often said that when you laugh, the world laughs with you; however, when you cry, you usually cry alone. Such was

the saga of individuals inflicted with HIV/AIDS worldwide from the time the disease was first discovered. The fear of contracting the disease by social contact drove employers, business owners, neighbors, friends, and even family members to condemn the individual with HIV/AIDS to isolation and discrimination.

Numerous legal issues and dilemmas thus accompany this epidemic for individuals with HIV/AIDS both in the employment arena and socially as well. For example, individuals with HIV/AIDS have been discriminated against, fired from their jobs, denied access to health care and life saving medications, excluded from schools, isolated socially and had their privacy invaded. Fortunately, however, the approximately 1.5 million individuals with HIV/AIDS living in the United States are not without recourse (2). This is because in 1998 the U.S. Supreme Court for the first time recognized (to be discussed in more detail later) that for all practical purposes, any asymptomatic individual with HIV is an individual with a disability (3). Thus, individuals with HIV/AIDS could seek legal recourse under the laws designed to protect the disabled.

The United States has several laws in place to aid individuals with disabilities such as individuals with HIV/AIDS to combat environmental discriminatory practices. Examples of these laws include Americans with Disabilities Act (ADA), Rehabilitation Act (RA), Occupational Safety and Health Act (OSHA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), Family Medical Leave Act (FMLA), Consolidated Omnibus Budget Reconciliation Act (COBRA) Fair Housing Amendments Act (FHAA), and Architectural Barriers Act (ABA) that may be used to aid individuals with HIV/AIDS in seeking legal recourse against **workplace-related** and **societal** injustice. However, it is important to edu-

cate the individuals with HIV/AIDS about their legal rights under these laws. Additionally, it is important to educate the individuals with HIV/AIDS about the necessary legal documents such as Powers of Attorney, Last Will and Testament, Living Will, Advanced Medical Directive, and Do Not Resuscitate Orders that must also be in place so that their rights and wishes are legally enforceable.

Discrimination against individuals with HIV/AIDS occurs whether or not their symptoms are outwardly manifested. Employment-related discrimination prevalent in the workplace is evident in all types of work settings such as offices, factories, stores, and other job sites. Specific examples of workplace discriminatory practices include qualified applicants/employees being unable to secure job interviews or receive job offers and/or receive eligible promotions, raises, or certain employment-related benefits. However, administrators in the workplace must make every effort to respect the rights of individuals with HIV/AIDS for reasons discussed below.

### **Workplace Discrimination**

In the 21st century, more HIV positive individuals are becoming part of the work force. This is because 80% of the 1.5 million reported cases of HIV/AIDS in the U.S. are within the working age group of 25-54 (3). Also, as more effective drug therapies are being discovered, HIV positive individuals are not only living longer but are also experiencing a better quality of life. As a result, more HIV positive workers are returning to the workforce and desiring to stay productive for longer periods of time. However, these individuals with HIV/AIDS may have reduced work capacities or other associated disabilities and find themselves becoming subjects of employment related discriminatory practices in areas such as hiring,



firing, job interviews, medical examinations, job assignments, training and promotion, wage benefits such as health insurance, and leave assignments. As recourse against such discriminatory employment practices for individuals with HIV/AIDS and other disabilities, the federal government enacted several laws such as the Americans with Disabilities Act of 1990 (ADA), Rehabilitation Act of 1973 (RA), Occupational Safety and Health Act of 1970 (OSHA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), Family Medical Leave Act of 1993 (FMLA) and Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

In the paragraphs that follow each of the above stated laws, together with examples of prohibited employer acts and permitted employer acts where applicable, is discussed in some detail.

#### **Americans with Disabilities Act (ADA)**

Americans with Disabilities Act of 1990 (ADA) codified as 42 U.S.C. Sections 12101-12213 (Title I–IV), prohibits certain private employers, state and local governments, employment agencies and labor unions from discriminating against disabled individuals in

- employment (Title I)
- state and local government services (Title II)
- transportation (Title II)
- public accommodations (Title III)
- telecommunications (Title IV) [4][5].

Title I of ADA specifically addresses employment-related issues and applies to employers with more than 25 employees as of July 26, 1992, and is also applicable to employers with more than 15 employees as of July 26, 1994 (6). Where applicable, Title I of ADA protects employees, applicants for employment, and individu-

als who have a known relationship or association with an individual with a disability (7). That is, under Title I of ADA, employers, employment agencies, labor organizations and labor-management committees are prohibited from discriminating against a **qualified individual with a disability** on the basis of the disability in hiring, firing, training, promoting, compensating, and providing other employee privileges (8).

ADA defines a qualified individual with a disability as an individual who has a record of, or is considered as having a physical or mental impairment that substantially limits the individual's ability to perform one or more major life activities and who can perform the essential job functions as defined by the employer with or without **reasonable accommodation** on the part of the employer (9, 10). Examples of areas where an employer can make reasonable accommodation to enable the qualified individual with a disability to function within the work environment include making facilities accessible and usable, restructuring the job, modifying the work schedule, reassigning the employee to a vacant position for which the employee is qualified, adjusting/modifying/acquiring equipment, devices, training materials, examinations, and providing interpreters (9, 10). Specific examples of prohibited employer acts and permitted employer acts under Title I are presented in Table 1 below (11).

It is important to note, however, that an employer is required to provide reasonable accommodation only if the disability of the qualified applicant or employee is known to the employer. The employer may become informed either through the employee's/applicant's asking for accommodation to be made or if the employee's/applicant's disability is such that it impairs the employee's ability to ask the employer for an accommodation but the accommodation is obvious to the

**Table 1**

<b>Number</b>	<b>Prohibited Employer Acts</b>	<b>Permitted Employer Acts</b>
1	<ul style="list-style-type: none"> <li>• Cannot reject applicant because of disability. For example, cannot refuse to hire or retain an individual with HIV/AIDS unless               <ol style="list-style-type: none"> <li>i. the individual poses a direct threat; and</li> <li>ii. the individual can cause substantial harm. HIV will rarely ever qualify as a direct threat since its mode of transmission is through certain body fluids and not casual contact.</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Can select the most qualified applicant</li> </ul>
2	<ul style="list-style-type: none"> <li>• Cannot require applicant to take a pre-job offer medical exam</li> </ul>	<ul style="list-style-type: none"> <li>• Can inquire pre-employment into applicant's ability to perform essential job functions.</li> <li>• Can require a post-job offer medical exam if all entering employees for particular job category are subjected to taking the same medical exam, and</li> <li>• Post-employment medical exams can be required only if they are work related and a business necessity, e.g., to determine fitness to perform a particular job; or safety on the job.</li> </ul>
3	<ul style="list-style-type: none"> <li>• If post-job offer exam reveals disability, cannot deny employment unless reason for denial is:               <ol style="list-style-type: none"> <li>i. work related;</li> <li>ii. related to business necessity; and</li> <li>iii. no reasonable accommodation is available</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Can require an employee with a disability to maintain the same standard for performance or production in essential job functions as other similarly situated employees with disabilities with/without reasonable accommodation.</li> </ul>
4	<ul style="list-style-type: none"> <li>• Cannot keep medical information in general personnel files.</li> </ul>	<ul style="list-style-type: none"> <li>• Medical information must be kept separate and confidential.</li> </ul>
5	<ul style="list-style-type: none"> <li>• Cannot discriminate when providing health insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Must offer same health insurance coverage to all employees regardless of disability</li> </ul>

employer; and the accommodation does not impose an *undue hardship* on the employer's business (12,13).

For further clarity, ADA defines "undue hardship" to be an action that would require a *significant amount* of expenditure or difficulty in implementation (12, 13). However, the ADA does not clearly state what is regarded as a significant amount by the federal government. Instead the ADA states that the determination of whether an expenditure may be regarded as a significant amount for a particular employer will depend upon the nature and cost of the accommodation needed vs. size of the employer's organization, resources available to the employer, nature of the employer's business; and the structure of the employer's operations (12,13).

An employer, however, is not required to make accommodations to existing facilities unless the employer has an applicant or employee with a disability, and even then the employer is only required to make those accommodations that would be necessary for the particular individual to perform the job. In the event of non-compliance by the employer, an employee/applicant must file a Title I complaint against the employer either with the Equal Employment Opportunity Commission (EEOC) within 180 days of the date of alleged discrimination or with a designated state or local fair employment practice agency within 300 days of the date of alleged discrimination if the alleged discrimination is also covered by a state or local discrimination law (14, 15). Further, an individual may file a lawsuit in Federal Court against an employer for alleged discriminatory practices but only after the individual has gone through the procedural process with the EEOC and is given a "right-to-sue-letter" by the EEOC (14,15).

It is important to note, however, that certain organizations such as private

membership clubs that are tax exempt under Section 501 (c) of Title 26 of the Internal Revenue Code are excluded from being bound by Title I provisions even if these employers have 15 or more employees (16). Examples of a private membership club include a religious foundation, charitable trust, scientific organization, or public safety organization (16). Additionally, employers such as the United States (U.S.) Government or any corporations that are wholly owned by the U.S. Government are also excluded from being bound by Title I provisions even if these employers have 15 or more employees (16). This is because government entities are bound under another federal law, the Rehabilitation Act as follows.

#### **Rehabilitation Act (RA)**

To address discrimination issues arising among government employees, the federal government promulgated the Rehabilitation Act (RA), which is the federally applicable counterpart to the ADA and is codified as 29 U.S.C. Sections 791,et. seq. The RA follows the same standards as the ADA and prohibits all federal agency programs, all programs receiving federal dollars and all federal employers including federal contractors from discriminating against individuals with a disability in employment situations (17).

In addition to drafting laws and regulations on the global issue of disability, the federal government also enacted several laws to address certain specific areas of potential abuse by employers. An example is a law that addresses unsafe employee working environments such as the Occupational Safety and Health Standards Act of 1970.

