SAHARA Journal Mission Statement

The journal publishes contributions in English and French from all fields of social aspects of HIV/AIDS (care, support, behaviour change, behavioural surveillance, counselling, impact, mitigation, stigma, discrimination, prevention, treatment, adherence, culture, faith-based approaches, evidence-based intervention, health communication, structural and environmental intervention, financing, policy, media, etc.)

Déclaration de la mission du journal SAHARA

Le journal publie des articles en anglais et en français dans tous les domaines sociaux du VIH/SIDA (soins, traitement et counselling, soutien et prise en charge, changements de comportements, surveillance socio-comportementale, mitigation des impacts, stigmatisation, discrimination, prévention, adhésion au traitement, culture, approche basée sur la foi et la religion, interventions basées sur des succès documentés, communication en matière de santé, interventions structurales et environnementales, financement, politiques et médias).
ABSTRACT
For twenty years, a region of northern Uganda known as Acholiland has been heavily affected by war, leading to the formation of internally displaced people's camps, rape, transactional sex and child abductions. While it is clear that the war has had onerous consequences for the health of the Acholi people, the specific impact of the war on HIV transmission remains unclear, as the epidemiological evidence presents an ambiguous picture of HIV prevalence patterns. Other than a few non-governmental organization reports, very little qualitative data exists about the impact of HIV on the Acholi population. Attempting to formulate a clearer narrative of HIV transmission in Acholiland, this paper jointly analyses the historical and political context of the Acholi people and the war, the epidemiologic evidence of HIV prevalence patterns, and the ethnographic perspectives of Acholi healthcare workers and patients living with HIV/AIDS. Juxtaposing these sources of information allows for the emergence of a rich understanding of HIV in Acholiland. It is argued that three specific forms of violence – physical, symbolic and structural – create vulnerability to HIV infection in Acholiland, although to variable degrees dependent on location. The ethnographic evidence presented regarding HIV's impact on Acholiland suggests that an incorporation of historical, political, cultural and social factors must form the backbone of efforts both to understand HIV transmission and design strategies for curbing the epidemic in war settings.

Key words: War, socioeconomics, HIV prevention, social science, Uganda.

RÉSUMÉ
Pour une durée de vingt ans, une région du nord de l'Ouganda nommée Acholiland fut fortement touchée par la guerre. Cette situation a entraîné des camps de personnes déplacées à l'intérieur du pays, des violences, des rapports sexuels transactionnels et des enlèvements d'enfants. Il est évident que la guerre était à l'origine des conséquences pénibles sur l'état de santé du peuple Acholi. L'impact de la guerre sur l'infection au VIH reste toujours vague étant donné que l'évidence épidémiologique présente une image ambiguë des tendances de prédominance du VIH. En dehors de rapports de quelques organisations non-gouvernementales, il existe très peu de données qualitatives en ce qui concerne l'impact du VIH sur la population Acholi. Pour tenter de formuler un récit plus claire de l'infection au VIH à Acholiland, cette communication va, à la fois, analyser le contexte historique et politique du peuple Acholi et la guerre, l'évidence épidémiologique des tendances de prédominance du VIH et les perspectives ethnographiques du personnel de services de soins et des patients vivants avec le VIH/SIDA à Acholiland. La juxtaposition de ces sources d'informations permet une émergence d'une compréhension plus riche du VIH à Acholiland. On soutient que les trois formes de violence – physique, symbolique et structurale – créent la vulnérabilité à l'infection au VIH à Acholiland bien qu'aux degrés variables, cela dépend de l'emplacement. L'évidence ethnographique présentée par rapport à l'impact du VIH sur Acholiland nous apprend que l'incorporation des facteurs historiques, politiques, culturels et sociaux doit constituer le pilier des efforts afin de comprendre l'infection au VIH et de formuler des stratégies avec le but de freiner l'épidémie en situation de guerre.

Mots clés: Guerre, socio-économiques, prévention du VIH, Sciences sociales, Ouganda.

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INTRODUCTION
In Acholiland of northern Uganda, an area plagued by twenty years of war, the construction of a coherent narrative of HIV transmission has proved elusive. Epidemiological information assembled by the Ugandan Ministry of Health and UNAIDS, largely based on antenatal surveillance, has provided a constricted and fragmented snapshot of HIV prevalence trends since 1993 (Uganda Ministry of Health, 2003; UNAIDS, 2004). Researchers at a large private hospital in Acholiland have consistently demonstrated a high HIV prevalence and surmised a linkage with the war (Accorsi et al., 2001; Accorsi et al., 2005; Fabiani et al., 2006b). Yet, NGO reports claiming a heavy impact of HIV/AIDS on the local population have also been characterised as unsubstantiated and misleading (Allen, 2006; Lowicki-Zucca, Spiegel & Ciantia, 2005). Such conflicting declarations about the relationship between war and HIV transmission in Acholiland have left a rather muddled narrative of HIV transmission.

Disturbingly, but not unexpectedly, the voices of poor patients with HIV and their healthcare providers have been omitted from the discussion about how war in northern Uganda affects HIV transmission. Literature exploring HIV/AIDS in Acholiland is predominantly quantitative, leaving little room for social context and human experience. Regarding populations in war settings, Carolyn Nordstrom, a noted anthropologist, has written about the lives of poor individuals being “erased” (Nordstrom, 2004). The same may be said for people living with HIV/AIDS – analysis exploring HIV transmission is generally handed down, with the voices of HIV-infected individuals, who are often poor, in abeyance. Putting war and HIV/AIDS together, as in Acholiland, creates a setting in which the voices of the poor are particularly vulnerable to marginalisation. Perhaps, it is this omission which has left such a confusing picture of HIV/AIDS transmission in northern Uganda.

Such omissions can be countered with anthropological analysis drawing on ethnographic fieldwork. Thus, this paper attempts to begin constructing a narrative of HIV transmission in northern Uganda that focuses upon the perspectives of the local community in Acholiland, in addition to the epidemiologic and non-governmental organisation (NGO) literature currently relied upon. The anthropological perspective presented here is based upon two field visits of two months duration to Gulu district in northern Uganda, the first in July and August 2004 followed by a return in February and March 2006. Participant observation was the primary methodology used for this research in addition to an extensive literature review. Time in Gulu, a large region of Acholiland, was spent working in and seeing patients in a local hospital’s AIDS clinic; carrying out a qualitative questionnaire with TB patients, many of whom are co-infected with HIV; visiting internally displaced people’s (IDP) camps with local community leaders; and interviewing numerous healthcare workers, NGO staff and VCT counselors in medical facilities and organisations working on HIV prevention and treatment.

In striving to comprehend the complex interweaving of war and HIV transmission in northern Uganda, the task is far from complete. However, this paper offers an initial grappling with the lifeworlds of the Acholi people, in the hope of weaving a narrative of HIV transmission in Acholiland that reflects the melding of epidemiological evidence with the viewpoints of the people living with and working on HIV/AIDS in the region.

An indispensable gaze into the past and present of Acholiland
The region and town: Acholiland and Gulu
Four hours north of Uganda’s capital of Kampala by road, the town of Gulu occupies a space in the heart of Acholiland, a region of northern Uganda along the Sudanese border where the Acholi reside (see Figure 1). The Acholi are part of the Luo people, who trace their roots to the Bahr-el-Ghazal region in southern Sudan. In the 15th century, the Luo migrated into northern Uganda, with some eventually settling into what is today known as Acholiland (Nzita & Niwampa, 1995). Today, the majority of the Acholi, who make up 4.8% (1 145 357) of Uganda’s population, live within the provincial districts of Gulu, Kitgum, and Pader that comprise Acholiland. For twenty years, these three districts have been deeply wounded by a war between the Ugandan army and the Lord’s Resistance Army (LRA), an insurgency group. While the war has occasionally spilled out of Acholiland into the Lango and Teso regions, the bulk of the fighting and impact...
on the civilian population has taken place within the boundaries of Acholiland.

Largely due to population shifts associated with the war, Gulu town, serving as the capital of Gulu district, has grown to be the second largest town in Uganda, with a population of 119,430 (Uganda Bureau of Statistics, 2003). Remarkably, given the town's context of war, a sense of vigor and vibrancy infuse life in Gulu, not unlike that of other Ugandan towns. A central market hums with vendors hawking worn second-hand clothing, watches, cleaning products, soap, radios, pots and pans, and staple foods—sweet potatoes, beans, cassava, rice, and millet. Elegant, brilliantly coloured fabrics demarcate the storefronts of tailor's shops. Bicycles, dilapidated cars, and boda-boda motorbikes maneuver across the dusty tarmac roads of central Gulu. Perhaps this vibrancy all serves as an outward manifestation of a strong shadow economy, so often associated with conflict regions (Nordstrom, 2004).

Both the long drive from Kampala through remote, arid terrain and the context of the war can create an illusory sense of isolation in Gulu. Gulu's exclusion from the economic, health and educational development enjoyed by southern Uganda further bolster this imagined isolation. Yet, signs of interconnection with the world abound in Gulu and reveal that the sense of seclusion in Gulu is a myth. Locals fill internet cafes, which allow for connections with family and friends living in the Ugandan diaspora. Uganda's daily newspapers, The Monitor and The New Vision, arrive daily in Gulu. Truckers pass through with high frequency carrying food, petroleum and other cargo to northern Uganda and southern Sudan. The offices of international NGOs, such as the World Food Program (WFP) and Médecins Sans Frontières (MSF), are scattered throughout town, providing tangible reminders that Gulu's lifeworld is indeed interwoven within an international narrative of humanitarian aid.

Historically, social, political and economic networks between Acholiland and the world materialised far before the recent arrival of globalisation and humanitarian aid. Contact with outsiders has shaped Acholi society in sundry ways for the last three to four hundred years. When the ancestors of the Acholi moved into the land now referred to as Acholiland, they encountered the Langi people and eventually forced the movement of the Langi into what is today's Lira District (Nzita & Ntwampa, 1995). In the late 17th century, idea exchange with the kingdom of Bunyoro-Kitara just south of Acholiland resulted in Acholi adoption of Bunyoro sociopolitical organisation characterised by chiefdoms. In the 1850s, Arabs connected with Khartoum introduced slave and ivory trade into Acholiland and incorporated the Acholi into socially disruptive economic networks that stretched great distances. The origins of the Acholi name have been traced to this period of time when the traders started using the term “Shuuli” to describe the people living in Acholiland. The slave traders were eventually supplanted in 1872 by representatives of the Egyptian administration, known as the Jadiya, who were bolstered by Britain's abolitionist spirit; however, the Jadiya proved even more oppressive and unjust, and were driven out by 1888. All of these processes have been linked with the formation of an Acholi sense of ethnicity (Atkinson, 1989).

Shortly after the Arab slave traders arrived, the European explorers John Hanning Speke (1862) and
Samuel White Baker (1863-64 and 1872-73) travelled through Acholiland, interacted with the Acholi people, and conveyed their experiences back to Europeans through writing. In reference to the Acholi, Speke wrote, “What politeness in the midst of such barbarism!!!” (Speke, 1863). Stereotyped observations, such as Speke’s, paved the way for the racist ideologies that would buttress the colonial project. The arrival of colonialism, which lasted from the late 19th century to 1962, brought European domination and oppression to the Acholi (Finnström, 2003). It was during this period of time that the rigid concept of an Acholi tribe was developed by the British (Atkinson, 1989). Colonialism enshrined an unbalanced interconnectedness between the Acholi and the world, one that reinforced an inferior position of the Acholi as receivers, dependents and borrowers of foreign structure and enlightenment. This unbalanced transfer of resources and ideas into Gulu and Acholiland continues today through the activities of international NGOs, who justify their presence on the basis of the devastating social consequences of the war. Often conspicuously absent from analysis of the current situation in Acholiland, the history of colonialism is particularly salient in understanding the current war in northern Uganda, and thus instrumental in efforts to formulate a narrative of HIV transmission in Acholiland.

The omnipresence of war
War in northern Uganda has ravaged civilian life. Violent conflict between the Ugandan People’s Defence Forces (UPDF) and the LRA for the past twenty years has encompassed and pierced the social experience of the Acholi. While the Acholi certainly remain engaged and active in their social worlds, the loss of family members, displacement, and physical violation have taken an enormous psychological, social, physical and cultural toll on Acholi communities.

Although the war officially started in 1986, the conflict in northern Uganda represents an aggregate of tension accumulated through years of disagreement and strife over power and resource allocation between northern and southern Uganda. Rooted, in part, in the divisive oppression of colonialism that pitted the people of northern and southern Uganda against each other, today’s violence reflects years of grinding poverty, an unrestrained desire for power, and a disordered global economic order fond of breeding inequality. While pre-colonial discord did divide northern and southern Ugandans, colonialism exacerbated the existing division (Jackson, 2002). During colonialism, the Acholi were given roles in the military (Finnström, 2003). Generally, southern Ugandans were given more distinguished and reputable positions as civil servants in the colonial administrations. Differential treatment and distinction fomented distrust, envy and bitter sentiment between the North and South (Refugee Law Project, 2004).

Further, inequality and disparate access to economic resources have precipitated animosity between geographical locales. Socioeconomic indicators reveal a pervasive poverty in northern Uganda relative to the rest of the country. In 1999-2000, monthly household income in northern Uganda was $36, one-half of the national average of $72 (Uganda Bureau of Statistics, 2003). The adult literacy rate in northern Uganda is 46%, far short of the national average of 63%. Only 57% of the North’s population has access to toilet facilities, compared to 86% overall in Uganda (Uganda Bureau of Statistics, 2001). Northerners feel as though they have been intentionally excluded from Uganda’s economic growth by southern-led governments. Recognising the explosive potential of inequality and disparity, Paul Jackson, a specialist in international policy, asserts “the socio-economic division between north and south has fueled continuous ethnic violence” (2002, p.29). This north-south tension persists today as manifested by the recently concluded presidential and legislative elections in which northerners overwhelmingly supported opposition candidates who received much less support in the south (UN Office for the Coordination of Humanitarian Affairs, 2006).

The current war in northern Uganda originated with the tumultuous seizure of national power by Yoweri Museveni, a Southerner and Uganda’s current president, in 1986. Museveni wrested control of the government from President Tito Okello, a Northerner supported by a military largely comprised of Acholi soldiers. With the reversal of command, Acholi ex-soldiers fled back to northern Uganda and southern Sudan, where frustration and a desire to reclaim national control prompted the sequential formation of armed resistance movements in 1986 and 1987, which ultimately culminated in the LRA, led by Joseph Kony (Gersony, 1997). Since 1987, the LRA and the
Ugandan national army have settled into an unending cycle of violence.