### **The Occupational Safety and Health Standards Act of 1970 (OSHA)**

The Occupational Safety and Health Standards Act of 1970 (OSHA), codified as 29 U.S.C. section 652 et. seq., was designed to protect workers from workplace exposure to HIV and hepatitis by providing blood borne pathogens standards. To remain compliant under this act, employers must provide a workplace that is free from serious recognized hazards and conform to applicable OSHA standards. The OSHA standards require an employer to make sure employees have and use safe tools and that work equipment is properly maintained. OSHA also mandates that employers establish and update safety and health policies, communicate the established and updated policies to the employees and refrain from discriminating against employees who exercise their rights under OSHA (18).

As an example of compliance with OSHA, an employer may need to formulate and implement an exposure control plan such as providing employees with protective clothing and puncture-proof receptacles for tainted needles and other medical wastes, implementing a Hepatitis B vaccination program for employees, providing employees with information and training regarding workplace hazards, and documenting and keeping records of any exposure to incidents (18). Thus, under OSHA standards, individuals with HIV/AIDS who have a compromised immune system may thus have a better chance of maintaining gainful employment by not having to be exposed to hazardous chemicals and substances that may impair their health further.

Another area of concern for the federal government was inaccessible/unaffordable employee health insurance coverage and unrestricted disclosure of patient information. To address this issue, the federal government formulated

the Health Insurance Portability and Accountability Act of 1996.

### **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Another federal statute in the employment arena that has potential applicability for individuals with HIV/AIDS is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA addresses barriers for vulnerable populations such as the HIV/AIDS individual population relating to healthcare coverage and job mobility. The main employment related goals under HIPAA are to provide protection against discrimination to individuals with group coverage, enable small group employers to acquire and maintain health insurance more easily and provide individuals who transfer/drop out of group coverage with new options to get individual coverage. Specific examples for employers regarding achievement of the above stated HIPAA goals include

- limiting how the employer can use pre-existing condition exclusions
- not permitting a group health plan to deny coverage to an employee or charge the employee additional fees because the employee is or has a family member with past or present poor health
- guaranteeing individuals who have lost their insurance through their employer the right to purchase individual health insurance
- guaranteeing employers or individuals who purchase health insurance in most cases, the ability to renew the health insurance policy regardless of the health status of the employees or individuals that are covered under the insurance policy (18).

In addition to employers, health care entities providing care to patients such as

individuals with HIV/AIDS are also subject to HIPAA regulations and are required to maintain patient confidentiality by notifying patients regarding their privacy rights and how their medical information may be used. HIPAA also requires the health care entities to obtain patient authorization prior to disclosure of patient information, secure patient records that contain patient identifiable health information so as to limit accessibility to the public not in need of records, and adopt and implement privacy procedures for the health care institution, or plan (19,20). As a result, under HIPAA individuals with HIV/AIDS are more informed and have more control over their health information and how their information may be/has been used and disclosed by the health care entity (19, 20). It also provides the individuals with HIV/AIDS with the right to examine and obtain a copy of the patient's health records and request corrections to the records (19, 20).

In addition to addressing confidentiality of patient records and information and ensuring availability of renewable health insurance coverage during employment regardless of medical condition, the federal government also addressed an employee's inability to request extended medical leave to care for self or family member through enactment of the Family Medical Leave Assistance Act of 1993.

#### **Family Medical Leave Assistance Act of 1993 (FMLA)**

Another statute of significance for the HIV/AIDS individual is the Family Medical Leave Assistance Act of 1993 (FMLA Public Law 103-3). FMLA applies to all private employers who have at least 50 employees within a radius of 75 miles from the work place. Under FMLA, eligible employees can take leave up to 12 weeks/12-month period to attend to a serious health condition or to provide care to

an immediate family member who has a serious health condition—such as HIV/AIDS (21, 22). The FMLA leave is generally unpaid; however, during the FMLA leave the employee's job is protected. When employees returns to work, the employee must be reassigned to the same or equivalent position with the same or equivalent pay, benefits, and working conditions. Also, the employee can continue his/her group health insurance while on leave. However, FMLA will only become applicable if individuals with HIV or AIDS are willing to disclose their medical information to the employer, as employers are not required to provide unpaid medical leave under FMLA if they are not informed that a disability or serious health condition such as HIV/AIDS exists (21,22).

Another issue that is a major area of concern for an employee at the end of his/her term of employment is the possibility of denial of insurance coverage following employment termination due to employee's medical condition. The federal government enacted the Consolidated Omnibus Budget Reconciliation Act of 1986 to address this very issue as discussed below.

#### **Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)**

Individuals with HIV/AIDS along with individuals with other debilitating long term medical conditions were often faced with gaps in insurance protection following termination of employment. These lapses in insurance protection were due to denial of coverage by insurance carriers secondary to the individual's medical condition. The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) was thus enacted to address this very issue. Under COBRA employees are permitted to continue their health insurance for a *certain period of*

*time* even after termination of employment. However, employees are required to pay for this coverage and the period of time varies based on the event leading to loss of employment as follows:

- 18 months, if employment is terminated
- 18 to 29 months, if the employee has a disability
- 18 months, if the employee changes employment status from full-time to part-time employment with subsequent loss of benefits including insurance
- 36 months, in the event of divorce or legal separation from covered employee
- Indefinite coverage, for eligible spouse and dependents up to age 23 in the event of death of covered employee (23).

Other examples of medical benefits under COBRA for individuals with HIV/AIDS may include insurance coverage for hospital visits -- inpatient and outpatient, doctor visits, surgery, prescription drugs, and other major medical benefits such as dental and vision care. The employer is required to give employees notice of their right to continue their insurance coverage and, upon notice, employees must accept coverage within 60 days or lose their right to receive continued insurance coverage (23).

In addition to suffering employment-related discriminatory practices in the workplace, the individual with a disability such as an individual with HIV/AIDS may also face societal discrimination. Societal discriminatory practices are evident in public areas such as public accommodations, restaurants/retail stores, health clubs, gymnasiums, physician offices, private schools, and day care centers.

Specific examples of societal discriminatory practices include the public property's being physically inaccessible or unusable by individuals with a disability due to lack of available parking spaces for handicapped vehicles, absence of wheelchair access to public property, absence of elevators in multiple story buildings, and absence of handicapped accessible restrooms, corridors, water fountains, and telephone booths. However, the days of ignoring the disabled are long gone and owners and operators of public facilities are cautioned to make every effort to respect the rights of individuals with a disability such as individuals with HIV/AIDS for reasons discussed below.

### **Societal Discrimination**

Societal discrimination against individuals with HIV/AIDS takes a double toll on these individuals. In the more obvious scenario, individuals with HIV/AIDS over the course of their disease process may develop decreased strength and decreased endurance which may cause these individuals to have difficulty climbing stairs, walking extended distances, and using the public restroom and other facilities. As a result, individuals with HIV/AIDS like other individuals with disabilities may be unable to have access to and enjoy public facilities unless certain modifications and adaptations are made to existing public accommodations.

Further, many businesses in the community may attempt to deny services to individuals with HIV/AIDS just because the individuals have a diagnosis of HIV/AIDS and regardless of whether their symptoms are outwardly manifested. As a result, reactions of the owners of such businesses in the community to the individual with HIV/AIDS may cause the individual to feel as though he/she is disabled even if the individual has no physical disability because of the disease. This

creates mental stress for such individuals who see themselves being treated as lepers or outcasts in their own communities.

A classic example of this is evident in the case of *Abbott v. Bragdon*, a lawsuit filed by Sidney Abbott against her dentist, Dr. Random Bragdon. Sidney Abbott needed a tooth filled by her dentist, Dr. Random Bragdon of Bangor, Maine. Dr. Bragdon, however, refused to perform the tooth filling as an office procedure when he discovered that Ms. Abbott was HIV positive (25). Instead Dr. Bragdon suggested doing the procedure in a hospital setting, which meant incremental costs for Ms. Abbott (25). Ms. Abbott filed suit of discrimination and alleged that since she was a disabled individual, Dr. Bragdon by refusing to treat her in his office, was in violation of the ADA (25). Ms. Abbott based her claim to being disabled on the language in the ADA which states that individuals with "a physical or mental impairment that substantially limited *one or more of the major life activities*" of individuals "regarded as having such an impairment" are to be considered as being disabled (25). Ms. Abbott reasoned that because of her HIV positive status she is unable to have children and hence unable to enjoy one of life's major activities and is therefore "disabled" (25).

The U.S. Court of Appeals held that Ms. Abbott is disabled because her HIV status prevented her from having children (26). Further, the court held that Ms. Abbott's request for treatment in Dr. Bragdon's office was appropriate as the treatment did not pose any "direct threat" to Dr. Bragdon (26). Dr. Bragdon appealed to the U.S. Supreme Court. The U.S. Supreme Court in 1998 also held that HIV-infected individuals are protected by the federal ban on discrimination against the disabled, even if they suffer no symptoms of AIDS (3,27). However, the U.S. Supreme Court added that the First Circuit Court of Appeals had not investigated the

issue of whether treating Ms. Abbott in Dr. Bragdon's clinic would pose any significant health and safety risk to Dr. Bragdon. Therefore, the U.S. Supreme Court remanded the case back to the circuit court, which in turn affirmed that with the availability and use of universal precautions now, HIV/AIDS individuals do not pose a direct threat to the health and safety of others (27). Thus, such individuals are protected under the ADA, which is the landmark federal law for prohibition against discrimination in jobs, housing, medical care, and other businesses that serve the public.

The federal law ADA mandates that all individuals, including individuals with a disability, must be given an equal opportunity to enjoy public goods, services and facilities. Thus, under Title III of ADA, service providers are prohibited from refusing service to individuals with disability such as HIV/AIDS in facilities open to the public. Examples of facilities open to the public are restaurants, retail stores, health clubs, gymnasiums, private schools, day care centers, physician offices, health care facilities, movie theaters, convention centers, homeless shelters, adoption agencies, and social service facilities (28). Additionally, ADA requires that public accommodations be made accessible to individuals with a disability if the accommodation can be made with ease and is not too costly (28). However, the federal government, in an effort to ensure that fair housing requirements were being enforced and civil rights protections were made available to families with children and persons with disabilities, also enacted the Fair Housing Amendments Act as follows.

#### **Fair Housing Amendments Act of 1988 (FHAA)**

The FHAA is codified as 42 U.S.C. Sections 3601, et. seq., and prohibits

owners of private housing, owners of housing receiving federal funds, and state and local government housing from discriminating against individuals with a disability such as HIV/AIDS with respect to housing issues such as selling, renting, buying, financing, zoning practices, and designing new property (29). FHAA made it unlawful to discriminate in selling or renting homes, defining terms, conditions, or services or providing facilities to individuals based on the individual's disability or family status (30). FHAA instituted seven design standards for all newly constructed multi-family housing of four or more units that were ready for first occupancy on or after March 13, 1991 (31). Thus, like the ADA, the FHAA requires owners to make reasonable accommodations to their property so as to make the property accessible to individuals with a disability. Examples of accommodations that may be needed by individuals with HIV/AIDS include easy-opening doors, wider doors to provide scooter/wheelchair access, larger rooms to provide wheelchair turning space, ramps at entrances of housing complexes, grab bars in bathrooms, elevators in public multi-story housing complexes and marked parking spaces in the parking lot. Also, property owners cannot refuse to rent property to HIV positive individuals because HIV/AIDS generally does not pose a direct threat to anyone in a public accommodation.

Another protection available under the FHAA is the right of an individual with a disability to request permission to make reasonable modifications to the facility at his/her expense if such modification is necessary to permit full use and enjoyment of the premises by the individual with the disability (31), provided the individual with the disability also agrees to return the facility to its original state upon leaving the facility (31). Complaints of violations of FHAA are required to be

filed with the Office of Fair Housing and Urban Development within one year or to initiate a federal lawsuit with two years (32).

If however, the federal government is involved in either funding or occupying a facility open to the public then the applicable statute with respect to public accommodations is the Architectural Barriers Act.

### **Architectural Barriers Act of 1968 (ABA)**

The Architectural Barriers Act of 1968 (ABA) codified as 42 U.S.C. Sections 4151 et. seq. prohibits owners of structures that are either designed, constructed, or altered with federal funding or leased by a federal agency to make their structures physically accessible as per federal standards (33). An example of a type of facility subject to the ABA regulations is the U.S. postal service facilities. If the U.S. postal facility has only steps to access its building then the building would not be accessible to a wheelchair bound individual. As a result, the particular U.S. postal facility in question would be out of compliance with the ABA. Complaints for ABA violations against the U.S. postal facility could then be filed with the U.S. Architectural and Transportation Barriers Compliance Board ("Board"). The Board is charged with conducting an investigation into the complaint and if the complaint is valid, the Board has the authority to mandate compliance, impose penalty, and pursue legal action to gain compliance (33, 34).

Serious illness and death are outcomes that are often forgotten when one is trying to cope with the day-to-day battles of being an individual with HIV/AIDS. However, since these may be the inevitable realities of life, individuals with HIV/AIDS must be proactive in planning for the future. This plan includes making



certain legal arrangements as discussed below so that the future needs of the individual with HIV/AIDS and loved ones are taken care of.

### **Legal Documents**

In addition to the federal government's enforcing laws to protect the legal rights of individuals in the workplace and public areas, individuals should also take steps to protect their own legal rights. The first step in protecting ones legal rights is to ensure that legal documents such as the ones listed below are completed in a timely manner:

- A. Powers of Attorney
- B. Last Will and Testament
- C. Living Will/ Advanced Medical Directive
- D. Do Not Resuscitate Order.

### **Powers of Attorney**

With the progression of the disease process, there may come a point when the HIV/AIDS individual may be unable to take care of legal, business and financial issues. In such a situation, the law permits the individual (Grantor/Principal) to grant power to another individual (Agent/Attorney-in-fact) to act on his/her behalf in handling the individual's legal, business and financial matters through the execution of a legal document called the Power of Attorney (POA) document. Once executed, the Attorney-in-fact has the authority to sign legal, business and financial documents on behalf of the Principal, make asset management decisions such as buying/selling property, managing bank accounts, and making other business decisions. However, the individual with HIV/AIDS must be competent at the time of assigning the POA, which must be signed before a notary. Additionally, the POA will be effective

only so long as the individual is not incapacitated unless the grant is written as a durable power of attorney (DPOA), which in some jurisdictions may be used as a living will. However, the DPOA will become ineffective at death, revocation, or court order (35).

Moreover, the grant may be written as a springing power of attorney wherein the POA only becomes effective when the HIV/AIDS individuals become incapacitated. This enables the HIV/AIDS individual to have control of all decision making up to the point of incapacitation. Regardless of whether the POA is general, durable or springing, the HIV/AIDS individual has the authority to revoke the grant at any time unless the POA was legally made irrevocable by its own terms or by some legal principle (36).

### **Last Will and Testament**

In the event of death of an HIV/AIDS individual who does not have a written will, a court will makes decisions regarding who will be the beneficiaries of the assets of the deceased individual. More importantly, the court will also be the authority to assign guardians for the individual's children, if any, based on state law. In most cases, the next of kin stands to inherit everything. Next of kin is generally defined as a legal spouse, or blood relative such as parents, grandparents, children, siblings, uncles, aunts, nieces, and nephews (37). However, if the HIV/AIDS individual does not want the above named next of kin to be his/her beneficiaries or would like to appoint someone else as a guardian for minor children, then the HIV/AIDS individual must have a last will and testament document in place. The Last Will and Testament is a tool designed to provide an individual with HIV/AIDS an opportunity to state beneficiaries of his/her assets after death and state guardianship preferences for minor children

(27). To be complete however, this document should include detailed information such as the following:

- Name and address
- Listing of all assets—briefly describe each asset
- Listing of beneficiaries—include relationship
- Listing of alternate beneficiaries
- Listing of any gifts to be given with names of recipients
- Establishment of a Trust if desired [may decrease taxes]
- Acknowledgment to cancel all debts owed to individual if desired
- Named Executor to manage the individual's estate
- Guardian's name for minor children—individual vs. couple
- Alternate guardian's name
- Signed
- Witnessed—# varies/state but cannot be beneficiary. (37)

The Executor named in the will must be selected with great care as he/she is the most essential component to successful implementation of the deceased's wishes. The Executor of the will bears several responsibilities such as paying creditors, paying taxes (federal and state income taxes, and federal estate tax for estates over \$ 600,000), distributing assets according to the will, informing Social Security office and other agencies regarding the individual's death, canceling the deceased's credit cards, and carrying out the deceased's funeral and burial wishes (37).

Once drafted, the Last Will and Testament should be updated any time there is a significant change in conditions, for example acquisition of new assets, birth or adoption of new child, marriage, divorce, and death. The update may be accomplished in one of two ways, that is, either by writing a codicil (supplement written following the same formalities as the

original will) or by drafting a new will. Once completed, the Last Will and Testament should be stored in a safe but accessible place. As stated earlier, the Last Will and Testament provides an individual the opportunity to state beneficiaries of his/her assets after their death and state guardianship preferences for minor children. It is not designed to provide the individual an opportunity to state his/her desires regarding medical decision making prior to death. To do this, the individual must have executed a living will discussed below.

### **Living Will**

The Living Will is also referred to as a medical directive or advanced health care directive. It is similar to a healthcare proxy. The Living Will is a written document in which the individual with HIV/AIDS may state his/her wishes regarding desired life sustaining measures or other medical treatments and health care related decisions, and appoint someone to carry out stated wishes in the event the HIV/AIDS individual is unable to make those decisions. The Living Will must be executed in the presence of a witness and must be stored in a safe but accessible place.

Once executed, the Living Will becomes effective only when the individual's physician determines that the HIV/AIDS individual is unable to make the above stated decisions (38,39). However, in the event an individual with HIV/AIDS is admitted to a medical facility without a Living Will, the medical facility may request a Do Not Resuscitate Order to be placed in such individual's medical record for reasons stated below.

### **Do Not Resuscitate ("DNR") Order**

In the event of hospitalization of the terminally ill HIV/AIDS individual, the

individual may not wish to prolong suffering and may desire to experience a more natural demise without painful or invasive medical procedures. In such cases, the admitting medical facility provides the terminally ill HIV/AIDS individual, or the named individual on the Living Will, advance directive of the HIV/AIDS individual or someone entitled to make decisions on behalf of the HIV/AIDS individual such as a health proxy, the option of executing a DNR Order in conjunction with the individual's physician. (40). The DNR Order also known as a No-Code Order is a written order from a physician stating that resuscitation should not be attempted on the HIV/AIDS individual in the event of cardiac or respiratory arrest. It may be noted that in some jurisdictions the DNR Order may also be instituted solely on the physician's initiative if resuscitation would not alter the ultimate outcome of the illness. It is important to note that absence of a DNR Order is a presumption of consent to be resuscitated (40).

Thus, in this current day and age, for the individual with HIV/AIDS to have quality of life, the individual must, in addition to addressing the medical aspect of the HIV/AIDS pandemic, also address its legal aspects. Individuals with HIV/AIDS must therefore become well-informed of their legal rights so that they are not intimidated by the U.S. legal system and can confidently navigate their way to seeking the correct legal recourse against any societal injustice occurring either in the employment arena or other non-employment related areas. Also, individuals with HIV/AIDS must learn to use the wide array of legal documents discussed above so that their rights and wishes can be legally enforced if they become incapacitated or die. They can be assured then that their wishes will be carried out.