Violence in Acholi life

The convergence of three forms of violence — physical, symbolic, and structural — in the lives of the Acholi has made this conflict distinctly devastating. First, the physical violence of the war has overwhelmingly affected civilians. While the total number of civilians killed over the course of the war is unknown, a recent study revealed that there were an average of 146 violent deaths per week in Acholi IDP camps (World Health Organisation, 2005). An estimated 66,000 thousand children have been abducted for some period of time by the LRA (Survey of War Affected Youth, 2006). Many are then trained as child soldiers or used as sexual slaves (Human Rights Watch, 2003). Acts of physical violence committed by LRA commanders or child captives are often distinctly gruesome. However, UPDF soldiers have also been implicated in gross human rights violations, including physical torture, rape, and murder of the civilian population (Human Rights Focus, 2002).

The threat of physical violence has incited population displacement on an enormous scale within northern Uganda. Under the orders of the Ugandan government, 1.2 million Acholi, 94% percent of the population in Acholiland, have left their homes and congregated into 105 IDP camps. In some camps, the population density exceeds 1,700 people per hectare creating crowded, squalid conditions (Civil Society Organisation for Peace in Northern Uganda, 2006). Delivery of humanitarian aid requires military escort to most camps, creating formidable obstacles to the establishment of sustainable projects that meet IDP needs. Detached from their land, IDPs rely upon food delivery from the World Food Program (WFP), a source of humiliation and shame. In order to supplement an insufficient supply of WFP foodstuffs, women, risking their safety, cultivate small plots of land on the perimeter of the camps. The hope of improved security, based upon UPDF protection, has not materialised in the camps. Violent attacks occur regularly, in which the LRA abduct children, loot, kill, and burn homes, leaving camp residents forlorn and uncertain about the future.

The assembly of individuals and fragmented families into congested IDP camps has created a new social world for most in the camps. No longer spread over large tracts of land, the Acholi live in homes densely crowded within designated camp boundaries, generating new forms of social intimacy. While immediate families often remain united, extended families, an important source of relationship and solidarity, have been disrupted and segregated. Power and hierarchy have reemerged in the camps. Camp leaders, elected by the residents, serve to make decisions about camp life. Micro-economies have arisen in many camps in the form of vendors selling WFP rations or goods transported to the camp from a distant city.

The physical violence has also stirred another form of migration. Children, known as ‘night-commuters,’ who reside near larger towns, walk to hospitals, schools and other forms of temporary shelter on a nightly basis to avoid abduction. Each night the town of Gulu receives up to 25,000 night-commuters (United Nations OCHA, 2003). Unaccompanied by their parents, the children settle overnight in unsupervised and unorganised locales. These children often suffer the violence of rape and disease. As so often happens in war, violence has severely disrupted the lives of children in northern Uganda.

In addition to entangling children, violence in northern Uganda ramifies in patterns that have a distinct gender distribution. Caught in a web of vulnerability created by the social disarray of war, Acholi women have been raped by both LRA and Ugandan soldiers. Members of The AIDS Service Organisation (TASO) in Gulu report that UPDF soldiers often rape women collecting firewood or cultivating land on the edges of camps. Young females are raped while away from parental guidance and protection (World Vision, 2004). Abducted girls are given as ‘wives’ to LRA commanders and are expected to fulfill the sexual desires of male rebels. It has been argued that the LRA “has not raped indiscriminately,” yet a recent survey showed that 21% of abducted youth had witnessed rape or sexual abuse against women (Allen, 2006; Survey of War Affected Youth, 2006).

A second form of violence embedded within the lives of the Acholi is symbolic violence, which in the words of Pierre Bourdieu is “violence which is exercised upon a social agent with his or her complicity” (Bourdieu & Wacquant, 2004, p. 272). Bourdieu
illustrated symbolic violence through an exploration of gender inequity, an example most fitting for Gulu, particularly for impoverished women. Generally in Acholiland, poor women must maintain the home, collect firewood, prepare meals, watch the children and cultivate crops, if land is available. Women serve meals to men and eat after males, often in segregated areas. Sexual relations are often at the discretion of the male, whom the woman must obey. Males often pursue polygamous relationships, in which a woman is one of several wives. Unlike males, females generally leave school at a young age in order to work around the home. If resources are slim, females are expected to generate income, often turning to transactional sex as a means of ensuring personal and family survival. Males are authority figures, serving as traditional, government and religious leaders. Dufereence and respect are directed towards men, while servitude and subordination characterise a woman's social position. Gender imbalance colours life in northern Uganda, especially among the poor and uneducated. In a war setting, symbolic violence adds to the vulnerability of women already victimised by physical violence, and figures importantly in assembling a narrative of HIV transmission in Acholiland.

Understanding historical, social, political and economic forces are indelible prerequisites for developing narratives of HIV transmission. As we will see, the everyday violence of war present in Acholi life for the past 20 years matters deeply for HIV transmission. A history of colonialism and exclusion from Uganda's recent economic success are key pieces of the story as well. To do without them risks the formation of an acontextual narrative with questionable accuracy.

Towards a narrative of HIV in Acholi life

An epidemiologic perspective of HIV in Acholiland offers a rather perplexing picture that rests on a history of data limited to specific populations and geographic locales. Uganda's Ministry of Health has tracked HIV prevalence in Acholiland through antenatal clinic (ANC) surveillance at St. Mary's Hospital Lacor, a private, non-profit hospital in a rural location that provides a considerable portion of the inpatient and outpatient care for Gulu town and the surrounding rural population. The earliest data from Lacor, recorded in 1993, demonstrated an HIV prevalence of 27.1%, the highest percent recorded anywhere in Uganda. Within two years, this number dropped to 14.7%. In the late nineties, the ANC HIV prevalence at Lacor stabilised around 12% and has remained nearly the same since (see Figure 2). The earliest data from Lacor, recorded in 1993, demonstrated an HIV prevalence of 27.1%, the highest percent recorded anywhere in Uganda. Within two years, this number dropped to 14.7%. In the late nineties, the ANC HIV prevalence at Lacor stabilised around 12% and has remained nearly the same since (see Figure 2). In 2002, the Ugandan government reported an HIV prevalence of 11.9% for Gulu (Uganda Ministry of Health, 2003; UNAIDS, 2004). Other rural regions of Uganda have registered a far lower HIV prevalence among their populations. Between 1991 and 2002, the overall median HIV prevalence outside of major urban areas in Uganda declined from 12.8% to 4.7%. In rural regions abutting...
Acholiland, HIV prevalence has been drastically lower than that measured at Lacor throughout the pandemic. For example, on the western side of Acholiland, the district of Moyo in the West Nile region reported an HIV prevalence of 5.0% in 1993 and 4.3% in 2002. Nebbi, another district in the West Nile, had a prevalence of 1.3% in 2002. On the eastern side of Acholiland, the Matany ANC surveillance site in Karamojong had a prevalence of 2.8% in 1993 and 0.7% in 2002 (Uganda Ministry of Health, 2003).

Some argue that Lacor’s ANC data should be compared to urban ANC statistics because of Lacor’s close proximity to Gulu town, the largest urban center in northern Uganda (Allen, 2006; Lowicki-Zucca et al., 2005). However, the socio-demographic profile of Lacor’s ANC site reveals that more than half of the women tested described themselves as living in a rural location (Fabiani et al., 2006b; Fabiani et al., 2001b).

In addition to the official government statistics reported from Lacor hospital, a team of researchers from the Istituto Superiore di Sanità have traced HIV prevalence among patients at Lacor hospital for numerous years. Since 1989, they have periodically measured HIV prevalence among patients in Lacor’s medical wards. In 1989, 57.9% of patients admitted to medicine were HIV-positive. HIV prevalence among medicine inpatients reached a peak of 67.7% in 1994 and then declined to 46.1% by 2002, but still remained a leading cause of inpatient death (Accorsi 2004; Accorsi et al., 2005; Fabiani et al., 1998). Further, ANC surveillance done by this team at Lacor showed a significant decrease of HIV prevalence between 1996 and 1999, from 14.4% to 12.1%, consistent with government reports. However, analysis of this data by area of residence showed a significant increase in HIV prevalence of women living in rural areas from 12.6% to 16.9% (Fabiani et al., 2001a). ANC surveillance data gathered between 2000 and 2003 showed a non-significant decrease from 12.1% in 2000 to 11.3% in 2003; increased age, urban residence, being unmarried, increased age of partner, modern occupation of partner, and short time of residence at the current address were found to be associated with HIV infection. These findings led the team to conclude, “The HIV-1 prevalence in this rural district is high and similar to that observed in urban antenatal clinics, probably reflecting the effect of the last 18 years of civil strife” (Fabiani et al., 2006b, p.586).

To the contrary, the same set of statistical data has generated skepticism over the view that the war has contributed to HIV transmission in northern Uganda. Tim Allen, a noted anthropologist with extensive experience in northern Uganda, observes “Indeed, the decline in antenatal prevalence recorded at Lacor is one of the steepest recorded anywhere in the country” (Allen, 2006, p.17). Statistical analysis of ANC HIV prevalence between 1993 and 2002 at Lacor does show one of the greatest decreases in Uganda (Lowicki-Zucca et al., 2005). Using this data, Allen argues that NGO claims asserting that the war has driven high HIV transmission are mythical (Allen, 2006).

However, just as hasty conclusions that blame the war for HIV transmission can be made by NGOs, overemphasis can be placed on ANC prevalence trends to exclude the possibility that the war has increased HIV transmission. The pitfalls of ANC surveillance, especially from earlier in the epidemic, have been well-described (Ghys, Kufa & George, 2006). It is quite possible that the data from Lacor in 1993 over represented the actual HIV prevalence in Gulu. If this is the case, then focusing on the more recent HIV prevalence recordings at Lacor may offer a clearer picture of the local epidemic. Data since 1998 demonstrate a largely unchanged HIV prevalence in Gulu. A stabilised HIV prevalence hints that new infections are offsetting the decrease in HIV prevalence that would be expected from AIDS mortality in a
setting where antiretroviral therapy (ART) is unavailable (large-scale access to ART was not offered in Gulu until September 2004). While numerous factors could account for the persistence of new HIV infections in Gulu, violence associated with the war cannot be dismissed as one possible explanation.

In response to claims that the war in northern Uganda has promoted HIV transmission, it has also been pointed out that the stability of the HIV prevalence seen in Gulu has also been seen in Mbale and Mbarara, two areas of Uganda not affected by conflict (Lowicki-Zucca et al., 2005). Yet, without a detailed qualitative analysis of the factors promoting HIV transmission in all of these locales, it cannot be concluded that HIV prevalence stability in one area is or is not sustained by the same factors as in another area. The reasons for minimal decline in HIV prevalence in Gulu, Mbale, and Mbarara could overlap or be completely different, thereby demonstrating the importance of understanding HIV transmission on a local level, a topic to which we will return later.

While extensive HIV surveillance has been conducted at Lacor as a proxy estimate for HIV prevalence in Gulu district, little data has been gathered in Kitgum and Pader, the other two districts comprising Acholiland. One study conducted by the Italian NGO AVSI reported HIV prevalence among pregnant women in Kitgum to be 9.9% at St. Joseph’s Hospital and 7.8% at Kitgum Government Hospital. The same report observed an HIV prevalence of 4.6% in Pader at Kalongo Hospital (Ciantia, 2004). When considering both these data and that of Lacor, it is important to remember that ANC surveillance underestimates the HIV prevalence among the general female population, but approximates the prevalence in the entire general population (Fylkesnes et al., 1998; Fabiani et al., 2006a; Glynn et al., 2001; Walker et al., 2003).

Both the potential for bias with ANC surveillance data and the paucity of HIV prevalence data for much of Acholiland create much ambiguity about the quantitative impact of HIV on the Acholi population. Two recent studies, however, enhance the epidemiological perspective of HIV prevalence in Acholiland. First, in 2004-05, the Ugandan government conducted a sero-behavioural survey that randomly tested individuals residing in households across the country. The survey demonstrated an HIV prevalence of 7.1% for men and 9.0% for women between the ages of 15-49 in the North Central region, which included Apac, Gulu, Kitgum, Lira and Pader districts. The overall prevalence for both sexes in the North Central region was 8.2%, just shy of the country’s highest prevalence of 8.5% seen in the Central region and Kampala. Uganda’s overall prevalence for men was 5.2% and for women was 7.3%, resulting in an overall prevalence for both sexes of 6.3% (Uganda Ministry of Health, 2006). Again, the regions bordering Acholiland had far lower HIV prevalence - 2.3% in the West Nile region and 3.5% in the Northeast region (Karamojong). While the sero-behavioural survey succeeded in gathering an accurate estimate of HIV prevalence, the findings are limited by the clustering of districts into regions, thereby making district- and community-specific analyses difficult.

Secondly, in July 2005, the WHO conducted a health and mortality survey among IDP camp residents in Gulu, Kitgum, and Pader. The survey found a crude mortality rate (CMR) of 1.54 deaths/10,000/day, which translates into nearly 1000 excess deaths per week. Following malaria, HIV/AIDS accounted for the second highest cause of death (13.5% of all deaths) in all camps throughout Acholiland. Stratification by geographical locale though revealed a variable impact of HIV/AIDS on mortality across Acholiland. In Gulu district, Gulu municipality and Kitgum district, HIV/AIDS was the second leading cause of death, accounting for 15.6%, 19.7%, and 15.1% of all deaths respectively. In Pader district, however, HIV/AIDS only accounted for 6.1% of all deaths (World Health Organisation, 2005).

The epidemiological data and the arguments generated by this data lead to few definitive conclusions about the impact of the war on HIV transmission in northern Uganda. The data do demonstrate that HIV has had a large impact on a population that has also been afflicted by war. But, many questions are left unanswered by the quantitative data. Why does the HIV prevalence in Acholiland differ so drastically from the neighbouring regions of West Nile and Karamojong? Why has HIV prevalence stabilised in northern Uganda since the late 1990s? How is HIV being transmitted in Acholiland? Might the IDP camps actually protect individuals from HIV infection? Why does HIV prevalence vary across the three districts of Acholiland?
Acholiland? These questions, qualitative in nature, require stepping beyond the confines of statistics and engaging social experience. In the shadows of both the war and the disease statistics in Acholiland are the voices of patients and healthcare workers, two groups with intimate experience of HIV’s impact on the Acholi people.

Healthcare worker perspectives on HIV in Acholiland. In recent years, it has become increasingly clear to academics and world leaders that the synergy of poverty and violence generates conditions gravid with the possibility of disease (Annan, 2001; Farmer, 1999; Farmer, 2003; Garrett, 2000; Levy & Sidel, 2000). This lesson has been long recognised by healthcare workers who work in such settings and intimately encounter the ominous implications of poverty and violence for health. Such has been the case for healthcare workers in Acholiland. As a team of healthcare workers at Lacor hospital recently observed, “Long-term war and population displacement, sudden destitution, the collapse of social structures and the breakdown of the health system all contribute to increasing the risk of HIV/AIDS, emerging infectious diseases, malnutrition and war-related injuries shaping the ‘disease profile of poverty’” (Accorsi et al., 2005, p.226).

Nowhere does the disease profile of poverty become more evident than in Lacor’s AIDS clinic. Every day, long queues of HIV-positive patients line the benches of the waiting area in the clinic. For the hospital staff, the vast numbers of patients crowding the AIDS clinic manifest the seriousness of the HIV epidemic in northern Uganda. Dr. Betty Mutebi*, the Director of the HIV/AIDS Department at Lacor until recently, reflected:

6000 patients visit the AIDS clinic each month ... the prevalence of HIV has stayed around 11 or 12 percent for a number of years, and people tell me that HIV is increasing in the (Internally Displaced Peoples) camps, although I can't confirm that as we don't have the capability to do the testing.

Dr. Benjamin Ojok, who oversees Lacor’s public health efforts in Acholiland, added:

I’ve been working here at this hospital for 8 years and I have seen the burden of HIV grow on the population rather than reduce.

Both physicians, individuals who encounter Acholi patients with HIV on a daily basis, strongly suggested that HIV constituted a major health problem in the Gulu area. Kenneth Opit, the current director of the Gulu branch of The AIDS Service Organisation (TASO), a leading HIV prevention and care organisation in Uganda, affirmed these sentiments: HIV/AIDS has penetrated everywhere up here ... everyone is either affected or infected.

Lacor’s clinical staff also readily point out the myriad ways in which violence contributes to the sustained presence of HIV within Acholi social experience. In a series of conversations, Matthew O wang, an HIV counselor at Lacor, repeatedly focused upon the capability of violence to shape the spread of HIV. When asked about the etiology of HIV transmission in northern Uganda, he articulated:

As I see it, there are three factors linked to HIV transmission. First, gender inequality. This is connected to poverty and occurs because women are without education, jobs and food. They, thus, need to rely on men for survival and are put in positions without power. Secondly, the war has resulted in the destruction of values. The war has disturbed people in a major way and has led to children without parental guidance which gives rise to children with STDs and HIV. Lastly, polygamy. Women enter into this because of money, or at least the desire to survive. Men are not faithful, even in monogamous relationships ... people go outside of their relationships all the time.

In another conversation, Matthew reflected further on the linkages between war and HIV transmission:

HIV is also being spread by soldiers who are raping women. During the day, women go to the fields on the perimeter of the camp to raise crops and there they are vulnerable to rape by male soldiers ... Further, without an education, women have no way to earn money. Thus, they turn to prostitution as an option for receiving money, food, clothing, school fees, etc. Within the social network, soldiers are the ones who have money and thus the women head to the soldiers, who are also frequently away from their own families for payment ... just like so many things here in the north, HIV transmission is connected to insecurity, socioeconomics and education.

Implicit in all of his observations was an unyielding belief that the war and poverty figured centrally in the high HIV prevalence recorded in Gulu.

Matthew’s conceptualisation of effective HIV prevention also reflected his belief in the centrality of war and poverty in the transmission of HIV in Acholiland. When asked to offer suggestions for reducing HIV in Gulu, he bluntly responded:

If this war stops, then the problem here stops. Let us also hope that people can change their practices. But, this change is contingent on changes in socio-economics.

In Matthew’s vision, defeating HIV rested upon the elimination of war and poverty. Matthew believed in the value of behaviour change but recognised that
behaviour could only change in an environment that permitted individuals to act agentically.

Healthcare workers also repeatedly attributed blame to the IDP camps for HIV transmission in Acholiland. Frank Ocen, who has worked in Pabbo IDP camp for a number of years as a community health worker, scribbled the following list when asked to clarify the relationship between HIV transmission and the IDP camps:

1. Prostitution more common in the camps
2. Child abuse in the camps
3. ‘Negative’-culture now practised
4. Extensive sexual network that exists in a situation of human crowding
5. Peer pressure for the youth
6. Close quarters allows for one to see what others are engaged in
7. Rape
8. For women, sex is survival
9. Lack of youth-friendly services
10. Poor communication between parents and children

Echoing Matthew’s view on the impetus behind transactional sex, Frank added:

In the camps prostitution is about earning a living in a setting where there are no other options for earning an income. The women enter this lifestyle because they are poor and need to raise their economic status. Sex is survival.

Frank also identified polygamy as a culprit in HIV transmission. Using a set of diagrams, Frank explained:

First women go outside of their partners for sexual desires. When there is more than one woman to each man, the women are not satisfied sexually and must go outside the relationship to be fulfilled. A woman may go for two months without sexual relations if faithful to a male ... men also go outside relationships for personal feelings ... and then in the camps all of these people are closer together which makes HIV transmission easier. Polygamy occurs because people are in need of producing and want to live on and may die today.

In Frank’s view, women enter sexual relationships outside of the polygamous unit in order to satisfy sexual desires that are not fulfilled through the infrequency of sex conditioned by polygamous structure. Men pursue sexual relations because of personal desire for increased social capital. Both men and women remain woven into polygamous units because of the desire to reproduce and extend the lineage. Lastly, he identified the war as the primary culprit responsible for the perseverance of HIV in Acholiland. Near the close of one conversation, he emphatically asserted:

If this war wasn’t here, [HIV] could have gone way down. If people could go home, then they could handle it at a community level.

Indeed, the war has impeded community-level efforts to prevent HIV transmission. After many years of operation throughout much of the country, TASO only arrived in Gulu in 2004 due to concerns over insecurity in Acholiland. Now operating from Gulu town, TASO provides HIV counseling and testing, preventative education, treatment of opportunistic infections, and HIV treatment.

Evelyn Musoni, the director of the TASO office in Gulu from 2004-06, offered an assessment of the factors causing HIV transmission in Acholiland that mirrored the perspectives of Frank and Matthew:

HIV spread much more rapidly here for a number of reasons. The biggest factors are the camps and the war. People have been forced into camps, yet are still sexually active. The disruption of the war has also resulted in fractured family and social structures. A second reason is poverty, in particular for the women. In Mbale, where I’m from, the people are very crowded onto the land and farming is difficult to survive on. But, up here, prior to the war, people had a lot of land and were able to make a living on farming. The war has taken all of this away from them. Their source of income has been cut off.

Evelyn identified social and economic factors as the primary agents driving the spread of HIV. Further, she asserted:

Without the war, there would definitely be much less HIV in Gulu because of the traditional culture.

When asked to elucidate her blaming of the IDP camps for the spread of HIV, she explicated:

The camps have forced people to live in one home as a family. Previously, children of a certain age would move into another hut on the family property. Thus, they would not observe the sexual activity of the parents. However, now the children witness the sexual activity of the parents as they reside in the same space. Also during the day, the women leave the camps to work in the fields. During that time, the men and children remain in the camps which results in a great deal of defilement and also allows for the children to become sexually active with each other.

In her view, camp life both allowed children to observe sexual practices and promoted unsupervised time for children, each of which encouraged sexual activity at an early age. Evelyn also identified behavior change as one of the key factors that led to the diminishment of HIV in southern Uganda:

The war has prevented any serious attempts at altering behavioral practices in the North. People in the south had changed behavior and thus reduced HIV.

She believed the same would hold true for northern Uganda. However, thus far, in her view, structural
factors, such as the war, had collapsed the possibilities for behavior change. The obstruction of agency blunted an individual's ability to safely command a life-world free of encounters with HIV.

These same perspectives on HIV transmission and prevention in Acholiland were repeatedly uttered in casual conversations with other healthcare workers at Lacor Hospital, Gulu public hospital, Comboni Samaritan (a Gulu NGO committed to service provision and solidarity with people living with HIV/AIDS), and other NGOs. Words to the contrary were rarely heard amongst those living and working in Gulu. The voices of healthcare workers presented here offer a fairly uniform conclusion about the narrative of HIV in Acholiland: that war and HIV/AIDS are inextricably linked in that setting.

Patient perspectives on HIV in Acholiland
While healthcare workers, academics and government leaders may be positioned to make informed observations about the connections between poverty, violence and HIV/AIDS, it is only patients living with HIV and AIDS who can offer the lived experience of becoming infected and living with the illness. Yet, with a few exceptions, the voices of patients living with HIV and AIDS are glaringly absent in efforts to unravel the trajectory of HIV within communities. Regarding Acholiland, the published literature on HIV lacks any personal narratives of individuals living with HIV. Without their voices, how can conclusions be confidently drawn about the impact of HIV in Acholiland and the factors promoting its transmission? A more complete narrative of HIV in Acholiland would seem to require the inclusion, and even the privileging, of those living with the disease. In an effort to begin filling in this gap, brief narratives of Brenda and Joseph, two individuals with HIV who were interviewed in March 2006 in Lacor's TB ward, are now presented. Their stories are representative of far more interviewed at Lacor hospital and in Pabbo and Opit IDP camps.

Brenda is a 50-year-old Acholi widow who developed a new case of pulmonary TB in early March 2006. She was admitted to Lacor hospital with a congested cough in late February and was quickly diagnosed with TB. For Lacor's physicians, the diagnosis was quite simple as Brenda was known to be HIV-positive, sharply increasing her chances of having a latent TB infection turn active. As an inpatient, she was started on a TB treatment plan that would last eight to nine months depending on her progress.

Brenda's recent history has been one of hardship. For the past number of years, Brenda has been living in Amuru IDP camp, the second largest IDP camp in Gulu district. In the crowded vicinity of approximately 30,000 other camp inhabitants, Brenda lives in a circular home made of clay and bricks with a grass-thatched roof. She lives with seven other people, including her two children for whom she is responsible. She and her family members have access to a pit latrine. Prior to living in the camp, Brenda was a peasant farmer, generating small amounts of income to support her family. However, now in the camp, opportunities for farming are minimal, leaving her and her family with very little income.

The war has taken a great toll on Brenda. When asked how the war has impacted her life, she narrated:

This war has caused me great loss. I have had the loss of many relatives. My daughter died in this war and my husband too. We have also lost our ancestral lands and been displaced into these camps, which have caused us much disease, loss of work, hunger, and many problems.

In Brenda's mind, the camps are in part responsible for her poor health:

This war has hurt my health because it made me to contract the disease HIV as a result of staying in the camps. This HIV is what is now causing my problems with TB... and for me being sick is difficult as I must travel over 10km to get to the nearest health facility.

While Brenda is uncertain about how and from whom she contracted HIV, she is quite adamant that the consequences of the violence in the war are to blame.

Joseph is a 35-year-old married Acholi male who is a soldier in the UPDF. After completing primary school many years ago, Joseph stopped going to school, which he believed was connected to the war:

The war was connected to me dropping out of school. Money for school fees was no longer available because the war stopped all chances for work. What could I do then? School was done, I couldn't work, so I joined the army. This war led me to join the army.

As a UPDF soldier, Joseph now lives in the military barracks just outside Gulu town with his wife. He has
four children, with whom he lives in a circular clay home with a grass-thatched roof. Although based at the military barracks, he spends much time away from his family while on military operations outside of town.

At some point over the last few years, Joseph got HIV on one of those military operations. He too attributes blame to the circumstances of the war:

This war made me affected with HIV/AIDS and TB. The poverty, lawlessness and social disruption have let HIV go wild. I am now infected and nothing can change that.

Late in 2005 Joseph developed classic symptoms of TB – cough, night sweats and weakness. In mid-December 2005, he was started on a standard TB treatment plan. Initially, he took the medicines daily as prescribed; however, in early February 2006, he was sent out on a military operation and failed to take his medications until he returned to Lacor’s TB clinic in early March to restart treatment.

The narratives of Brenda and Joseph illustrate lives in which war and HIV have collided. Is this collision linked? Although unable to delineate the exact mechanisms linking the arrival of HIV and war into their lives, Brenda and Joseph are convinced that the two are intertwined. For them, it is not a coincidence that war and HIV disrupted their lives in the same span of time.

War, HIV and Acholiland: Complex relationships and anthropological insight

Incorporating historical and political context and the voices of healthcare workers and patients offers the opportunity to significantly broaden the analysis of HIV transmission in Acholiland and its impact upon the Acholi people. Previous work on this topic has been lop-sided in favor of epidemiological evidence, providing a rather acontextual assessment of HIV’s movement in the Acholi community. In contrast, an analysis which incorporates historical and social context, epidemiological evidence, and the perspectives of healthcare workers and patients living with HIV/AIDS offers a better chance of formulating a coherent, accurate narrative of HIV. Such an expanded analysis allows for a number of novel lessons to emerge about the relationships between war and HIV in Acholiland and beyond.

First, the physical, symbolic and structural violences in Acholiland described earlier create a number of unique exigencies that distinctly increase risk for HIV transmission. The mass abduction of children into the LRA makes youth particularly vulnerable to HIV infection. Males abducted into the LRA are coerced through physical violence to use rape as a weapon of war, while many of the girls are forced into sexual slavery as ‘wives’ to LRA commanders. A further consequence of the abductions is that parents of abducted children desire to replace them with more children. Subsequently, northern Uganda has one of the highest fertility rates in the world at 7.9 births per woman, providing ample opportunity for HIV transmission between sexual partners and from mother-to-child (Uganda Ministry of Finance, Planning and Economic Development, 2003).

For those children not abducted, night-commuting, with its own risks of HIV infection, has become a way of life for many youth (Women’s Commission for Refugee Women and Children, 2004). These children are often sexually victimised, and even when the sexual activity is consensual, it often occurs at an early age and without the benefit of information about safe sexual practices, creating an environment favourable for HIV transmission (World Vision, 2004). The IDP camps would also seem to contribute to the creation of a social setting favourable for HIV transmission. Healthcare clinics and activities, including HIV testing, prevention and care, are minimal in the camps.

Women, tending crops and collecting firewood on the perimeters of the camps, are attacked and raped by both Ugandan soldiers and members of the LRA (Akumu, Amony & Otim, 2005). Further, women living in the camps are frequently driven to transactional sex in order to provide for their children and attain the means for educational opportunities.