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## *Research Note*

# **Urban Poverty Management in Nigeria: A Critique of the National Poverty Eradication Program in Surulere, Lagos, Nigeria**

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### **Abstract**

Poverty is a very serious problem in Nigeria today. It is a cancer that has eaten deep into the framework of society and has become increasingly disturbing to successive administrations. In fact, various policies and programs aimed at reducing this scourge have been formulated and implemented by government and many non-governmental organizations over time. Unfortunately, most of them have met with repeated failure. This study examines the impact of one of such government-sponsored initiatives –The National Poverty Eradication Program (NAPEP)– in ameliorating the plight of the urban poor in Surulere Local Government Area of Metropolitan Lagos. The study reveals that NAPEP, though lofty at conception, is not achieving its objectives because the program is not being effectively implemented. It was discovered that the program is highly politicized; hence politicians, rather than the poor, are the major beneficiaries. Furthermore, program monitoring is virtually non-existent. The study also reveals that while government efforts are laudable, non-governmental organizations and community-based efforts are more effective in poverty alleviation, especially at the grassroots. The paper concludes by suggesting pragmatic strategies for achieving effective poverty control. These strategies fall within the framework of sustainable urban development and include applying the norms of urban governance to poverty alleviation.

### **Introduction**

Poverty in Nigerian cities is endemic. While available statistics put the national poverty level at 65.6% as of 1996, a number of real indicators show that the

current poverty level is actually higher than that. Jimoh (1997) claims that 8 out of every 10 urban households are poor. Urban poverty implies not only poor income, few material assets, and low quality of life but also poor diets, poor

environment, poor physical health, and immense psychological stress arising from the need to survive. Moreover, social and political disadvantages are synonymous with poverty.

The Nigerian government has, at various times since independence, implemented at its three tiers of various policies and programs aimed at achieving economic growth and the reduction of poverty. In fact, prior to May 1999, at the federal level there were 15 core ministries and 30 core institutions, agencies and programs, each independently addressing poverty issues in Nigeria. These programs have met with varying degrees of success. In 2000, the federal government introduced the Poverty Alleviation Program. Its failure led to the establishment of the National Poverty Eradication Program (NAPEP) in January 2001 as a comprehensive program for the management and control of absolute poverty.

Many studies have been carried out on urban poverty in Nigeria. While, Ogundele (2000) asserts that government-sponsored poverty reduction programs usually benefit the executors rather than the indigent masses, Olanrewaju and Okoko (2000) posit that effective poverty alleviation can be only achieved through the empowerment of the poor to initiate, design, execute and manage their own priorities.

It is in light of these findings that this paper seeks to inquire into the impact of NAPEP as an instrument of poverty reduction in the lives of the urban poor residents of Surulere Local Government Area of Metropolitan Lagos.

In order to sharpen the focus of the enquiry, the paper looks into the concept of urban poverty, and traces the incidence of poverty in Nigeria and government's various attempts at its alleviation over the past thirty years before embarking on an in-depth study of the impact of NAPEP in

Surulere. Surulere is presented as a case study because many of the communities located therein have been identified as blighted areas in metropolitan Lagos since 1984.

### **What Is Urban Poverty?**

Poverty can be said to refer to specific forms and levels of deprivation which impose major limitations on normal human functioning and existence (Akinyele, 1994). Poverty is inseparably linked to lack of control over resources including land, skills, knowledge, capital and social connections (United Nations, 1996).

Poverty is a major factor in urban congestion and environmental degradation. It is an enormous threat to the political stability, social cohesion and environmental balance of our cities, and until it is tackled decisively, sustainable urban development will remain a mirage. It results from the interplay of many factors. For example, the socio-economic circumstances brought about by rapid urbanization, inappropriate development policies, marginalization and natural disasters push more people into unemployment and underemployment that in turn results in low earning power. This fuels food insecurity and malnutrition and later manifests itself as poor health and housing, which further compounds the poverty problem and manifests itself in unnecessary aggression, deviant behavior and crime.

The Christian Michelson Institute in 1998 argued that efforts at reducing urban poverty must take into account the quadruplet issues of livelihood, resources, knowledge and rights of the urban poor. Livelihood represents the current condition of individuals and households and the means by which they reproduce themselves. Resources represent access to assets such as markets, labor, land and



basic services. Knowledge is also a resource and an important dimension of poverty, while rights include formal, traditional, civil and political rights. In this multi-dimensional framework, poverty reduction addresses not only improvements in livelihoods but also improvement in access to resources, expansion of knowledge and increased empowerment

### **Methodology**

Both primary and secondary sources of information were used in this study. Primary data were obtained by direct observation and informal interviews with some stakeholders involved in both PAP and NAPEP. These stakeholders include beneficiaries and trainers of the programs, local politicians and residents of Surulere. Secondary data were extracted from published and unpublished sources, especially the NAPEP database and handbooks

### **The Study Area**

This research is set within the Surulere Local Government Area of Lagos Metropolis. Surulere was chosen because minimal research has been carried out there, hence the non-availability of literature on poverty in Surulere. Furthermore, it presents an interesting mix of both low and middle-income earners residing together.

Surulere is located in the western part of the metropolis. According to the 1991 census, Surulere has a population of 462,261. Geo-politically, it is made up of two constituencies of six wards each. The spatial distribution of the population is related to the level of economic development.

Constituency 1, also called New Lagos, came about in 1952 when it was made a resettlement center for the

displaced of Oko Awo in Central Lagos. It is made up of the planned residential areas of Akinhanmi/ Cole (ward E), Shitta/ Akerele, Ogunlana Drive and environs (ward G1), Tejuosho/ Ojuelegba and environs (ward F1), Stadium/ Gbaja (ward F2), Adeniran Ogunsanya and Adelabu Streets (ward G2), Bode Thomas, and Iponri and Iganmu industrial estates (ward G3). Constituency 1 is made up of mixed land uses including residences, industries, commercial concerns and government facilities. While parts of ward G1, wards G2 and G3 still remain planned and home to middle-income earners, the other wards are overpopulated and can be termed slum settlements. Wards E, F1 and F2 were identified as blighted areas as far back as 1984. Social and technical infrastructure facilities are available within Constituency 1 though they are grossly inadequate, especially in the densely populated areas of Shitta, Ojuelegba and Tejuosho

Constituency 2 is made up of the unplanned and densely populated geo-political wards of Coker, Orile Iganmu, Aguda, Ikate, Ijeshatedo, and Itire. In fact, all the communities located in Constituency 2 were identified as blighted areas (Ogundele, 2000). The inhabitants are multi-ethnic migrants. They exhibit the major indicators of urban poverty. Basic infrastructure facilities are unavailable and the area is prone to flooding especially during the rainy season.

### **Urban Poverty in Nigeria: An Overview**

Nigeria as a nation is blessed with abundant human and natural resources. Paradoxically, the national poverty level does not reflect this. In fact, the country has the largest number of poverty alleviation agencies, institutions, programs and policies in Africa, yet its poverty profile keeps growing. Urban

poverty, in particular, has been exacerbated in Nigeria by low levels of social development resulting from corruption, misallocation of funds, poor investment habits, poor family planning habits, minimum wage laws and declining life expectancy. Based on the *World Bank Poverty Assessment of Nigeria* (1996), the changes in the economy and poverty since 1970 could be summarized as follows :

1. **1970 – 1979:** With the first oil shock of 1973, there was dramatic positive impact on most economic indicators. Though the era was replete with gross misallocation and waste of resources, real per capita income rose sharply and steadily until 1977 and remained constant till 1980. The rapid expansion of social services contributed to the overall improvement in welfare for many Nigerian families. Employment opportunities increased sharply in urban areas; hence, there was a massive migration from rural areas. There was only a relative reduction in national poverty as 18 million Nigerians (28.1% of the total population) fell below the poverty line at the end of this period.

2. **1980 – 1985:** In this period, there was a clear deterioration in welfare and a corresponding increase in poverty. Average per capita and real incomes in both the agricultural and non-agricultural sectors fell. This was due to the collapse of the oil market. By this time, Nigeria was a mono-product economy depending mainly on proceeds from crude oil sales. Government policies at this period favored importation, which resulted in negative growth in the non-oil sector; hence, there was a decline in economic productive activity, which precipitated urban unemployment. Statistics reveal that 35 million Nigerians became newly poor during this period. By 1985, 46.3% of the entire population were poor.

3. **1985 – 1992:** The Structural Adjustment Program (SAP) was

introduced in 1985, ostensibly to overturn the economy. SAP remains by far the most far-reaching policy measure affecting the poor in the nation. Oil revenue remained low and government debts increased. Mass retrenchments ensued in the urban areas, especially in government agencies and manufacturing industries. Layoffs from government agencies and industries were absorbed in the informal sector. The Peoples Bank of Nigeria was established to cater for the banking needs of the poor. The National Directorate for Employment was also established to deal with mass unemployment. Marginal economic development was recorded in the rural areas because of the ban on imported foodstuffs and the establishment of the National Directorate for Foods, Roads and Rural Infrastructure (DFRRI). As a result of SAP, the middle class was destroyed and 34.7 million more Nigerians became newly poor. By 1992, 42.7% of all Nigerians were poverty stricken. Nigerians are yet to recover from the effects of SAP.

4. **1992 – May 1999:** Events since 1992 saw to the virtual collapse of the Nigerian economy. Rapid inflation and widespread corruption prevailed, and by 1997, 67 million Nigerians, representing 65.6% of the population, lived below the poverty line. The poverty alleviation program of that era was the Family Economic Advancement Program. Its main thrust was the development of small and medium scale enterprises and the development of cottage industries. This was not achieved because the monies allocated for these projects were siphoned into the foreign bank accounts of the executors.

5. **May 1999 till present date:** With the advent of democracy, the federal government produced a new economic blueprint. It is centered on a market-oriented, private sector-led, technology-

driven and highly competitive strategy for achieving national growth and development. Its guiding principle is poverty eradication, and the federal government committed itself to upholding principles of transparency and accountability.