Gleaned in part from the narratives of healthcare workers and patients in Acholiland, the delineation of these risk factors for HIV transmission helps in explaining why HIV prevalence in Acholiland remains high. The war and its concomitant forms of violence are unique to Acholiland in recent times in Uganda. These forms of violence are also largely absent in Acholiland’s neighbouring regions, perhaps explaining the sharp falls in HIV prevalence encountered when crossing from Acholiland into the West Nile or Karamojong regions. Understanding the impact and
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The creation of IDP camps could make it easier to disseminate HIV/AIDS information to many people because of their relative power and economic advantages in comparison to female camp residents. The creation of IDP camps could make it easier to disseminate HIV/AIDS information to many people because of their proximity and the increased number of potential partners. At this time, how all of these factors have played out is simply unknown. Unveiling the realities requires detailed social analysis of further ethnographic fieldwork. Complementing this work with studies on HIV incidence would be the surest way of getting closer to an accurate depiction of HIV transmission in northern Uganda.

While numerous theories can be posited about the relationship between HIV transmission and war in northern Uganda, none diminish the strength of the premise that HIV has had a heavy impact on the Acholi population, as demonstrated by epidemiological evidence. Ancillary evidence also supports this view: after starting an HIV treatment programme in September 2004, Lacor hospital quickly enrolled 1000 patients in the programme out of an HIV/AIDS clinic with 6,000 regular attendees. Records from a voluntary counseling and testing site in Pabbo IDP camp reveal that about 10% of people tested are HIV-positive. Numerous other TB patients, many also co-infected with HIV, echoed the words of Brenda and Joseph and reported, “This war has caused me to get TB and HIV/AIDS,” whether because of crowding in the IDP camps, transactional sex, or the lack of money for education. Although impossible to draw quantitative conclusions based on such observations, they do offer a window into a world upon which, alongside war, HIV has certainly impacted.

A second lesson is that any inquiry into the relationship between war and HIV transmission must recognise the likelihood of variability in experience for both particular settings and across disparate, distant settings. In Acholiland, ANC prevalence testing and the socio-behavioural survey demonstrates a variable impact of HIV upon the population. For example, HIV prevalence appears to be highest in Gulu district followed by Kitgum district and then Pader district, where HIV prevalence is far lower and commensurate with the levels seen in other rural areas of Uganda. Juxtaposing these epidemiological findings alongside the social context may offer some clarity regarding this variability.

Throughout much of the war, Pader has been the district most afflicted with violence, thus creating a high level of isolation; to a lesser degree, such has also been the case for Kitgum. As HIV transmission in Uganda has often spread along trucking routes and major highways, the relative isolation of Kitgum and Pader may have prevented a significant introduction of HIV into the population thus far. This isolation would hold down HIV prevalence despite the presence of rape and transactional sex and the absence of HIV.
prevention efforts, all consequences of the war that would be expected to promote HIV transmission (Lyons, 2004). Gulu district, on the other hand, has maintained more extensive linkages with the rest of country, creating a conduit for increased HIV transmission into the community. Additionally, stratification of Lacor’s ANC surveillance data between 1996 and 1999 revealed that while the overall HIV prevalence decreased, it was actually increasing among women living in rural areas (Fabiani, 2001a). These examples illustrate that claims asserting a homogenous impact of HIV throughout Acholiland, whether arguing a high or low impact, are of questionable veracity. More nuanced analysis, drawing on epidemiological, social and historical evidence, reveals a varied experience with HIV across Acholiland.

Further, the lesson of variability has applicability to broader discussions about the relationship between war and HIV, a topic with a history of discrepant findings and conclusions. Smallman-Raynor and Cliff reported in 1991 that the spread of HIV in southern Uganda in the early 1980s was epidemiologically associated with the movement of Tanzanian soldiers northward in a war against Uganda (1991). In 1998, the UN published a document entitled, “AIDS and the military,” warning that in times of conflict the prevalence of sexually transmitted diseases, including HIV/AIDS, among military personnel can be 50 times higher or more than the civilian population (UNAIDS, 1998). This work, in combination with other efforts to map out the relationship between war and HIV, led to more recent attempts to synthesize general principles and recommendations for HIV prevention in conflict settings (Hankins et al., 2002; Interagency Standing Committee, 2004; Mock et al., 2004). Tracing this history of attempts to gaze into the murky realm of war and disease would seem to indicate that war brings increased HIV infections for civilians and military personnel alike.

An alternative line of thinking, however, has emerged in recent years that cautions against the blanket assumption that war translates into increased HIV infections (Spiegel, 2004). This position presents evidence that war, by virtue of its tendency to isolate populations, can actually protect a population from HIV infection. Support is drawn from macro-level analyses that track HIV prevalence in countries with a history of civil conflict anytime since the arrival of the AIDS pandemic. West African countries, such as Sierra Leone, are put forward as places with intense levels of conflict in which HIV transmission remained ostensibly low (Kaiser et al., 2002). The same applies for Angola (Spiegel & De Jong, 2003). Further, it is pointed out that in Mozambique, HIV prevalence remained low throughout its war and that, in fact, the cessation of violence marked the inception of an increase in the spread of HIV (Mock et al., 2004). The reverse logic is also applied to marshal support for this position by highlighting that the highest rates of HIV in the world are found in southern Africa where no civil conflict exists.

So, how are we to assess and digest these ostensibly divergent perspectives on the relationship between war and HIV? The variability of HIV prevalence seen in Acholiland teaches that extreme caution must be applied in crafting generalisations about the relationship between war and HIV. War in one locale means something entirely different than war in another locale. In this light, Arthur Kleinman, a noted anthropologist, warns against assuming the existence of a universal experience of violence: Possessing different histories, sustained by different social dynamics, we assume, nonetheless, that the outcome in trauma and suffering is the same. But why should that be? Why should the trauma and suffering be as different as a different form of violence or its sources are? (Kleinman, 2000)

We must recognise the ways in which night commuters are a phenomenon unique to Acholiland. The exact political and social structure of IDP camps is also a specific consequence of the war in Acholiland. The likelihood of a high presence of HIV amongst the population earlier in the war might also distinguish certain parts of Acholiland from other conflict settings. This is all to say that just because war in Mozambique or Angola didn’t cause widespread HIV transmission does not mean that the specific exigencies connected with war in another locale cannot. In the same vein, just because the war in Acholiland might be associated with increased HIV transmission does not mean that blanket statements can be made about war’s potential to spread HIV. The desire to generalise too easily lures one towards uninvestigated, incomplete conclusions. Maintaining honest integrity towards local context offers a means of keeping us from being lead astray.

Finally, the setting of Acholiland demonstrates the vital importance of carefully considering local context in
This expanded purview would also suggest that augment HIV risk significantly in northern Uganda. Shelter, health, education and economic opportunity social and economic rights, including the right to food, address. This includes recognition that a lack of basic and political forces that underpin risk must also be accounted for in the design of successful HIV prevention programmes. To reduce HIV transmission in Acholiland, the social and political forces that underpin risk must also be addressed. This includes recognition that a lack of basic social and economic rights, including the right to food, shelter, health, education and economic opportunity augment HIV risk significantly in northern Uganda. This expanded purview would also suggest that interventions by Uganda and other countries with significant influence there, must provide real security for vulnerable populations and develop economic opportunity in order to comprehensively address HIV risk. Further, conflict resolution and peace advocacy efforts would seem to have a particularly germane role in working to reduce HIV transmission in Acholiland. Of course, ending the war in Acholiland will not make HIV magically vanish, but it would remove a number of formidable obstacles to realistic reduction of HIV among of the Acholi population.

In closing, the formulation of a narrative of HIV transmission and the implementation of HIV prevention practices require engagement with complexity. The mini-ethnography of Acholiland presented above illustrates that a complex amalgamation of circumstances, processes and moments culminate in HIV transmission there. Numerous questions remain about HIV transmission in Acholiland: what is the specific HIV prevalence in the IDP camps? Has unclean medical equipment contributed to HIV transmission in Acholiland? How has HIV impacted the lives of children who have escaped the LRA? Has the UPDF had a role in spreading HIV? Most importantly, what forms of prevention will succeed in reducing HIV prevalence in Acholiland? An alignment of epidemiological study with anthropological analysis offers the most promising avenue for engaging these questions.

References


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trends among different risk groups in Gulu District, North Uganda (Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology, 18(5), 524).


World Vision International (2004). For confidentiality, the names of all interviewees have been altered.
ABSTRACT
Luo women are believed to acquire contagious cultural impurity after the death of their husbands that is perceived as dangerous to other people. To neutralise this impure state, a sexual cleansing rite is observed. In the indigenous setting, the ritual was observed by a brother-in-law or cousin of the deceased husband through a guardianship institution. However, with the emergence of HIV/AIDS, many educated brothers-in-law refrain from the practice and instead hire professional cleansers as substitutes. If the deceased spouses were HIV positive, the ritual places professional cleansers at risk of infection. Thereafter, they could act as a bridge for HIV/AIDS transmission to other widows and to the general population. This paper provides insights into reasons for continuity of widowhood rites in Siaya District. Twelve focus group discussions and 20 in-depth interviews were conducted. The cultural violence against Luo widows could spread HIV/AIDS, but Christianity and condoms act as coping mechanisms.

Key words: Coping mechanisms, cultural violence against widows, guardianship institution, HIV/AIDS, professional cleansers, sexual cleansing rite.

INTRODUCTION
HIV infection and AIDS have grown exponentially since 1984 when the first case was diagnosed in Kenya (Forsythe & R au, 1996). Data from the 2003 Health and Demographic Survey show that 6.7% of the Kenya population was found to be HIV positive (R public of Kenya, 2004). Women were more likely to be HIV positive than men: HIV prevalence in women aged 15-49 was 8.7%, and in men was 4.6% (N ASCOP, 2005). Data show disproportionate HIV/AIDS infection based on geographical areas, with urban areas being more affected than rural areas (N ASCOP, 2001; R epublic of Kenya, 2004). The highest prevalence was found in Nyanza Province (15% in adults); with Siaya district leading at 32% (N ASCOP, 2005). Despite recent data that show a dramatic drop in national prevalence among pregnant women in urban Kenya, the scenario in Siaya district is worrisome.

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What factors then, could be responsible for the high HIV prevalence in Siaya district?

Among the Luo of Siaya district, women are expected to observe a cleansing ritual, which has a sexual component, before being re-incorporated into society following the death of their husbands (Luginaah, Elkins, Maticka-Tyndale, Landry & Mathui, 2005). This ritual endangers widows' lives through possible infection with HIV/AIDS. Indeed, the Government of Kenya (GoK) has failed in its appeals to the Luo to abandon the life-threatening widowhood rituals (Republic of Kenya, 2001). While research has quantified the high prevalence of HIV/AIDS in Siaya district (NASCOP, 2005; Republic of Kenya, 2004), the underlying reason for the continuity of widowhood rites among the Luo has apparently not been addressed by researchers. The central problem of this study, therefore, revolves around the question, “Are Luo widows ‘compelled’ by male decision-makers to observe the cleansing widowhood rituals that endanger their lives or do they do so out of their own free will?” It is only after generating a database on patterns and reasons for sexual behaviour among the Luo that relevant mitigation interventions could be initiated to change their sexual behaviour and make it less risky for HIV/AIDS transmission.

This paper starts by presenting the research methods that were utilised in the study. This is followed by a brief overview of the study area and implications for HIV/AIDS transmission. Widowhood in the indigenous and contemporary Luo communities is discussed, and then the reasons for and against widowhood practices are explored. This is followed by the coping mechanisms that are employed by widows. The paper ends with a discussion and recommendations for the way forward to minimise the apparent risk for HIV transmission that is inherent in Luo widowhood rites.

**RESEARCH METHODS**

**Research design and description of discusants**

A qualitative study design using focus group discussions (FGDs) and in-depth interviews (IDIs) was used to generate data. The study generated responses on why the Luo observe widowhood practices despite the apparent health risks involved. The researcher probed participants' responses for clarification and detailed information on the Luo widowhood rites. Some discusants became so emotionally involved that they narrated their experiences of widowhood. Such discusants went beyond mere superficial responses by focusing on their experiences, feelings and firmly held beliefs. The use of qualitative methods was appropriate for this type of study because it facilitated the gathering of narratives and experiences related to widowhood among the Luo.

In each visited division, four FGD sessions were held with the following groups: male married adults, female married adults, widows, and elderly widows or widowers. Although the researcher had intended to interview six categories of respondents, including widowers and youth, saturation was reached after interviewing four groups during the pilot study. Consequently, twelve FGDs were held in total. This paper focuses on results of the FGD theme that examined the implication of cleansing and widow guardianship rituals among the Luo on the lives of widows in Siaya district.

**Description of the research site**

Siaya District is one of the 12 districts that comprise Nyanza Province. It is divided into seven administrative divisions, namely Yala, Wagai, Karemo, Ujunja, Boro, Uranga and Ukwala. These divisions are further divided into 30 locations and 128 sub-locations (Republic of Kenya, 2002).

**Sampling procedures**

Purposive sampling was used to select three out of the seven divisions of Siaya District. Yala division was selected because it is along the Busia-Uganda main road that has been greatly affected by HIV/AIDS. Boro division is near Uganda and is the administrative centre of the district, while Ukwala division is in the interior and close to Lake Victoria. Our purpose was to examine whether or not widowhood rites were observed in the different divisions. The selection of sub-locations was by random sampling.

**Recruitment and description of FGD procedures**

The recruitment of respondents was done with the help of community leaders: church ministers and administrators of women groups. Ten discusants, who were expected to be as homogenous as possible in terms of sex, age and marital status, were recruited for...
each FGD. A moderator led the discussions with the help of two note takers. The 12 FGDs were conducted in Dholuo language and were audiotaped. The FGDs comprised 10 discussants giving a total of 120. All sessions were conducted in classrooms of public schools and lasted for two hours. None of the participants dropped out from the study. The FGDs focused on widowhood rites, their purpose and consequences, and attitudes towards them.

Description of IDI procedures

IDIs were conducted with selected interviewees who had not participated in FGDs. IDIs were used to countercheck the information derived from the various FGDs in order to validate the data with personal experiences. This step was crucial because FGDs provide group reflections that may not tally with actual practices. In each division, four widows were randomly selected, totalling 12. In order to minimise bias in the recruitment of respondents, the researcher randomly selected four respondents from a list of widows who had not participated in FGDs. When visiting one of the widows, the research team met a professional cleanser whom the researcher also then interviewed. Other interviewees included: a long-serving Catholic priest, a reverend of the Anglican Church of Kenya (ACK), a priest in the Legio Maria Church, two officials from a women’s organisation called Maendeleo ya Wanawake (MYW), and two project managers of the Double Joy Children’s Farm, a centre that caters for orphans in Siaya district. In total, 20 people were interviewed in IDIs, which were conducted in the houses of respondents and lasted about two hours each.