#### **Poverty Alleviation Since May 1999**

Aliyu (2001) listed the following as being responsible for the failure of the numerous poverty reduction projects implemented in Nigeria:

- i. Absence of national policy on poverty eradication to be used by all tiers of government and other institutions;
- ii. Poor policy formulation, coordination and monitoring, which results in policy discontinuity and lack of sustainability;
- iii. Absence of effective collaboration and complementation among the relevant government institutions and agencies, thereby resulting in duplication of functions and unhealthy rivalry;
- iv. Lack of involvement of community groups and traditional authorities in project selection and implementation;
- v. Embarking on projects that have no relevance on the poor.

These problems set the agenda for the poverty reduction strategy of the present government. In January 2000, the federal government sought to streamline and rationalize the functioning of core poverty alleviation agencies and institutions. The following are some of the decisions taken to this effect:

- a. The formulation of a National Poverty Eradication Council for policy formulation, coordination and monitoring;
- b. The merging of the Nigerian Agricultural and Cooperative Bank, Peoples Bank of Nigeria and the Family Economic Advancement Program to form

the Nigerian Agricultural Cooperative and Rural Development Bank;

- c. The streamlining of the work and scope of the National Directorate for Employment to exclude credit delivery;
- d. The establishment of the Poverty Alleviation Program.

#### **Poverty Alleviation Program (PAP 2000)**

The Poverty Alleviation Program (PAP 2000) was established to provide meaningful hands-on employment to people all over the country. It was aimed at inculcating and improving better attitude toward a maintenance culture of highways, urban and rural roads and public buildings.

The program was implemented in every state of the federation. The 214,367 attachées, who fell into three main categories (skilled, semi-skilled and unskilled), were to be involved in activities such as cleaning of drainages, culverts and bridges, street sweeping and the installation of road signs, and the rehabilitation and maintenance of public buildings. They were paid a monthly stipend of ₦3,500 with disregard for any distinction among the various categories of attachés. PAP 2000 was phased out and replaced with the National Poverty Eradication Program (NAPEP) in January 2001.

#### **National Poverty Eradication Program (NAPEP)**

The National Poverty Eradication Program (NAPEP) was established in January 2001 with an overall target at eradicating absolute poverty by the year 2010.

The blueprint of NAPEP has the following features:

- i. Adopt participatory bottom-up approach in program implementation and monitoring;
- ii. Provide for rational framework which lays emphasis on appropriate and sustainable institutional arrangement;
- iii. Provide for pro-active and affirmative actions deliberately targeted at women, youth, farmers and the disabled;
- iv. Provide for inter-ministerial and inter-agency cooperation;
- v. Provide for the participation of all registered political parties, traditional rulers and the local communities;
- vi. Provide for technology acquisition and development particularly in agriculture and industry;
- vii. Provide for capacity building for existing skills acquisition and training centers;
- viii. Provide for agricultural and industrial extension services to rural areas;
- ix. Provide for institutional development for marketing of agricultural and industrial products;
- x. Provide for integrated schemes for youth empowerment, development of infrastructure, provision of social welfare services and exploitation of natural resources.

The main executors are the 28 identified federal ministries, agencies and parastatals. The National Poverty Eradication Council, which is headed by the President of Nigeria, formulates the policy thrust of the program. Coordinators at the local government, state and national levels translate, actualize and supervise the policy initiatives of the National Poverty Eradication Council. These coordinators are political appointees who also chair monitoring committees at their various levels.

At the local government level, the monitoring committee is made up of stakeholders and representatives of

relevant agencies and institutions including donor agencies, non-governmental organizations, organized private sector, political parties, traditional rulers, local council vice chairmen and supervisory councilors. The committees are expected to monitor the implementation of the program, propose new projects and ensure that the policy of NAPEP is followed strictly in the locality.

NAPEP activities are classified into four schemes:

1. **Youth Empowerment Scheme (YES)** aimed at capacity acquisition, productivity improvement, credit delivery, technology development and enterprise promotion;
2. **Rural Infrastructure Development Scheme (RIDS)**, which deals with the provision of potable water and irrigation facilities, rural and urban transportation, rural energy and power supply;
3. **Social Welfare Services Schemes (SOWESS)**, which deals with special education, primary health care services, establishment and maintenance of recreational facilities, youth and student hostel development, environmental protection facilities, food security provision, agricultural input provision, micro-and macro-credit delivery, rural telecommunication facilities, provision of mass transit and maintenance culture;
4. **Natural Resources Development and Conservation Scheme (NRDCS)**, which is concerned with the harnessing of agricultural, water and solid mineral resources, and the conservation of land and space, particularly for convenient and effective utilization by small-scale operators and the immediate community.

All these programs had a kick-off date of July 2001. Some of the targets set for the schemes include the reduction of the national unemployment rate from 80% in 1997 to 30% in 2003; the establishment of five local resource-based cottage industries per local government per annum; the increase in provision of access to safe water in urban areas to 85% by 2003; the construction of at least 100km asphalt surface road per LGA per annum; increase in adult literacy to 70% in 2003; improvement in access to health services, and the establishment of at least one destitute rehabilitation scheme in each LGA by 2003. Others are a full survey of erosion-threatened lands in 5 districts of each LGA by 2003; the promotion of the establishment of small-scale industries; effective waste utilization and management; accelerated land reclamation, and the evolution of a sustainable resource use through local and community participation.

Even though the program did not take off until November 2001, the National Priority projects of NAPEP under the various schemes for 2001 are as follows:

#### **Youth Empowerment Scheme**

- a. Assessment and evaluation of training centers;
- b. Establishment of a data bank for the unemployed;
- c. Training of 100,000 unemployed youth under Capacity Acquisition Program (CAP);
- d. Attachment of 50,000 graduates under Mandatory Attachment Program(MAP);
- e. Resettlement of 50,000 graduates of CAP through the micro credit program.

#### **Rural Infrastructure Development Scheme**

- a. Production of road maps for each state of the federation with emphasis on feeder roads and connections;
- b. Assessment evaluation and documentation of the 46,000 boreholes established between 1985 and 2000;
- c. Survey and documentation of rural electrification efforts and establishment of functional downtime monitoring units in each local government area;
- d. Provision of micro credit for agriculture;
- e. Assessment, evaluation and establishment of rural communication facilities.

#### **Social Welfare Services Scheme**

- a. Construction and rehabilitation of sports facilities in selected primary and secondary schools;
- b. Rehabilitation of selected primary healthcare centers;
- c. Capacity building for agricultural and industrial extension workers in every LGA;
- d. Rehabilitation of selected recreational centers in each state.

#### **Natural Resources Development And Conservation Scheme**

- a. Development and production of geological maps for selected minerals in Nigeria;
- b. Environmental protection and control projects in selected parts of the country.

Since these targets were set, no other priorities have been articulated; hence, the extent to which these projects have been

implemented and their effect on the lives of the urban poor in Surulere is discussed in the next section of the paper.

### **Poverty in Surulere**

Surulere is home to mainly low and middle-income earners. Poverty is prevalent in the blighted areas where the low-income earners live. The blighted areas, which cover over 75% of the entire area, lack access to basic social services.

There are 68 primary schools and 31 secondary schools in Surulere. There is also a women's education center and a public library. Over 50% of the inhabitants have at least primary school education, with many of them having some additional vocational skills, and so they are mostly involved in the informal economic sector. Economic activities include tie-dye in GI, saw-milling in Aguda, and trading in the Tejuosho/Ojuelegba axis. Over 60% of the inhabitants of this area live below the national poverty line as they earn between ₦5000 and ₦7500 (national minimum wage) monthly.

Homes in wards G1, G2, and G3 have pipe-borne water. While the middle-income earners install personal boreholes, the others have to rely on public wells and water vendors. Roads in Constituency 1 are mostly tarred. On the other hand, only major roads in Constituency 2 are tarred or graded.

Surulere residents, through their resident associations, embark on various community development projects. Such projects include vigilante groups for community security; and environmental sanitation activities such as drainage clearing and waste disposal. In Constituency 2, most of these associations also operate as credit and thrift cooperative societies.

### **Government Involvement in Poverty Alleviation**

This section attempts to look at the impact of government poverty alleviation projects in Surulere Local Government. PAP and NAPEP are examined.

#### **Impact of PAP 2000 in Surulere**

PAP 2000 was highly politicized. The local government chairman of the Peoples Democratic Party (PDP) served as the chairman/ coordinator for the program while other members of the party executives served in the secretariat. Most of them were semi-literate and so did not possess the requisite skills necessary to perform the administrative and managerial duties assigned to them.

PAP attachés to Surulere were mostly local politicians, their wards and political thugs who were selected through a process that was fraught with nepotism and favoritism. A majority of these attaches claim to have been posted to federal government agencies as clerical aides and cleaners. Over 60% of them never showed up at their duty posts, though they were remunerated. Accusations of corruption are rife. Up to date, PAP attaches to Surulere claim that they are being owed three months' stipend which the federal government claims to have released.

Non-political members of the public were not aware of the existence of the program in Surulere.

#### **Impact of NAPEP in Surulere**

The only NAPEP Programs in Surulere since November 2001 are the Youth Empowerment Scheme (YES) and the Rural Infrastructure Development Scheme (RIDS). No projects under the SOWESS and NRDCS have been implemented so far.

Under YES, in August 2001 a register was opened for the unemployed at the NAPEP secretariat. As of May 2002, 3,512 people, of whom 1,109 are graduates, had registered. Owners of cottage industries also registered as prospective trainers for the Capacity Acquisition Scheme. Their premises were inspected to determine capacity and ability, and they underwent an entrepreneurial development and management-training workshop in August 2001 organized by NAPEP in conjunction with the Center for Management and Development, Industrial Training Fund, the Nigerian Institute of Management among others.

Actual attachment of beneficiaries began in November 2001 when 211 youths were posted to various cottage industries to learn vocational skills under the Capacity Acquisition Program. Furthermore, 96 graduates were sent to government offices, private businesses and local entrepreneurs under the Mandatory Attachment Program. None of the trainers or attachés was chosen from the existing data bank. As a matter of fact, while distribution of application forms to both beneficiaries and trainers was done through local political channels, final selection was done centrally from the NAPEP national Secretariat in Abuja.

According to the NAPEP blueprint, CAP was meant to run for 6-9 months. It ran for only 3 months between November 2001 and January 2002. Allowances were not paid until the end of the program. On completion of their programs, rather than giving out micro-credit of N50,000 per beneficiary as stated in the blueprint, beneficiaries received only a few units of Keke NAPEP (auto-rickshaw), and sewing machines were distributed to some of them on hire purchase basis. Interestingly, neither tailoring nor auto-rickshaw operations and maintenance were offered as courses under the CAP.

MAP, also under the YES program, is a two-year attachment for graduates, who are second to private entrepreneurs to acquire necessary skills for self-employment. While 70% of those attached were bona fide graduates, most of them were rejected by private sector operators because of ignorance of the existence of the program and also because many of the beneficiaries had poor qualifications (third class and below). It was discovered that, where accepted, most of the graduates had a poor attitude toward work because they were not paid as, and when, due. Allowances had not been paid since September 2002. By the end of April 2003, a considerable number of the attachés had been dropped from the program for undisclosed reasons. Those retained in the program have not fared any better.

According to NAPEP RIDS targets for Lagos State, 24 community boreholes were to be constructed in Surulere. The local government NAPEP coordinator identified possible sites based on need. While it was confirmed that as of October 2001 contracts for the construction of the 24 wells had been awarded by the Ogun-Oshun River Basin Authority, by May 2003 only 16 boreholes had been constructed, of which fewer than 10 serve the local communities fully. The boreholes whose construction was awarded at ₦3.3million each were constructed with substandard materials.

Two years after the commencement of the program, as in all the other local governments in Lagos State, NAPEP in Surulere is yet to acquire a functional secretariat. Official duties are done from the home of the coordinator. Take-off grants for the programs are yet to be released. Furthermore, the Local Government Monitoring Committee is yet to be inaugurated.

While NAPEP's goals and targets are laudable and highly achievable, the

program is underfunded and highly politicized; hence the average Nigerian is not likely to benefit. It scores high on media visibility but has a marginal impact at the grassroots level since the number of people benefiting from the programs is negligible compared to the need. For example, the 96 graduates attached through MAP represent only 7.96% of the unemployed graduates registered with NAPEP in Surulere, while the 211 CAP beneficiaries represent only 8.07% of the unskilled unemployed persons registered. Since NAPEP's target is to reduce national unemployment from 80% to 30% before 2003, it has yet to make meaningful impact in this regard.

The coordinators, especially at the local government level, are not equipped to perform the duties expected of them. In fact, though they are respected politicians at the local level, they serve as mere administrative assistants since the main bulk of their duties are done by the national secretariat. Many of them do not have a clear understanding of their appointments as they are yet to undergo any orientation or training. The coordinators are also not given the wherewithal to initiate programs peculiar to their localities, though it is clearly articulated in the NAPEP blueprint.

It is clear from the foregoing that NAPEP is not achieving the goals it set for itself. It has been unable to commence two of the schemes in the program and has achieved minimal success in those it has commenced. NAPEP is being implemented through a top-down approach. Major stakeholders, especially the poor, are not consulted before decisions concerning them are made. Furthermore, there is no specific program targeted at women's empowerment even though women make up a significant percentage of the urban poor.

Effective poverty alleviation in our urban centers only be achieved when

issues such as sustainable development and good urban governance are addressed. The following section is therefore devoted to the position of this paper, which is on the development of an effective poverty management strategy.

### **Strategies for Better Urban Poverty Management**

Effective urban poverty control can be actualized only through the application of a pragmatic approach involving civic reorientation, urban redevelopment and the entrenchment of a results-oriented system of urban management. This can be achieved through the application of the norms of good urban governance and the implementation of poverty reduction programs.

Urban Governance is defined by *UN-Habitat* (2002) as the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action can be taken. It includes formal institutions as well as informal arrangements and the social capital of citizens.

Good Urban Governance implies that city governments respond to and are accountable to all urban residents, including the poor. It implies inclusive and participatory approaches in which each group and stakeholder has adequate representation. Good Urban Governance, based on the principle of urban citizenship, affirms that no man, woman or child can be denied access to the necessities of urban life, including adequate shelter, security of tenure, safe water, sanitation, a clean environment, health, education and nutrition, employment and public safety and mobility. Through good urban governance, citizens are provided with the



platform which will allow them to use their talents to the full to improve their social and economic conditions.

The Global Campaign on Urban Governance was launched in 1999 by the United Nations Human Settlement Program (UN-Habitat) to support the implementation of the Habitat agenda goal of “sustainable human settlement development in an urbanizing world.” The campaign’s goal is to contribute to the eradication of poverty through improved urban governance. The campaign’s theme, “The Inclusive City,” seeks to promote growth with equity; hence, participatory planning and decision-making are the strategic means for realizing the vision. The Nigerian Campaign for Good Urban Governance was launched by President Obasanjo on April 10, 2001.

The global campaign proposes that good urban governance is characterized by the following norms:

- i. Sustainability in all dimensions of urban development
- ii. Subsidiarity of authority and resources to the closest appropriate level
- iii. Equity of access to decision-making processes and the basic necessities of urban life
- iv. Efficiency in the delivery of public services and in promoting local economic development
- v. Transparency and accountability of decision-makers and all stakeholders
- vi. Civic engagement and citizenship

- vii. Security of individuals and their living environment.

These norms, which are independent and mutually enforcing, are responsive to the issues of the urban poor. Furthermore, elements of inclusiveness permeate them all.

Practical Means of applying these norms, especially with regard to the implementation of NAPEP in Surulere, are tabulated below:

Applying the norms of good governance to the implementation of NAPEP, especially at the local level, will help significantly in reducing urban poverty. NAPEP can be revolutionized by the decentralization of responsibilities and resources to the local coordinators and monitoring committees based on the principles of subsidiarity and accountability, and encouraging the participation of civil society, especially women, in the design, and implementation and monitoring of local priorities based on the principle of civic engagement.

Furthermore, building the capacity of all actors to contribute fully to decision making and urban development processes based on the principles of equity and efficiency; facilitating networking at all levels by the principle of civic engagement; and based on the principles of sustainability and security, taking full advantage of modern information and communication technologies to support good urban governance and sustainable urban development will result in improved welfare for the community and, consequently, poverty will be alleviated.

**Table 1: Principles, Objectives and Practical Measures for Urban Poverty Management**

<b>PRINCIPLES</b>	<b>OBJECTIVES</b>	<b>PRACTICAL MEASURES</b>
<b>SUSTAINABILITY</b>	<b>Balanced Social, Economic and Environmental Priorities</b>	Undertaking consultations with stakeholders to agree on a broad-based mission statement and long term strategic vision for the program using relevant development strategies.
	<b>Stakeholder Involvement</b>	Ensuring financial viability by promoting economic activity through the participation of all citizens.  Stakeholders should nominate the beneficiaries of projects.  Promote the transfer of appropriate technologies.
<b>SUBSIDIARITY</b>	<b>Local Autonomy and Accountability</b>	In consultation with local authorities, develop clear constitutional framework for assigning and delegating responsibilities and commensurate powers and resources from the wards through to the neighborhood level.  Promote decentralized cooperation and peer – to – peer learning.
<b>EQUITY</b>	<b>Resource Allocation</b>	Establish investment incentives for targeted sectors and geographic areas.
	<b>Empowerment</b>	Ensure both women and men have equal access to decision making processes.  Establish quotas for women representatives in both the Local Monitoring Committees and the program beneficiaries.  Ensure Development Policies support the Informal Sector.
<b>EFFICIENCY</b>	<b>Management and Service Delivery</b>	Promoting integrated inter-sect oral planning and management.
	<b>Efficient Investment in Infrastructure</b>	Delivery and regulation of public services through partnerships with the private and civil society sectors.

<b>TRANSPARENCY AND ACCOUNTABILITY</b>	<b>Transparent and Accountable Decision Making Process</b>	Regularly organized and open consultations of citizens on important issues such as participatory budgeting and monitoring mechanisms in the process.  Creating public feedback mechanisms such as hotlines, procedures for public petitioning and public interest litigation.
	<b>Access to Information</b>	Promoting the public's right of access to information.
	<b>High Standard of Ethics and Professional Conduct</b>	Developing practically enforceable standards of accountability and service delivery especially with political office holders.
<b>CIVIC ENGAGEMENT AND CITIZENSHIP</b>	<b>Leadership for Public Participation</b>	Making use of mechanisms such as town hall meetings, citizens forum and participatory strategy development including issue specific workgroups.
	<b>Building Democratic Culture</b>	Promoting the ethic of civic responsibility especially with regards to voting for accountable and responsible leadership and protecting community property.
	<b>Enablement</b>	Enabling equal contribution of men and women and the full participation of the citizenry in civic life.
<b>SECURITY</b>	<b>Environmental Management and Disaster Preparedness</b>	Implementing environmental planning and management methodologies based on stakeholder involvement.
	<b>Personal Safety, Crime Control and Prevention</b>	Creating a culture of peace and encouraging tolerance of diversity through public awareness campaigns.
	<b>Security of Tenure and Livelihoods</b>	Promoting security of livelihoods particularly for the urban poor through appropriate legislation and access to employment, credit and education.

## Conclusion

It is an international consensus that good governance is a crucial pre-requisite for poverty eradication (UN-Habitat, 2002). Increasingly, good governance is acknowledged as critical for unleashing national energies for poverty reduction. Furthermore, it is universally agreed that poverty elimination starts with listening to the poor, fostering their initiatives and giving them a chance. The poor must have a voice and a choice in decisions that affect their lives.

Positive institutional responses at the local level contribute to a significant reduction in poverty; hence the implementation of NAPEP, bearing in mind the principles of good governance will go a long way in the mitigation of poverty in our urban communities.