Research assistants

The study employed the services of six research assistants (RAs) of both sexes. RAs interviewed discussants of the same gender to minimise embarrassment that sometimes occurs when discussants are interviewed by the opposite sex. RAs were mature in age to enable discussants to interact with them freely. RAs were selected from graduate students at Kenyatta University, based on gender and ability to communicate fluently in both English and Dholuo language. Recruitment of RAs was based on scores obtained after administration of a test to check students’ fluency in the two languages. The RAs performed different roles leading the discussions (moderators), taking notes (note-takers) and audiotaping the sessions.

RAs were trained in ethical issues concerning involvement of human subjects in research. Again, a review of the entire proposal was made to clarify issues to be investigated. Finally, RAs were trained on how to conduct FGDs and IDIs as a way of collecting qualitative data (Ulin, Robinson & Tolley 2005). The training also covered the use of recording instruments and note taking. Data from recorded interviews was transcribed and translated as soon as the FGDs and IDIs for any one particular day were complete, to facilitate recall of information.

Ethical issues

Our research protocol was submitted to the Office of the President for ethical approval before the study started. Thereafter, we approached the administrative and local leaders in Siaya district to seek their consent, show them the ethical approval certificate from the government, and request for support and security.

Additionally, informed consent of respondents was sought before their participation in the study. Respondents were assured of confidentiality and were asked not to share the information outside the group. The researcher also informed the participants that they were free to decline to participate, not to respond to a particular question or to quit if they so wished. Again, they were informed about the reimbursement of US$3 at the end of the session for travel and appreciation of their valuable time. Their willingness to be audiotaped was also sought.

Pilot study

A pilot study was conducted to test the research instruments in Boro Division. The pilot study enabled the researcher to revise the instruments by using terms that resonated with the language used in the study area. The research team learnt that the local Luo name for HIV/AIDS is ayaki, meaning extreme thinning followed by death. We also learnt that the physical symptoms of cultural impurity, ‘chira’ are almost similar to HIV/AIDS symptoms. The only difference being that cultural impurity can be treated using herbs, but HIV/AIDS has no cure. This knowledge enabled us to add some questions to our research tool to find out whether or not the Luo distinguish between the two health conditions and the implications of their interpretation. Results of this objective are outside the scope of the current paper.
**Data collection**

Data were collected from February to June 2004. Data were recorded using codes rather than names of respondents, to ensure confidentiality of personal details that emerged during the discussions. The interviews were conducted in Dholuo for better expression. At the end of the sessions, moderators and note-takers listened to the tapes, transcribed the data and also edited them to come up with a clean report for each FGD. This was followed by translation of the reports from Dholuo into English.

**Data analysis**

Qualitative information obtained through FGDs and IDIs were analysed manually. The analysis of the data took the following steps. The transcribed scripts were read to explore emerging themes. Coding was done according to themes. Further coding was done based on sub-themes. Thereafter, information related to each code was displayed in detail. The data were then reduced, as the research team explored similarities and differences in responses based on gender, age and geographic location. The meanings and behaviour of respondents were examined including unique cases that were reported. Finally, the data were examined to get patterns of widowhood behaviour, its causes and effects on Luo widows in Siaya district.

**RESULTS**

**Study area and implications for HIV/AIDS transmission**

Siaya district is one of the nine districts of Nyanza Province. This study was conducted in three of the district’s six divisions: Boro, Ukwala and Yala. The total area of the district is 3,523 km², of which about 1,005 km is lake water (Republic of Kenya, 2001). The population is largely rural and youthful, with at least 58% being between the ages 0-19. The district has more females than males since men migrate to urban areas for employment. Fish trade is the main economic activity. Siaya district is one of the least economically developed regions of the country, recording among the highest levels of women’s illiteracy (Republic of Kenya, 2004). Consequently, most girls do not qualify for highly paying jobs and this translates into low economic status for women, particularly widows who cater for their households alone.

Low literacy also affects the nutritional status of children and mortality rates. The majority of underweight children are under 12 months old. The main causes of malnutrition in the district include: low calorie intake due to bad eating habits, lack of food, low agricultural production, low incomes, low literacy rates among women, lack of clean safe water, and poor sanitary standards (Republic of Kenya, 2004). The infant mortality rate (IMR) at 211 deaths (children under 5 years) per 1,000 births was ranked as the third highest in Kenya in 1989. This figure declined to 130 deaths per 1,000 births in 1992 and to 102 in 1995, compared to the national average of 60 deaths per 1,000 births (Republic of Kenya 2001). Mortality is currently on the increase because of the high incidence of HIV/AIDS in the district, thereby reducing the gains made in the IMR reduction. The poor nutrition status, high infant mortality rate and HIV/AIDS in Siaya district seem to be intertwined. This is because lack of food is a risk factor for HIV infection and also hinders effective management of the epidemic (NASCOP, 2005). Could widows in Siaya district equally be lacking food? If so, what implications does this have for their susceptibility to HIV/AIDS transmission? The next section examines the intervention that was employed in the indigenous Luo setting to cater for the basic needs of widows.

**Guardianship and cleansing of widows in the indigenous Luo community**

According to participants, a widow was confined to her homestead for a whole year, since she was considered as culturally impure and dangerous to the community. During this time, a widow had a dream where she engaged in sex with the deceased. The sex dream was an indicator that the widow was free to be cleansed. Indeed, widowhood taboos were lifted after the final post-burial ritual where the life of the deceased was celebrated. Thereafter, widows were given to men in the community to guard over them, with a view to providing basic and emotional needs. Widows chose their successors but made their decision public before a group of elders. The senior widow (first wife in a polygamous marriage) announced the choices that junior widows had made. Screening of the chosen names was done to ensure that no taboos were broken. For instance, discussants observed that a man could not guard a widow if his wife was nursing twins. Again, the ritual was so complicated that only men with established families were free to guard widows. Sometimes, men declined the requests of widows if they felt unfit to perform the role.
A guardian was supposed to engage in sex with a widow to free her from taboos and also from the spirit of her dead husband. Sometimes, a guardian would be too nervous to have a successful sexual union with a widow. Consequently, a widow informed the community if the ritual had been successful. Each guardian went to the homestead at his own time, starting with the senior widow. The ceremony did not necessarily take place on the same night for all widows, since junior widows could only be visited by their chosen guardians after the cleansing of the senior widow. The venue for the ritual was the deceased's house where the widow had continued living.

Discussants observed that ritual sexual intercourse began after supper and was done in three phases: a few metres from the house, then between the doorposts of the house, and finally at the sleeping place. If the sexual union was successful, the guardian cut the banana fibre string that had remained around the widow's neck, to symbolise that she was now ritually separated from the deceased's spirit. This ritual was referred to as cutting the symbolic string of the mourning period 'okola', since it was the first time a widow had sexual union with another man.

Later on, the guardian took the widow to his home for reconciliatory ceremonies. While there, medicinal herbs were drunk by the widow, guardian, his wife and children to protect them from any bad omen due to their close contact with the widow. Thereafter, the guardian took over the responsibility of catering for the needs of the widow and her offspring. The first task was to construct a new hut for the widow. A guardian also led the new family in observing religious functions and took care of dowry negotiations when the deceased's children wanted to marry. However, guardians could not misuse the property of the deceased, since elders vetted their actions. Guardians who failed to perform their roles were divorced and new ones chosen with the help of elders.

Apart from the above-mentioned conventional method of separating a widow from the deceased's spirit, results of FGDs indicate that sex was not mandatory in all cases of guardianship. The following alternatives were mentioned by discussants:

A brother-in-law gave an elderly widow tobacco to smoke. This was passed through the space between the wall and the roof. Thereafter, the two sniffed the tobacco 'ndawa' together (FGD with female elders, Ukwala division).

If a widow died before observance of the cleansing ritual, a person was hired either to lie on top of her without performing any sexual act or alternatively, the person lifted his leg to point a penis at the vagina of the corpse without penetrative sex (FGD with male elders, Yala division).

Symbolism in the above-mentioned practices indicates an intention to make love. Widows in the indigenous Luo community had some authority over their own lives, since they were involved in choosing their guardians. Additionally, post-menopausal widows were not forced to make love. Does the same situation hold today?

Cleansing of widows in the contemporary setting

Due to the fear of contracting HIV/AIDS, some relatives of the deceased hire professional cleansers to engage in sex with widows. Commenting on this new phenomenon among the Luo of Siaya district, Ocholla-Ayayo (1996, p.4) observes that:

A 'jakwiny', a sexual perverse, or psychopath capable of doing what normal human beings cannot do, is persuaded to perform cord cutting sex between a widow and the deceased husband so that the widow may be free to re-marry or to be inherited. Because of payment of a cow, goat or money to date, there are many jakwiny cleaners who move from one village to another where a man has died.

A respondent in our study noted the following:

Many educated men are afraid to have sexual contact with widows. Consequently, professional cleansers have sprung up to free widows from 'okola' bondage (Field supervisor of the Double Joy Children's Home, IDI Boro division).

Professional cleansers emerged in the 1990s when deaths from HIV/AIDS in Siaya district were at a peak. Referring to what happens in his village, a respondent noted that:

If the family suspects that the death was related to HIV/AIDS, a professional cleanser is hired and given alcohol. Thereafter, he is taken to a widow's house to perform a sex ritual on her. Family members sometimes supervise the ritual to ensure that the penis penetrates the widow's vagina to effect the cultural cleansing (FGD with married men, Ukwala division).

Data indicates an emphasis on sex in cleansing of widows in recent times. Field data revealed an isolated recent case in which a drunken professional cleanser raped an elderly widow. In the respondent's words:

A 70-year-old woman lost her husband in 2003. Although she did not want to observe widowhood rites, her sons and brothers-in-law insisted that they were important to enable the deceased to rest in peace. One evening, her two brothers-in-law visited with a stranger and convinced the widow about the necessity to observe the cultural rite. The elderly woman assumed that the stranger was going to give her tobacco so that
Discussants observed that such rape of an elderly widow inflicted physical and psychological violence against her and was contrary to cultural expectations.

When asked whether or not sex should be involved in the cleansing of widows today, respondents stated as follows:

- Sex is a must. This is because the prime function of cleansing is both to free the widow from okola, bondage as well as enabling her to get children so as to perpetuate the deceased's lineage (FGD with widows, Boro division).
- A professional cleanser, jakowiny clears all obstacles that could have been on the way in readiness for the guardian to take over the widow (FGD with widowed men, Yala division).

From the above responses, sex seemed to be central in the cleansing ritual, irrespective of the physical qualities of the male cleanser. The cleansing performed by a professional cleanser was perceived as a prelude to placing a widow under a guardianship institution, by a brother-in-law, if she remained healthy. However, if her spouse was HIV positive, the widow was also likely to be positive, and could transmit the virus to the guardian together with his wife or wives.

Reasons for observing widowhood rites

Data revealed that many widows were forced by circumstances beyond their control to participate in widowhood rites. Relatives of the deceased might force a widow to observe the ritual so as to set her offspring culturally free to construct houses, marry, plant and weed their farms. For example, farms among the Luo were planted in the order of seniority. A mother must plant before her sons. Yet a sex ritual to symbolise fertility must precede the planting process. Some widows who had been 'forced' by culture to observe widowhood rites maintained that:

- My in-laws brought a filthy-looking stranger to cleanse me. I did not like the idea but had no option since I was protecting my children against chira, impurity. Besides, clan members insisted that I underwent all the rituals to enable my sons to marry and construct houses of their own. There was too much pressure exerted upon me that I decided to solve the immediate problem rather than fear HIV/AIDS transmission that was a future possibility (FGD with widows, Boro division).
- Even with my advanced age, my sons subjected me to great suffering. They hired a mentally impaired man to cleanse me so that they could be free to re-marry in case their spouses died (FGD with the elderly, Yala division).
- My brother was involved in a road accident three months after the burial of my husband. It was a very difficult situation because my brothers-in-law wanted to attend the funeral with me. Yet I could not leave the deceased's homestead before being cleansed. I had to send someone to Ng'aya Market to hire any available professional cleanser to perform the ritual (FGD with widows, Boro division).
- Many widows reiterated that they observed the cultural widowhood rites as a survival strategy to protect their property. Commenting on their dilemma, some widows observed that:

  - I had no choice since it was the only way I could continue staying on the land of my deceased spouse. I had nowhere else to go. My parents were dead. Yet my brothers would not have me go back home (FGD with widows, Ukwala division).
  - My brothers-in-laws gave me two choices either to be cleansed and later on be placed under a guardianship institution, or to go away and lose all the property. I obliged (Widow, IDI, Yala division).
  - If I had any other way, I would have avoided the ritual. But I lacked money and land to keep me going. I had to do what my in-laws wanted so that I could continue living in their home (FGD with widows, Boro division).

Some respondents seemed to have internalised the cultural expectation and saw it as their only option, as indicated in the following responses:

- I observed the cleansing ritual because Luo widows are supposed to do so. I paid a goat to a professional cleanser for his services (FGD with widows, Boro division).
- A mother’s action determines how her children will live in future. I had to observe the rites so that my children could re-marry if their spouses died and construct houses when the right time comes (FGD with widows, Yala division).
- The family of my husband brought a cleanser for me. Thereafter, one of my brothers-in-law guarded over me for a while. Right now, a cousin of my late husband fulfils my sexual needs before visiting his two wives (Widow, IDI, Yala division).

Opposition to widowhood rites

However, a few respondents showed outright rejection of the two widowhood rituals with, a view to avoiding HIV/AIDS infection as well as avoiding exploitation by guardians. They stated that:

- Unlike in the old days, life with a guardian today is full of tension. His wives are usually resentful of the relationship. Besides, it is better to avoid sharing men to avoid HIV (FGD with married women, Boro division).
- Brothers-in-law sometimes compel the widow to be inherited so that they can get access to the property of the deceased. Guardians are parasites who mind about their welfare but not that of the widow and her offspring (FGD with elderly respondents, Ukwala Division).

Many widows noted that they had refrained from the guardianship institution. Female respondents pointed out that guardians no longer provided basic needs as was the case in the past. The institution created social tension among women, created an economic burden on widows, and sometimes led to physical violence against them. Christian widows who refused guardianship requested their church ministers to...
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Condoms are laced with ayaki (HIV/AIDS). We do not want to get killed. The cleansing ritual cannot be successful if a barrier is placed between the ritual performers. We must respect the dignity of the ritual of separating the ghost of the deceased from a Luo widow (FGD with married men, Yala division).

Why on earth should I use a condom? Sex is enjoyable when it is skin to skin. I am a true Luo man who, like a cow, should die when chewing its cud (Professional cleanser, IDI, Boro division).

Condoms are for prostitutes. A cleansing ritual is a decent cultural obligation. Besides, our church does not allow condom use (Pastor of Legio Maria Church, IDI, Boro division).

Coping mechanisms

First, some widows with HIV attempted to avoid widowhood rites and cautioned their relatives and sexual partners to avoid them with a view to preventing HIV/AIDS transmission. However, respondents noted that most men, especially those with a lower educational status, insisted on having sexual relationship with widows even after being warned about the HIV status. Risk factors for such behaviour were identified as the apparent good physical health that most widows exhibited for about three to four years after the internment of husbands, alcohol and drug abuse, poverty, belief in witchcraft and lack of disclosure of the cause of death. When asked why people risked their lives through widowhood rites, respondents observed that:

Most people have sex with widows/widowers under the influence of alcohol. Again, poverty has forced many men to operate as professional cleansers. Such people will continue to cleanse widows so long as the bereaved families can pay them (Priest of Roman Catholic Church, IDI, Yala division).

It is not easy to know with certainty whether a person died of AIDS or not since all diseases make people thin, even chira cultural impurity. People cannot refuse to make love to widows just because of rumours (FGD with widows, Boro division).

Some people die of AIDS-related complications before the symptoms are seen. Such people leave their wives as carriers but healthy. When a man cleanses or guards over such a widow, he contracts HIV and takes it to his wife/wives (An administrator of MYW, IDI, Boro division).

Second, some Luo widows with HIV proposed the use of condoms to protect themselves as well as their sexual partners from re-infection. Data revealed that condoms were unpopular for varied reasons. They spread the epidemic, rendered the cleansing ritual unsuccessful, reduced sexual pleasure and were for prostitutes. In respondents' own words:

Condoms are laced with ayaki (HIV/AIDS). We do not want to get killed by the foreign disease (FGD with widowers, Boro division).

Third, Christianity was also used as a coping strategy by widows, especially the elderly. This was revealed in the following responses:

Why observe such a sinful practice? Jesus Christ is the overall protector of all people. Widows should not be afraid of death because everyone will die (FGD with widows, Ukwalwa division).

Prayer encourages me to keep up with life despite the odds against me. I am HIV positive and my family has rejected me because I refused to be cleansed. I rely on the Lord our saviour through prayer as my only friend. This is because God knew what could befall me before I was born (Widow, IDI Boro division).

It emerged from the findings that widows from mainstream churches were more likely to refrain from observing funeral rites than those from African instituted churches. These divergent positions were clear from the following observations:

As a member of St. Monica Women Group in the Roman Catholic Church, the Christian community has given me a lot of support despite hostility from my in-laws. Members of my group visited me when no one else could visit me for fear of contracting cultural impurity, chira. The priest prayed for my new house, witnessed its construction and provided the iron sheets for thatching instead of a guardian. So far, nothing has happened to me and my children. We trust in Jesus Christ for eternal protection (FGD with elderly females, Yala division).

Cleansing rituals existed in the Old Testament. Again, widow ‘inheritance’ was allowed. Our Luo culture is indeed very similar to the Biblical practice and such care of widows should be encouraged in the current difficult economic environment. Otherwise, it can be so unfortunate for Luo men to leave widows without caring for their needs as demanded by both the Bible and culture (Pastor of Legio Maria Church, IDI, Boro division).

Fourth, higher education and economic empowerment provided safety nets to avoid the rituals. His revelation was clear from FGDs and IDIs data whereby most widows with secondary school education and economic stability ignored the cultural requirement of guardianship. An educated widow noted that:

I cannot observe such a rite unless I want to die and leave my children as orphans. I have a job and I am ready to work so hard to provide whatever my children require (Widow, IDI, Boro division).

On the other hand, widows with primary school education and no economic empowerment accepted the cultural demands. According to a respondent:
If I had any other way, I would have avoided the ritual. But I lack money and land to keep me going. I had to do what my in-laws wanted so that I could continue to live in their home (FGD of widows, Yala Division).

Fifth, many young widows who refrained from observing widowhood rites migrated to towns and beaches to engage in petty trade. Sometimes, these young widows made secret sexual liaisons. According to a widow:

When my husband died, I refused to be cleansed by a professional cleanser as demanded by my brothers-in-law. I was sent away with my three children and lost the shop that my husband and I were operating. In the absence of any means of survival, I went to the beach to trade in fish. In the process, I met a fisherman and we became lovers (widow, IDI, Ukwala division).

Data showed that some widows approached unsuspecting men to cleanse them, either to psychologically free themselves from the assumed fear of supernatural punishment as a consequence of not observing widowhood rites, or as a survival strategy. To this end, whereas the guardianship institution was declining, we cannot state with certainty that widows refrained from having sexual liaisons, hence possibly transmitting HIV/AIDS if infected.

DISCUSSION

Professional cleansers, who could act as a bridge for HIV transmission, have emerged in Siaya district because most educated Luo men reduce their risk for infection by declining to guard widows. Although such men protect themselves, they endanger widows’ lives, thereby demonstrating gender polarisation. Patriarchy that places a lower premium on the lives of women compared to that of men needs to be critiqued (Oduyoye, 1995). Although Luo widowers also observe a sex ritual for cleansing purposes, they chose their sexual partners and are more likely to engage in safer sex compared to widows who are at the mercy of professional cleansers. From an etic viewpoint, it could have been better for the Luo to drop the aspect of ritual uncleanliness of chief mourners altogether.

However, from an emic perspective, the psychological fear of infecting children with cultural impurity, chira, and the subsequent desire to neutralise it, are the driving forces for cleansing rites. This belief is deep-seated among the Luo such that it cannot easily be challenged and discontinued.

The Luo male decision makers are responsible for establishing all norms. The fact that widows require cleansing as a pre-requisite for incorporation into their society and as a means of neutralising the assumed cultural impurity means that their decision is culturally compelled rather than self-willed. Indeed, the use of drunken strangers as sexual partners seems to violate the widows’ rights of association and safety. Thus, the act constitutes cultural violence against Luo widows. This finding corroborates other studies which state that widowhood rites are mandatory from a cultural perspective (Ambasa-Shisanya, 2004; Gennep, 1960; Owen, 1996). Yet these rites could endanger lives of ritual participants through infection with HIV (Ilinigumugabo, 1995; O duyoye, 1995; O wen, 1996). Yet these rites could endanger lives of ritual participants through infection with HIV (Ilinigumugabo, 1995; O duyoye, 1995; O wen, 1996). Yet these rites could endanger lives of ritual participants through infection with HIV (Ilinigumugabo, 1995; O duyoye, 1995; O wen, 1996). Yet these rites could endanger lives of ritual participants through infection with HIV (Ilinigumugabo, 1995; O duyoye, 1995; O wen, 1996). Yet these rites could endanger lives of ritual participants through infection with HIV (Ilinigumugabo, 1995; O duyoye, 1995; O wen, 1996).

In practice, however, widowhood rites continue unabated in some communities in Kenya, such as the Teso, Mijikenda, Pokot and Abaluhya (Ambasa-Shisanya, 2004). Njau and Njeru (1997) established that 84% of their sample in Nairobi and Kajiado districts reported having known specific cases of wife inheritance. Ndolo (1995) found that 53% of her sample from the Luo community was in support of widow guardianship, as opposed to 48% that disapproved of the practice. Kawango (1998) observed that 71% of her respondents from the Luo community would like their children to participate in the widow guardianship institution. It is not clear why some communities in Kenya seem to have discontinued widowhood practices while others have retained them. The Luo, as indicated in the above recent studies, still prefer to practise widowhood rites, despite their awareness that the rites could transmit HIV. This finding corroborates those of other studies that knowledge about HIV does not always translate into behaviour change (NASCOP, 2005; Ocholla-Ayayo, 1996).

Widowhood rites enhance HIV transmission, especially when the ritual performers, as in the case of the Luo, are uncircumcised. Uncircumcised males suffer bruises during intercourse that expose their partners to infection more readily than circumcised males (Scott, Weiss & Viljoen, 2005). When a professional cleanser is infected, he could transmit HIV to many widows. Alternatively, widows whose husbands were HIV
positive could easily transmit the virus to their ritual performers and other social partners, “if the couple was not discordant”. Our study established that the sexually active widows who move to beaches and urban areas to engage in petty trade easily formed sexual liaisons with fishermen. If safe sex is not practised, HIV positive widows could infect their sexual partners, who also infect their wives. In order to prevent such a vicious cycle of HIV infection among the Luo, Ocholla-Ayayo (1996) advocates for continuity of guardianship institutions.

The researcher recognises the support that was accorded to widows in the indigenous Luo community through the guardianship institution. Despite infringing on the human rights of widows to free association, the intervention was the best option in a situation where women lacked education and economic empowerment. However, field data revealed that the institution no longer serves the role for which it was intended. Instead, it exposes widows to abuse and economic impoverishment. The situation is worse if widows are HIV positive, because they could be thrown out of the homestead altogether. Poindexter (2005) and Owen (1996) concur that widows are subjected to a lot of suffering, especially if they are HIV positive. The present study established that the suffering of Luo widows takes many forms, such as being forced to relocate to urban areas and beaches. In order to curb such suffering, this paper advocates for an alternative guardianship institution through exclusive use of symbolism for cleansing purposes. In other words, the need arises to re-introduce cleansing through symbolism, as was the case for elderly post-menopausal widows. The Luo Council of Elders should play its appropriate indigenous role by ensuring that widows access the property of the deceased and live in the community without any abuse of their sexual and other rights by brothers-in-law. Nevertheless, the sexually active widows should be free to engage in consensual sexual relationships, as long as they engage in safe sex using condoms to prevent HIV transmission.

Data reveal that most respondents did not use condoms in sexual encounters. In many cases, alcohol use and misconceptions about condoms hindered some Luo men from using condoms. The low usage of condoms is supported by research findings that men in Kenya engage in extra-marital affairs, yet they do not protect their wives from HIV/AIDS, since 48% of such men never use condoms with their wives (Muvadi, 1995). Even if Luo widows want to use condoms, the majority cannot afford female condoms. Besides, they are unavailable in most chemists and not dispensed freely in public toilets and hospitals unlike male condoms. Therefore, the government should consider creating more awareness about female condoms and providing them free of charge, to empower women to have control over their sexuality and prevent HIV infections. Furthermore, there should be a change in attitude among men about condom use, if the devices are to play an effective role in preventing HIV/AIDS transmission in Siaya district.

The intervention of education has helped Luo educated men and widows to refrain from the life threatening widowhood rituals. Illiteracy could explain why some people fail to take cognisance of the window period, thereby exposing themselves to HIV. Some less educated Luo people are more likely to observe widowhood rites during the window period, unaware that they are exposing themselves to the epidemic. Such people associate the image of thin people with HIV/AIDS. Therefore, there is a need to change the initial information that was given to people about HIV/AIDS. Awareness campaigns need to continue so that the Luo can better understand facts about HIV/AIDS. Faith-based initiatives, for example, should target members of the African Instituted Churches who engage in practices such as unsafe sex and polygamy that predispose them to HIV infections.

This study established that gender discrepancies in access to education and subsequent lack of economic empowerment of women contributes to many Luo widows observing widowhood rites as a survival strategy, unlike the highly educated widows who adopt safer alternative coping mechanisms. The data corroborates findings from other studies that the inability of some widows to provide basic necessities to their children has led them to engage in risky activities such as prostitution, with a view to surviving now rather than leaving their children to die of hunger (Owen, 1996). Equally, the present study established that poverty drives some men to act as professional cleansers. Yet multiple sexual partners expose individuals to the possibility of HIV/AIDS and sexually transmitted infections (STIs) (Ray, 2004). Some Luo widows with STIs, for example, may lack...
money to pay for hospital treatment. Unfortunately, the presence of STIs that cause overt ulceration such as syphilis, chancroid, and trichomonas create a positive environment for infection with HIV/AIDS (Mabey & Mayaud, 2004). Thus there is a need to improve the socio-economic status of women and the overall poverty in Siaya district. This long term objective could be attained if girls are encouraged to go to school, and loans provided to both men and women by micro-financing institutions for starting small-scale businesses.

Apart from education and economic empowerment, there is a need to improve legal structures so that widows can inherit the property of the deceased directly, instead of owning it through their sons, as is the case in Kenya today. This will prevent widows from risking their health for the sake of property. Again, the human rights of mentally impaired persons need to be respected so that they are not abused by relatives to act as professional cleaners for survival.

CONCLUSION

In conclusion, it is important to re-examine the values and norms in African cultures that ensured smooth running of families, such as the use of symbolism in cleansing running widows. In conformity with the cultural practice, Luo elders should be meeting in all villages on a weekly basis to discuss how they could combat HIV and AIDS. These weekly meetings should be used to create more awareness about the window period, to change the association of HIV with thinness, to address alcohol and drug abuse, as well as the myths about condoms as risk factors for HIV transmission. Furthermore, awareness should be created about the need for economic empowerment of girls, women and professional cleaners to prevent their susceptibility to HIV transmission during widowhood and to also fight poverty. Emphasis should be placed on the need for equal access to opportunities like education, and resources like land along the gender divide.

References


Footnotes

1The term widow is used because a male relative takes over responsibility for the widow and her offspring. The person remains a protector and provider but not a husband since the widow remains the wife of the late so and so. 13:17:4.

2In Kenya, there is a need to improve the socio-economic status of women and children.

3Indigenous refers to pre-Christian and pre-colonial practices in the Luo community.

4The term is used from the indigenous perspective. Otherwise, it is a derogatory term that implies women, just like children are immature and require a man to look after them. Yet this is not the case these days, especially when women are empowered economically.

5Some respondents observed that condoms have a lubricant that has been mixed with the HIV. For this reason, there was reluctance among some people to use condoms fearing exposure to the virus. Such a rumour could have emanated from a person living with HIV with the intention of exposing other people to the virus.

6The Luo Council of Elders comprises representatives from all Luo communities in Kenya. The board of managers convene meetings from time to time to deliberate upon issues of national concern such as HIV/AIDS.

7The window period refers to the time between infection with HIV/AIDS and development of antibodies to fight the new infection. It lasts from 3 to 6 months.