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# **Adoption of Innovative Rural Development Technology**

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## **Abstract**

Low productivity in agriculture and other economic endeavours is a recognized problem of most rural settings in Nigeria. This study examines an innovative diffusion process as a phenomenon of change for higher agricultural productivity in the rural areas of Adamawa State in Northeastern Nigeria. A stratified random sampling technique was used for the study on 154 settlements in fifteen local government areas in the northern part of the State. These include the headquarters of three local government areas and five districts. Kendal's ranking coefficient method was applied to categorize the settlements. The rank scores were converted to "z" scores and the settlements stratified on two urbanization scales of low and high. Chi-square test was applied to test the significance of the difference between the high and low urban groups. The results showed that settlements in the high urban group were more susceptible to a faster rate of adoption of improved innovations for higher productivity than those in the low urban group, thus confirming the hypothesis that urbanization is an important factor in rural economic and social processes of change and that the effects are proportional to the size of the urban centres.

## **Introduction**

There are numerous developmental conditions that undergo changes; examples of which are technological, socio-economic, political, physical and environmental. Change implies a process of diffusion of a new phenomenon, which may either be material or non-material. The study of the spread has been found to be usually selective because of the major factors that influence the pattern and intensity of the spread. However, the diffusion of innovations is generally

considered fundamental to developmental changes in all societies.

Nigeria, like most of the countries in Africa, has gone through a lot of developments in the last couple of decades. This has happened as a result of her economic contacts with the outside world. These contacts have led to the introduction of a new monetary economic system, a better and more efficient transport network, and numerous economic and political institutions, which affect most aspects of life. These developments are possible, in part, through the processes of both interna-

tional and national diffusion. A number of innovations were first introduced by imitations from the western world. These innovations diffused to major towns, particularly Lagos, from whence they also diffused to the hinterland. Thus, our major towns, which are the centers of the relatively new commercial economy, political decision-making processes and transportation, function as the "head-link" between the outside world and the rest of the country. It could be justifiably asserted that our present level of national development is, to a large extent, the result of the diffusion of innovations at the two levels identified. It is the understanding of this process at the sub-national central place system that this inquiry seeks to verify.

### **Literature Review**

Scholars who have been historically influenced by the anthropologists first showed interest in diffusion research in planning. Anthropologists and sociologists are traditionally interested in inter-cultural and intra-societal diffusion studies respectively. The best-known early scholars with interest in diffusion are Carl Sauer (1952) and Dan Stanislawski (1964). Sauer studied the domestication of plants and animals. He tried to establish their centers of origin and their spread on a worldwide scale. Stanislawski described the origin and spread of the grid-pattern types of towns throughout history. The two scholars' specific contribution lies in emphasizing the spatial dimension of diffusion.

Hagerstrand's studies in southern Sweden beginning in the early '50's were and are an important stimulus for diffusion studies by planners. He laid more emphasis on the spatial aspects than the early generation of scholars who studied diffusion of innovations. He saw diffusion as a way of explaining distributional change. Apart from the factors of space or distance, Hagerstrand also recognized the importance of population distribution and the role of the mass media in the process. Despite

this recognition, however, his major emphasis was on demonstrating the significance of distance and diffusion of innovations which occurred over space.

The spread of innovation and the introduction of quantitative and probabilistic approach to the study of diffusion are the two major contributions that he made to diffusion studies. Arguing that the distance-decay effect on diffusion is by itself not a sufficient explanation for diffusion, he based all the causal explanations on other factors, interaction and communication among individuals. He used indicators of interaction such as telephone calls and migration fields as a basis for building a distance-decay function, which in turn provided the basis for the simulation of innovation diffusion using the Monte Carlo method.

He basically approached diffusion through the study of information diffusion, and only a few variables that influence the circulation of information were considered (Hagerstrand, 1952, 1966, 1967). It could therefore be justifiably asserted that his work did not provide a full answer to the problem of understanding the process that underlines innovation diffusion. Secondly, enough attention was not paid to the significance of urban social and economic factors that affect diffusion.

Hagerstrand's quantitative approach has been refined and extended by many planners working on specific concepts and through the mathematical manipulation of distance and time variables (Brown, 1973; Cassetti 1969). Most of these works strongly emphasize distance-decay and hierarchical effects. Little emphasis is laid on the supply and demand factors of innovation and the behavioral characteristics of the potential adopters. Space and time are generally considered to be the external elements of diffusion process. However, the flow of information, nature of communication network and interaction among potential adopters, social, economic, cultural and psychological attributes of potential adopters strongly

determine the acceptance, rejection, and the spread of innovations. They need to be strongly emphasized in diffusion studies.

### **Objective of the Study**

Innovations are ideas, institutions, techniques, goods, etc., whose acceptance results in the capability of doing things that could not be done before or not done as well. Innovations are generally classified as material and non-material. However, not all innovations fall neatly into these two classes. This study will deal only with material innovations. The material innovations concern those things which enhance rural productivity, in particular agriculture and small-scale industrialization. These innovations are activities or ideas with associated material objects whose acceptance involves taking a certain amount of risks on the part of the entrepreneur. The acceptance of the innovation pre-supposes, in this context, an acquisition of the appropriate technical skill and or entrepreneurial expertise. Examples of such innovations include adoption of new farming inputs and techniques, adoption of new machinery for processing, beneficiation and fabrication.

This article examines how innovations are structurally tied up with the size of settlement. Although it is intuitively known that the major urban settlements are centers for the acquisition of technical skills and entrepreneurial expertise that attract a large inflow of immigrants, not much is known quantitatively about the influence of urban centers on the establishment of entrepreneurial innovations in the minor urban and rural settlements. The article endeavours to answer the following questions that are designed to fill a gap in knowledge of the innovative diffusion process. The questions are:

1. What innovative rural technology is available in a given level and hierarchy of urban settlement?

2. What are the main urban factors affecting the adoption of innovative rural technology?
3. What are the particular ways in which the sizes of urban settlement affect the diffusion process?

Apart from the academic interest in this study, the findings will help to draw the attention of those in authority to the need to understand the urban forces affecting the adoption of innovative rural technology as well as its productivity and constraints.

### **Conceptual Framework**

Planners have shown great interest in diffusion research in recent years (Ellinger, 1994; Abumere, 1997; Ayeni, 1998; Cuervo and Hin, 1998; Graham and Marvin, 1998). Two main classes of findings are generally recognized: descriptive and explanatory. The former mainly describes how innovation spreads, while the latter identifies and explains the relative significance of the factors that affect the diffusion course. These two classes are very closely related. In fact, it is difficult to separate them in reality although the "explanatory" approach is intended to lead to concentration on the prediction of future pattern (Ugbomeh, 1993; Smith, 1994; Udo 1997).

The three main descriptive findings of diffusion are the neighborhood effects that the closer a potential adoption unit is to the source of an innovation or to another unit that has already adopted the innovation, the greater the probability that it will adopt that innovation before potential adopters that are further away. On the other hand, the hierarchical effect implies that for a defined hierarchical base, be it in terms of size, social status, etc., the higher the ranking of a potential adoption unit in that hierarchy, the greater the probability that unit will adopt the innovation before units that are lower on the hierarchy. This type of effect is found mainly in



the context of a central place system (Brown, 1973; Ayeni, 1998).

Within a given hierarchical level in a central place system, the probability of an urban center adopting an innovation is said to be roughly proportional to its interaction with those towns that have already adopted the innovation (Huang, 1974, p. 337). Hagerstrand termed this effect the "short circuits to the more important places at a greater distance" (Hagerstrand, 1952, p. 8). He identified three diffusion stages in a central place system. The First is the primary stage during which diffusion center is established. Second is the diffusion stage during which the neighborhood effect type of diffusion occurs in areas close to the diffusion center established in the lower-order central places. The last stage is that of saturation, after which diffusion ceases.

These two effects encompass the major principles of Walter Christaller's central place theory. They do not by themselves, however, provide an explanation of the process of innovation diffusion, but they have considerable empirical validity. A combination of the two produces the logistic curve. The S-shaped logistics curve is the geometric form of either the joint operation of the hierarchical and neighborhood effects (Huang, 1974) or the individual effect of these, which is mathematically consistent with either (Cassetti, 1969). In the case of diffusion in a central place system, high-order centers are located close to the origin of the curve. High-order places are peaks on the marketing surface as a result of their high potential adopter density and they are, in the case of entrepreneurial innovations, centers of high concentration of potential consumers. In each case, the curve results from the observed fact that the accumulations of the number of adopters (P) increase through the time (t). This is expressed thus:

$$P = \frac{U}{1 + e^{(a - bt)}}$$

Where

U = equilibrium point;  
a = the constant of integration that positions the height above t axis where the curve starts;  
b = the slope of the curve; and  
e = the error term.

The curve has proved to be a reliable method for characterizing the various stages of diffusion process, and it is also a means of classifying adopters into adoption categories (i.e. innovators, early adopters, early majority, late majority and laggards). It is important to note that it can be derived by different processes (Cassetti, 1969).

Closely related to these are the natures of the innovations' being diffused and the adoption units, both of which are of a particular significance to the understanding of diffusion process. Innovation attributes, both physical and economic, affect the time of adoption and the rate of diffusion and they determine the adoption unit. Like any other type, entrepreneurial innovations have specific types of characteristics that will enable us to identify their effects on the supply and demand patterns at all levels of central places to be sampled in the study area.

Information, communication and interaction are the major explanatory factors of diffusion. They, in sum total, make up the second-class diffusion findings in geographical research as well as in other disciplines, particularly rural sociology (Brown, 1973). The significant roles of information flows and communication are such that five stages of decision making about accepting or rejecting an innovation have been identified. These stages are awareness, interest, application, trial, and adoption. The stages are very similar to the "two step flow" of information hypothesis. They are intricately linked with the factor of social interaction networks of potential adopters who receive personal information through such networks. In our own research context, where it is

intuitively known that social networks of communications and interactions are strong, we will focus on the importance of information from family sources as it affects entrepreneurs and hence diffusion process. However, this approach will not play down the effects of impersonal information sources, which are usually urban-centred.