8The Luo Council of Elders comprises representatives from all Luo communities in Kenya. The board of managers convene meetings from time to time to deliberate upon issues of national concern such as HIV/AIDS.
Understanding and measuring AIDS-related stigma in health care settings: A developing country perspective

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ABSTRACT
AIDS-related stigma and discrimination remain pervasive problems in health care institutions worldwide. This paper reports on stigma-related baseline findings from a study in New Delhi, India to evaluate the impact of a stigma-reduction intervention in three large hospitals. Data were collected via in-depth interviews with hospital staff and HIV-infected patients, surveys with hospital workers (884 doctors, nurses and ward staff) and observations of hospital practices. Interview findings highlighted drivers and manifestations of stigma that are important to address and that are likely to have wider relevance for other developing country health care settings. These clustered around attitudes towards hospital practices such as informing family members of a patient’s HIV status without his/her consent, burning the linen of HIV-infected patients, charging HIV-infected patients for the cost of infection control supplies, and the use of gloves only with HIV-infected patients. These findings informed the development and evaluation of a culturally appropriate index to measure stigma in this setting. Baseline findings indicate that the stigma index is sufficiently reliable (alpha = 0.74). Higher scores on the stigma index — which focuses on attitudes towards HIV-infected persons — were associated with incorrect knowledge about HIV transmission and discriminatory practices. Stigma scores also varied by type of health care provider: physicians reported the least stigmatising attitudes as compared to nursing and ward staff in the hospitals. The study findings highlight issues particular to the health care sector in limited-resource settings. To be successful, stigma-reduction interventions and the measures used to assess changes, need to take into account the sociocultural and economic context within which stigma occurs.

Key words: Stigma, discrimination, health care worker, HIV/AIDS.
Understanding and measuring AIDS-related stigma in health care settings: A developing country perspective

INTRODUCTION
AIDS-related stigma and discrimination have serious individual and public health ramifications that contribute to a reluctance to be tested for HIV and to disclose positive test results to partners, poor treatment adherence, and increased risk of disability and drug resistance (van der Meij & Heijnders, 2004). Various studies have demonstrated that AIDS-related stigma is a common phenomenon worldwide, that occurs in a variety of contexts, including the family, community, workplace, and health care settings (e.g., Ogden & Nyblade, 2005; Parker and Aggleton, 2003; Reidpath and Chan, 2005).

The health care setting is a particularly conspicuous context for HIV/AIDS-related stigma and discrimination. In this context people living with HIV or AIDS (PLWHA) often discover their status, and it is where people living with HIV have the potential to gather information about how to care for themselves and prevent transmission to others, as well as to get treatment and care. Because of stigma, there have been various reports of HIV positive people receiving inferior care or being denied care altogether (Ogden & Nyblade, 2005). For example, health care workers are influenced by the attitudes of the greater society, and prevailing negative attitudes can result in discrimination.

In India, a country with an estimated HIV/AIDS epidemic of between 2 to 3.1 million people (WHO, 2007), over 80 percent of reported AIDS cases are due to unprotected heterosexual intercourse (NACO, 2006). The epidemic remains concentrated among vulnerable and marginalised populations including sex workers, injecting drug users and men who have sex with men (UNAIDS, 2006). The epidemic is perceived as a disease of “others” – of people living on the margins of society, whose lifestyles go against social norms and are often considered “wrong” or “sinful”. Social reactions have been quite negative. For example, 36 percent of respondents in one study felt it would be better if infected individuals killed themselves, and that infected people deserved their fate (Ambati, Ambati, & Rao, 1997). Stigma and discrimination against PLWHA have also been documented in the Indian health care setting.
including denial of care and overt labelling of their HIV-infected status (Bharat, Aggleton, & Tyer 2001). As was found in another study with PLWHA, AIDS-related fear and anxiety, and at times denial of their status, could be traced to traumatic experiences in health care settings for a majority of those interviewed (Bharat, 1996).

While AIDS-related stigma in health facilities has become better understood over the years, it is only recently that responses are moving beyond documenting negative experiences to implementing interventions (Brown, Macintyre, & Trujillo, 2003). However, evaluation of stigma reduction interventions remains challenging, due to a lack of appropriate and validated instruments to measure stigma and discrimination (Synergy Project, 2004). One such stigma-reduction intervention was recently piloted with health care workers in health care settings in New Delhi, India by Horizons/Population Council and SHARAN, an eminent AIDS service NGO in the country (Mahendra & Gilborn, 2004). The overall objective of the intervention research was to test the effectiveness of a stigma-reduction intervention, with the goals of reducing discriminatory practices and improving quality of care for PLWHA. This paper focuses on the formative findings that informed the development of an index to measure AIDS-related stigma among health care workers, the quantitative baseline findings related to expressions of stigma, and associations between stigmatising attitudes and other key variables, such as HIV-related knowledge. It highlights the manifestations and drivers of stigma that are important to address in the low-resource Indian health care context, and that are likely to have wider relevance for other developing country settings. Finally, the paper concludes with recommendations for appropriate interventions to address stigma in this setting, and a discussion about the usefulness of the index.

The need for a stigma index for the Indian health care setting

To measure stigma and discrimination in the health care setting, appropriate tools are needed. Although tools have been developed to assess stigmatising beliefs and discriminatory practices in general, many of them have been developed in the United States. For example, of the 14 HIV-related stigma scales or indices discussed in a recent review paper by van Brakel (2006), ten were developed in the United States and only three in developing countries. Similarly, examples of tools to measure stigma among health care workers can be found, but in general, these are for Western audiences. For example, of the six HIV-related instruments for the health care setting or health workers described in the van Brakel summary, only one had been developed in a developing country setting – Tanzania (Tanzania stigma-indicators field test group, 2005). A review of the five other published scales (Blumenfield et al., 1987; Dubbert, Kemppainen, & White-Taylor, 1994; Froman, Owen, & Daisy, 1992; Froman & Owen, 1997; Harrison, Fusilier, & Worley, 1994; Schondel, Shields, & Orel, 1992) reveals that the scales tend to focus on measuring (1) blaming attitudes toward people with HIV, such as that a person with HIV deserves to get the disease; (2) concerns related to casual contact, such as fears of touching people with HIV; and/or (3) general questions related to the provision of health care, such as whether the provider would be willing to offer equal quality of care to people with and without HIV. While each of these issues is important, the scales did not address a series of additional issues that may be particularly relevant in a health care setting with limited resources. The formative research (described below) highlights some of these issues.

Methods

Site selection

Three large hospitals in New Delhi, India were selected to participate in the intervention study. Researchers sought hospitals that reported admitting and treating HIV-infected patients and that represented a range of administrative functioning (public and private; central and state government administered). This followed a selection process wherein almost 20 hospitals representing three different administrative structures – central government, state government, and private – were identified from which six were short-listed. These six were selected because they had an in-patient capacity of over 500, employed more than 1,000 health care workers (which would allow for adequate sampling), and were treating HIV-infected patients. After reviewing the study protocol, three of the six hospitals expressed their interest and willingness to participate in the study. The study methodology was finalised in discussions with the hospital authorities.

In each of the hospitals, the researchers purposively selected four departments that were most likely to
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Report treating HIV-infected patients. These four departments were medicine, STD and skin, obstetrics and gynaecology, and surgery. After receiving approval from the hospital authorities and heads of the selected departments, the research project was conducted in the in-patient wards of the four departments.

Data collection
After site selection, the researchers began the study with a period of formative research. In this phase, qualitative interviews and focus groups with a variety of respondents and observations of practices in the hospital setting were conducted. The formative phase consisted of 59 key informant interviews with hospital staff, clients receiving in-patient care, and caregivers, as well as 30 structured observations (of five hours each for a total of 150 hours of observations) of the hospital environment and of provider-patient interactions. In addition, six focus group discussions with 40 people living with HIV who were receiving services from local AIDS service organisations, as well as caregivers from various agencies were also conducted.

Information was gathered about the manifestations of stigma and discrimination in the hospital setting, as well as the individual and institutional factors that fostered stigma and discrimination among health care workers. All interviews were conducted after receiving informed consent from the respondents.

Following the formative research, a baseline survey was conducted in all sites. In each hospital, three levels of health care workers who were most in contact with patients on a daily basis through providing hands-on care were recruited as survey participants. These were doctors, nurses and ward staff. Doctors and nurses provide medical care, while ward staff are responsible for the daily cleaning of the wards and departments. Using stratified random sampling, a proportional representation of the three levels of health care workers was selected from the four departments. While the private and public hospitals varied in size, the staffing size was similar in all three hospitals. Informed consent was sought from all staff for their participation in the survey. In all, a representative sample of 134 doctors, 375 nurses, and 375 ward staff, totalling 884 health care workers, were interviewed from the three hospitals at baseline. As a significant proportion of ward staff lacked basic literacy skills to read and write, all respondents were interviewed using a structured questionnaire to collect the required information.

Measures and data analysis
For this study, definitions of stigma and discrimination were based on a review of the existing literature and formative research findings. Stigma was defined as negative attitudes directed towards PLWHA because of their HIV status, and discrimination was defined as ‘enacted stigma’ or behaviours that stemmed from these stigmatising beliefs. The behaviour that PLWHA do not have the right to marry, that they ‘get what they deserve’, or that they should be kept at a distance from other patients were examples of stigmatising attitudes. The act of refusing to care for HIV-infected patients because of their status would be an example of a discriminatory behaviour.

Based on the formative research findings, items to measure HIV-related stigma in the study’s health care settings were developed and tested (see description in results). Respondents were asked whether they agreed or disagreed with 21 items, and answer choices were offered on a three point Likert scale (Agree [1], Can’t say [2], Disagree [3]), with a maximum total score of 63 for the 21 items. The 21 items were combined into an index. All items were coded so that a higher number always indicated greater stigma. Frequencies of stigma index items were analysed, as were characteristics of the stigma index (e.g., mean), and associations between the stigma index and key additional variables, including HIV-related knowledge and various discriminatory behaviours in the health care setting. T-tests of means, and one-way ANOVA tests were applied. All statistical analyses were conducted using the software package SPSS. Analyses of qualitative data focused on eliciting key themes related to stigma and discrimination.

Participant characteristics
Data from the baseline survey show that doctors and ward staff were predominantly male, whereas all the nursing staff were female. Doctors had the youngest mean age (31.2 years) and ward staff the oldest (37.8 years). Nearly two-thirds (65%) of doctors were below 30 years old, compared to 49 percent of the nurses and 33 percent of the ward staff. The majority of all staff interviewed had a service tenure of less than ten years. While all doctors and nurses had advanced educational qualifications, the educational background of ward staff varied from illiteracy to post-graduate degrees. Almost one-fourth of the ward staff had no schooling but reported having basic literacy skills.
Results
Formative research findings: Hospital practices
The formative research highlighted four types of discriminatory practices carried out by health care workers in the hospital setting: testing patients for HIV without their consent, disclosing test results to relatives and other health care workers without the consent of patients, labeling of HIV-infected patients' belongings or files, and unwarranted use of precautions to prevent transmission.

Testing patients for HIV without counselling and informed consent emerged as a common practice among health care workers. According to one inpatient, “My blood was tested twice ... No one told me why it was being tested.”

While some doctors were aware of the procedure of obtaining a patient's consent prior to an HIV test, they chose not to use it as they felt the patient would be unable to understand the consent form:

“I don’t think consent matters that much. Theoretically, it is nice to talk about consent, but practically it is not possible. Many people do not know how to read or sign. In that case, consent does not really matter.”

Routinely informing families about a patient's HIV status also was a common occurrence. According to a nurse, “If the result is positive, then the doctor tells the patient as well as his relatives.” This practice was corroborated by patients; according to one informant, “The doctor told me that I have AIDS ... he also told my relatives ... he did not ask me before telling them.”

In addition to improper disclosure of test results to family members, informants commented that health care workers frequently shared patients' status with each other. According to one nurse, “Everybody (doctors, nurses, sweepers and ward boys) who works with patients knows the status of the patient.” One patient reported the following: “All the staff in the ward knows my status. The doctor tells the nurse, the nurse tells the ward staff and they tell everyone else about me.”

One reason given for sharing a patient's status was to encourage health care workers to take “adequate precautions” to protect themselves while treating or handling the patient. According to one ward staff member, “When there is an HIV-infected patient in the ward, doctors tell us to be careful and use safety measures to protect ourselves.” Confidentiality of a patient's status was also breached by the use of markings or labels on beds and files. Observational data revealed that in some of the wards, use of labels such as 'High Risk', 'Barrier Precautions' and 'DANGER' were posted on top of patient's beds to indicate their HIV-infected status. Interviews with people living with HIV and their caretakers supported the observational data about labelling HIV-infected patients. According to one mother of an HIV-infected child, “Bed labels were put up for my baby. All who could read the label knew the status of my baby.”

Other subtle markers reported by health workers to indicate a patient's status to other staff included placing the bed at the end of the room or next to the toilet, placing a cloth screen around the patient's bed, and placing the patient in a separate ward or room. One nurse noted: “We move the HIV positive patient outside the room into the corridor so that he is kept separately from other patients.”

Another practice that indicated a patient's status was whether or not health care workers used gloves. In two of the three hospitals, the researchers observed that health workers only used gloves with patients whose beds or files were marked as HIV-positive. In the third hospital, researchers noted that nurses wore gloves during every interaction with patients, including those that involved casual contact like giving medicines to patients.

These practices of disclosing patients' HIV status to other health workers without their consent by overt and covert means were viewed by health workers as their right to know, in order to protect themselves from potential infection. According to one doctor, “You are concerned about human rights of people who are going to die soon – they are only a small fraction of patients. What about my right as a doctor – don’t I have the right to survive?”

Rather than practising universal precautions, many hospital staff took inadequate precautions with the general patient population, and excessive precautions with patients they knew to be HIV-infected. One nurse commented: “You know, every time we cannot wear gloves. We take precautions while dealing with these (HIV-infected) patients.”
The reason for selective use of universal precautions with HIV-infected patients was explained by the lack of availability of supplies, such as gloves, running water, etc., necessary for the practice of infection control in health care settings. Staff mentioned that if they were told of an HIV-infected patient’s status beforehand, it helped them protect themselves from potential infection. According to one nurse, “Precautions taken by us are not adequate, therefore once we know the status of the case we can prepare ourselves to take precautions in advance.”

Waste management practices also varied on the basis of a patient’s disease status, with extreme steps being reported for HIV-infected patients. According to one ward staff, “We burn the linen of the patient. Even utensils of HIV-infected patients are thrown away.” Sometimes, the patients were asked to bring their own supplies to the hospital so that they could be either returned or disposed off to avoid using them for other patients. A nurse commented, “All disposable items such as gloves, masks, etc. and AIDS kits are purchased by the patient or his/her family… after use they are disposed off.”

Formative research findings: Health worker attitudes toward people living with HIV/AIDS

In a second major theme, interviews with health workers also revealed that many held judgmental and prejudiced attitudes toward people living with HIV, and blamed their infection on specific attributes, such as their social class, occupational status or behavioural practices. According to one doctor, “HIV can spread only through errors of human behaviour.” Another doctor commented, “High risk population means lower class people – they live in slums in unhygienic conditions. These people sleep with anybody. In this class of people, extramarital affairs are common and also drug users and sex workers come in this category.”