Urbanization is normally referred to as a process of social change or transformation whereby the rural population moves toward an urban way of life physically, psychologically or both. The cities, which are said to spread the new value of modernity to the traditional rural society, break economic, social and cultural barriers, which resist change from a tradition-bound subsistence economy. Experts at the Sixth Rehovot Conference of 1971 on international economic development emphasized that urban growth is basic to agricultural development and that the modernization of agriculture in economically less developed countries is highly dependent on urban infrastructure.

In the present study, an attempt has been made to judge quantitatively the impact of urbanization on the adoption of new farm technology. The hypothesis is that urbanization is bringing about fast changes in the traditional agriculture. The study is empirical and is based on 15 Local Government Areas in Adamawa State, Nigeria.

### **The Study Area**

This study was carried out in fifteen local government areas in Adamawa State. A total of 154 settlements were involved in the study. These included three Local Government Area (LGA) headquarters, five district headquarters, and 156 villages.

### **Methodology**

The major sources of data for this study were the records of the Ministry of Industries, Ministry of Agriculture, Extension Services department, the Di-

rectorate of Employment, and maps showing the hierarchy of settlements. Questionnaire-based interviews were conducted as a means of extracting information about the selected variables. Also, personal observations were made on each settlement's basic characteristics.

Use was made of repetitive stratified random sampling techniques for each LGA to select the particular settlements in all levels of the hierarchy from which data were collected. A sampling fraction of 2/5 for each hierarchy was used, giving a total of 154 settlements. This method enabled an unbiased selection of urban centres and villages. For each of the selected centres, a simple random method was used in selecting the subjects for interviews.

The effects of urbanization were analyzed in the following order:

- i. Use of fertilizers;
- ii. Use of improved varieties;
- iii. Use of improved implements;
- iv. Adoption of plant protection measures and adoption of improved dairy techniques.

### ***Graduation of settlements according to the degree of urbanization***

Various authors have taken into account different indicators which reveal the degree of urbanization in a society. However, in the present study the following four criteria were selected for grading the 154 settlements selected, in terms of the degree of urbanization using Kendal's Ranking coefficient method (Uyanga and Mandal, 1989):

- i. Total population of the settlement;
- ii. Percentage of literates;
- iii. Percentages of non-agricultural workers to total population;
- iv. Number of industries;
- v. Number of registered vehicles.

The total rank-scores of 154 settlements were grouped into eleven class inter-

vals, and the mean and standard deviation of the distribution was worked out.

**Table 1: Total rank scores of the settlements studied**

Rank Scores	Number of Settlements
0-40	5
40-80	5
80-120	11
120-160	22
160-200	21
200-240	26
240-280	25
280-320	17
320-360	10
360-400	10
400-440	2
N = 154	

The test of the fit of the above data to the normal distribution was made and the fit was found to be very good ( $X^2$  6.18; degree of freedom 8).

To group the villages in high and low urban groups, first the total rank scores of all the villages were converted to "z" scores (standard normal variable) by the use of the following formula:

$$X = \frac{(x-m)}{\sigma}$$

Where:

x = any total rank score of a village;

M= mean of the distribution (219.0);

$\sigma$  = Standard deviation (91.5).

Accordingly, the villages were stratified on the urbanization scale on the basis of "z" scores in the following two groups:

- i. Low urban group: 64 settlements were classed in this group. These lie to the extreme left of the distribution curve with "z" scores below the mean.
- ii. High urban group: 90 settlements with "z" scores above the mean.

All the information of each interview schedule was tabulated and converted to indices and scores for quantitative comparisons, in order to test the significance of difference between the high and low urban groups, 'chi-square' test was applied. A statistically significant difference between the two groups in the level of adoption of innovation is considered a sufficient proof of the impact of urbanization.

### *Indices and Scales Used in the Present Study*

#### *Index for the adoption of improved implements*

Under the improved implements the following seven implements were considered:

1. Tractor
2. Pump
3. Thresher
4. Sprayer
5. Milling machine
6. Iron plough
7. Improved seed drill

The number of implements actually used by the respondents out of the above seven was recorded. Given equal weight, the adoption score was calculated as follows:

Improved implement adoption index =  
No of implements used x 100%

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7

#### *Adoption of plant protection score*

To judge the use of plant protection, questions were asked regarding the use of the following five plant protection practices:

1. Soil treatment
2. Seed treatment
3. Use of pesticides at the time of sowing
4. Spraying or dusting of pesticides
5. Rat control.

A three-point scale was used to judge the adoption quantitatively; yes = 2, No = 0 and seldom =1. The total score was then worked out based on the responses of the respondents.

#### **Adoption of improved dairy techniques**

To judge the adoption of improved practices in dairying, the following were included:

1. Use of artificial insemination;
2. Inoculation of milk cattle;
3. Purchase of improved fodder;
4. Growing fodder especially for milk cattle.

The total score for the adoption of improved practices in dairying was calculated with the use of the 3-point scale in the same way as it was done in the case of the plant protection score.

### **Research Results**

#### **Use of Fertilizers**

The use of fertilizers is considerably higher in the settlements with a higher urban influence. The total per hectare average of fertilizer used is = N

= 85.00 and =N=310.00 per year in the low and high urban groups respectively. Thus, the cost of fertilizers used is nearly three times higher in the high urban settlements. The respondents have been classified on the basis of the type of fertilizer used.

From the above table it is clear that the use of other types of fertilizer is common to all the settlements. The use of chemical fertilizers is larger in the high urban settlements (Table 2).

**Table 2: Type of fertilizer used by the respondents**

Group	Percent respondents using the type of fertilizer	
	Chemical fertilizer	Other types
Low urban	12	23
High urban	88	77

In high urban settlements, irrigation facilities are more abundant and, the use of chemical fertilizers is considerably higher. The chi-square test applied to the group data in terms of the cost of chemical fertilizer used, shows that the calculated  $\chi^2$  was higher than the critical value at one percent level (Table 3).

**Table 3: Cost of chemical fertilizer used by the respondents**

Group	Per acre annual cost of chemical fertilizer used (=N=)						
	Less than 50	50-100	100-150	150-200	200-250	250-300	300 and above
Low urban N=64	52	6	2	2	2	-	-
High urban (N=90)	30	20	13	4	6	2	15

Chi-square =40.4  
Degrees of freedom = 6

Difference is significant at 1 per cent level

**Adoption of Improved Varieties**

The cultivators in the high urban group where a considerable share of land is devoted to commercial crops were more sensitive to the use of improved varieties. The average percentage of crops grown with improved varieties is 63.2 in the high urban group as compared to 11.3 in the low urban group.

The respondents of both the groups have been classified into five categories the percentage crops grown with improved varieties. The chi-square test applied is statistically significant at one percent level and confirms the fact that the use of improved varieties in the villages with higher urban influence is considerably higher (Table 4).

**Table 4: Percentage of Groups under the Improved Varieties**

Group	Less than 20%	20-40%	40-60%	60-80%	80% and above
Low urban N=64	51	5	5	2	1
High urban (N=90)	10	13	17	16	34
Chi-square =78.6		Difference is significant at 1 per cent level			
Degrees of freedom = 4					

**Use of Improved Implements**

To compare the use improved implements by the respondents of the high and low urban groups, a combined index was computed as described in the methodology. The use of improved im-

plements was found to be considerably higher in the villages with higher urban influences, the index being 57 as compared to a mere 9 for the low urban villages. The chi-square test applied to the

ground data was significant at one percent level (Table 5).

**Adoption of crop protection measures**

A computed score based on the use of soil treatment, seed treatment, insecticide spray, and rat control measures has judged the difference in terms of the crop protection measures. The use of crop protection measures is nearly five times higher in the high urban villages. The chi-square test applied to the data was significant at one percent level (Table 6).

**Table 5: The Use of Improved Implements**

Group	Index of the use of improved implements				
	Less than 20	20-40	40-60	60-80	80and above
Low urban N=64	52	9	2	0	0
High urban (N=90)	10	12	27	22	19

Chi-square =90.38      Difference is significant at 1 per cent level  
 Degrees of freedom =4

**Table 6: Use of Crop Protection Measures**

Group	crop protection score				
	Less than 2	2-4	4-6	6-8	8 and above
Low urban N=64	44	13	2	2	1
High urban (N=90)	10	15	25	15	25

Chi-square =60.67      Difference is significant at 1 per cent level  
 Degrees of freedom = 4

### Adoption of Improved Techniques in Dairying

The quantitative judgment of the use of improved techniques in dairying was made with the help of a score prepared on the basis of the use of the artificial insemination, inoculation, pur-

chase of improved fodder, and growing special fodder for cattle.

The average score is 4.1 for the high urban group and low (3.4) for the other group, indicating that the respondents of the low urban group also use improved techniques in dairying to a considerable extent. The chi-square test also reveals that the difference in the two groups is only fairly significant and thus, not well marked (Table 7).

**Table 7: Use of Improved Dairy Techniques**

Group	Score of improved dairying			
	Less than 2	2-4	4-6	6 and above
Low urban N=64	19	18	16	11
High urban (N=90)	3	25	34	28

Chi-square =9.65  
Degrees of freedom = 3

Difference is significant at 1 per cent level

### Conclusion

The study area was classified into urban categories and agricultural innovations in the component areas and was evaluated in the context of these categories. The study observed that despite cultural bias usually linked to localities and innovative initiatives, farm improvements were more likely to be adopted in settlements with higher urban influence. The empirical study in Adamawa State thus confirms the hypothesis that urbanization is an important aspect of the process of economic and social change. The villages with a higher urban influence are adopting innovations in agriculture at a considerably faster rate. Therefore, not only urban centres but also the large villages in the study area can be utilized as focal points to modify the tradition-bound subsistence agriculture to a more developmental and productive type.

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