Once infected, some health workers felt that PLWHA should not lead a normal healthy life by marrying and procreating. They also mentioned that an HIV-infected woman should terminate a pregnancy rather than give birth to a child who could be born with HIV infection.

The people living with HIV whom we interviewed reported confronting judgmental attitudes of health care workers. According to one patient, some staff members were rude and overly inquisitive about how he got infected with HIV. “They asked me, ‘how did you get this, what all did you do, where has it come from?’ I feel that they are only concerned about how I got the disease.” Another patient mentioned that a doctor told his pregnant wife “just drop (terminate) the child” rather than giving birth to a child who may be born with HIV infection.

Designing and evaluating the stigma index

The formative research findings helped identify important dimensions of stigma and discrimination against PLWHA in health care settings in India. The researchers then conducted a review of available national and international literature on stigma reduction interventions and measures, to supplement and finalize a list of candidate items (50 items). These items were then reviewed by a team of specialists in India with HIV stigma-related experience.

After review, ten items were rejected and this revised list of 40 items was then translated and pre-tested in the participating study hospitals, with 45 respondents selected from departments other than the four selected for the study. Based on this pre-test, eight other items were removed – due to lack of clarity, etc. – and a list of 32 items was short-listed for use in the baseline survey. Twenty-one items were worded as statements and 11 were worded as questions. These 32 items address the main issues that emerged from the formative research, including attitudes of blame towards some groups of PLWHA, attitudes about personal contact with PLWHA in society, and attitudes related to hospital practices and policies towards PLWHA.

Following a review of baseline survey responses, it was determined that some questions were unclear to respondents, or where they answered 100% in one direction or another, they were removed from the index list. After a final consultation, 21 items were retained in the index. A higher score denotes a higher level of stigma. The internal consistency reliability for this index in the baseline survey was good at 0.742 (Cronbach’s alpha).

Responses to items on the stigma index

Attitudes towards PLWHA

Some statements assessed attitudes about casual contact with HIV-infected people in the social setting in which health workers lived and worked (SeeTable 1). There was a great deal of fear of casual contact with PLWHA: when health workers were asked if they
would share a meal with an HIV-infected person, less than half (41%) would be willing to do so. At the same time, health workers had a more supportive attitude toward working with a colleague who was HIV-infected, as 87 percent of respondents would be willing to work with an HIV-infected colleague.

Other statements in the baseline survey assessed blaming or judgmental attitudes towards PLWHAs. The majority of health workers seemed to associate HIV with negative or immoral behaviours, as for example, over two-thirds (68%) of respondents indicated that HIV is spread by immoral behaviours. HIV was also associated with populations at higher risk of exposure, for example, almost one half (43%) of respondents indicated that the only women who were at risk for HIV infection were sex workers.

A substantial proportion of respondents expressed explicit blaming attitudes; almost 40 percent indicated that men with HIV deserved to be infected and ill.

A series of items were also included to assess health workers’ attitudes towards safeguarding human rights of PLWHAs (Table 2). Health workers gave mixed responses about supporting the rights of infected individuals. While over three-quarters of health workers agreed that HIV-infected people had the right to decide who should know their status, an equally large proportion endorsed the view that HIV-infected women should not get pregnant and have children. Also, a majority (60%) did not agree that PLWHAs should have the right to marry.

### Attitudes towards practices in health care settings

A series of items were included regarding attitudes towards different hospital practices (See Table 2). Based on formative research, mandatory HIV testing appeared to be commonly practised in the participating hospitals. As per Indian national guidelines, mandatory HIV testing is considered a violation of patients’ rights, and voluntary counselling and testing is promoted as the appropriate practice. In the baseline survey, almost 90 percent of health workers endorsed the practice of conducting mandatory HIV testing prior to surgery.

More than half of the respondents (61%) also disagreed with the need for seeking patient’s informed consent prior to testing. Furthermore, over three-quarters of the respondents (79%) agreed that all pregnant women should be tested for HIV.

Regarding disclosure of HIV test results, over half of the respondents (57%) agreed that the patient had the right to decide about disclosing his/her HIV test results to relatives. However, there was almost unanimous agreement (94%) with the statement that doctors should inform the patient’s partner.

A majority of health workers (55%) agreed that patients should be distanced from other patients. Also, there was great support for infection control measures that would be unnecessary to prevent HIV infection. For example, two-thirds of respondents (67%) agreed that clothes and linen should be destroyed after HIV positive patients used them.

### Stigma index scores and key associations

The responses to all of the 21 items in the stigma index were combined into one score. The mean score for the full group of health workers (N = 884) was 42.79, with individual scores ranging from a minimum of 23 to a maximum of 61. The difference among the three groups of health care workers was significant (one-way ANOVA test p value of .000), with the ward staff having the highest mean stigma score of 47.80, followed by nurses (39.99) and then doctors who had the lowest score of 36.60.

### HIV-related knowledge and stigma

As part of the baseline survey, information about health staff’s knowledge about HIV transmission was collected - addressing general transmission and transmission in health care settings. Responses to the knowledge
questions were then compared with the staff’s scores on the stigma index. Consistently, health workers who had misconceptions about HIV transmission scored significantly higher on the stigma index than those with correct knowledge (see Table 3). For example, those who believed that being close to an HIV-infected patient could result in HIV transmission were significantly more likely to hold stigmatising attitudes.

Discriminatory practices and stigmatising attitudes

Associations between stigma index scores and discriminatory practices were also examined (See Table 4). Some questions relating to general hospital practices were asked of all staff, while other questions that were relevant to only certain cadres of health workers were asked of that particular subgroup. For example, only doctors were asked about their experiences providing HIV counselling and testing services, and all health workers were asked about whether they intentionally avoided touching HIV positive patients. Associations were tested between the behavior of the relevant group and the stigma scores for the subgroup in question.

The analysis determined that staff members who had scored higher on the stigma index were more likely to report discriminatory practices. Examples of these behaviours included: (1) avoiding going near HIV-infected patients, (2) sharing the patient’s HIV status with non-treating staff or with staff who did not directly interact with the patient, and (3) the inappropriate use of gloves during casual contact with HIV positive patients.

DISCUSSION

The formative data revealed important dimensions of stigma and discrimination particular to the health care setting in India, and possibly to other resource-limited developing world settings. These clustered around support for certain hospital practices, which when carried out by enough health workers, could contribute to the establishment of a normative environment that perpetuates discriminatory behaviours among health care workers. Examples of these hospital practices are the burning of linen of HIV-infected patients and charging HIV-infected patients for the cost of infection control supplies.

The inappropriate use of gloves and the misinterpretation of Universal Precautions, widely found in this study, is one particularly challenging issue for resource-limited health care settings. The National AIDS Control Organisation (NACO) has guidelines...
that state that ‘low risk’ activities such as touching HIV positive patients, transporting patients from one location to another, and injections and related activities do not require glove use; and these guidelines were reflected in the policies of the study hospitals. Thus, when health workers reported using gloves for these activities only with HIV positive patients, it was both indicative of discriminatory practices and potentially problematic in an environment where gloves were sometimes unavailable for needed procedures. Many of these findings correspond with findings from a large qualitative study conducted in health care settings in Mumbai and Bangalore, India. Drawing on key informant interviews, in-depth interviews, and focus group discussions, Bharat, Aggleton and Tyrer (2001) found that disclosure of HIV test results to family members of people living with HIV/AIDS, without consent from the person in question, was a fairly common practice. Other examples of stigmatising and discriminatory acts included denial of care, overt labelling of HIV-infected status on files and beds, and excessive use of barrier precautions by health workers.

There was a relatively high level of support for discriminatory behaviours in these hospital settings across all cadres of health workers. However, based on stigma index scores, attitudes varied substantially by category of worker. Physicians reported the least stigmatising attitudes, followed by nurses. Ward staff reported the most stigmatising attitudes. All of these health workers regularly interacted with HIV-infected patients. This finding highlights the importance of providing sufficient HIV-related education and stigma-reduction activities to all health workers who interact with PLWHA patients, and not only to professional staff, such as nurses, who are often the main recipients of training and interventions. It is important to include all staff whenever possible in stigma-reduction activities.

Findings from the literature review and the formative research also highlighted the need to develop a tool tailored to measure AIDS-related stigma among health workers in a limited resource setting such as India. Existing tools that were reviewed focused on fear of casual contact with, and judgmental attitudes toward, people living with HIV. While these topics were found to be relevant among the study population as well, and were reflected in the stigma index that was developed, other topics specific to the health care setting in a low-resource setting such as India also emerged as very important.

Study findings indicate that the index was sufficiently reliable (alpha = 0.74). Furthermore, stigma was associated with other key variables hypothesised to be related to stigma. For example, a growing body of data suggests that people with better knowledge tend to exhibit less stigmatising attitudes towards PLWHA. According to Lau, Tsui and Chan (2003), for example, stigmatising attitudes of youth were reduced after
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exposure to an educational intervention. This study supported these findings, as those health workers who scored higher on the stigma index were more likely to have less knowledge about HIV transmission, such as knowledge that HIV cannot be transmitted by touching an HIV positive patient or by handling dry linen. Discriminatory behaviours were considered another set of key variables, as more stigmatising attitudes would theoretically lead to more discriminatory behaviours. This supposition was also borne out, as respondents with higher stigma scores were more likely to carry out discriminatory behaviours, such as avoiding any contact with HIV-infected patients or sharing the HIV status of a patient with staff who did not treat or directly interact with the patient, due to unnecessary concerns about safety.

The baseline findings helped guide the development of an intervention. They highlighted that a stigma reduction intervention in the hospital setting needed to include activities at the individual and institutional levels. As a result of discussing the findings with hospital managers, a multi-level intervention that included participatory self-assessment, sensitisation training, development of posters reinforcing infection control procedures and policy reform was implemented. The findings from the intervention evaluation will be reported in a separate paper.

The findings reported on in this paper highlight that stigmatising attitudes and discriminatory behaviours towards people living with HIV/AIDS are big challenges in hospitals in India, and that there are particular issues in this limited resource setting that are often not taken into account in global discussions about HIV-related stigma in the health care sector. To be successful in this context and in other resource-limited settings, stigma-reduction interventions need to take into account the sociocultural and economic context within which stigma occurs.

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Footnotes
1 This index had resulted out of collaboration between a number of institutions, led by the International Centre for Research on Women, Mumbi University, and the Synergy Project TVS Associates, and one of the authors of the current paper (Dr. Puliere) had provided input into the development of the index.

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ORIGINAL ARTICLE

Food insecurity, HIV/AIDS pandemic and sexual behaviour of female commercial sex workers in Lagos metropolis, Nigeria

JL Oyefara

ABSTRACT

This study examined the role of hunger and food insecurity in the sexual behaviour of female commercial sex workers in Lagos metropolis, Nigeria within the context of HIV/AIDS. In addition, the study investigated the prevalence of sexually transmitted infections (STIs) and induced abortion among the respondents. Cross-sectional survey and in-depth interview research methods were adopted to generate both quantitative and qualitative data from the respondents. Findings of the study showed that 35.0% of the respondents joined the sex industry because of poverty and lack of other means of getting daily food. While all the respondents had knowledge about the existence of HIV/AIDS, 82.0% of them identified sexual intercourse as a major route of HIV transmission. There was a significant relationship between poverty, food insecurity and consistent use of condoms by female sex workers at P<0.01. Specifically, only 24.7% of the respondents used condoms regularly in every sexual act. Consequently, 51.6% had previous cases of STIs. The most prevalent STI among the respondents was gonorrhea, with 76.4% prevalence among ever infected female sex workers. This was followed by syphilis with a prevalence of 21.1%. In addition, 59.1% of the sample had become pregnant while on the job and 93.1% of these pregnancies were aborted through induced abortion. In conclusion, hunger and malnutrition were the factors that pushed young women into prostitution in Nigeria and these same factors hindered them from practicing safe sex within the sex industry. Thus, it is recommended that the Nigerian government should develop programmes that will reduce hunger and food insecurity, in order to reduce rapid transmission of HIV infection in the country.

Key words: Food insecurity, HIV/AIDS, female sex workers, Nigeria.

RÉSUMÉ

Cette étude a examiné le rôle de la faim et de l’insécurité des aliments sur le comportement sexuel de femmes travailleurs commerciaux du sexe à Lagos métropole, au Nigérien dans le contexte du VIH/SIDA. De plus, l’étude a examiné le taux de prédominance des infections sexuellement transmissibles (IST) et l’IVG auprès des personnes interrogées. U ne étude transversale et des méthodes de recherche par entretien approfondi ont été utilisées afin d’obtenir des données quantitatives et qualitatives de la part des personnes interrogées. Les résultats de cette étude ont montré que 35% de personnes interrogées ont commencé la prostitution à cause de la pauvreté et le manque d’autres moyens pour se nourrir quotidiennement. Pendant que toutes les personnes interrogées avaient le VIH/SIDA existait, environs 82% d’entre elles ont identifié les rapports sexuels comme étant la voie principale de l’infection au VIH. On a remarqué une relation importante entre la pauvreté, l’insécurité des aliments et l’utilisation du préservatif par les femmes prostituées à P<0,01. Spécifiquement, seulement 24,7% de personnes interrogées utilisaient le préservatif de façon régulière dans tous les rapports sexuels. Par conséquence, 51,6% ont eu de cas d’ISTs. La IST la plus prédominante était la blennorragie avec le taux de 76,4% de prédominance chez les femmes contaminées. Ensuite, le syphilis avec le taux de prédominance de 21,1%. De plus, 59,1% de l’échantillon sont tombées enceintes au cours de leur travail et 93,1% de ces grossesses ont été terminées grâce à l’IVG. En conclusion, la faim et la sous-alimentation sont des facteurs qui ont poussé les jeunes femmes dans la prostitution au Nigérien. Ces mêmes facteurs font obstacle à avoir des rapports sexuels protégés dans cette profession. Pour cette raison, il est recommandé que le gouvernement nigérien doit développer des programmes qui vont réduire la faim et l’insécurité des aliments afin de diminuer l’infection rapide au VIH dans ce pays.

Mots clés: Insécurité des aliments, VIH/SIDA, femmes travailleurs de sexe, Nigérien.

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INTRODUCTION
The Food and Agriculture Organisation of the United Nations (FAO) argued in 2000 that “hunger exacts a heavy toll, not only on the people without enough to eat but also on the society where they live. A chronically undernourished person has diminished physical and cognitive abilities, leading to decreased productivity. A society of undernourished people cannot progress” (FAO, 2000:3). In the same vein, speaking at the launch of the “Make poverty history” campaign in London’s Trafalgar square, Nelson Mandela commented that “like slavery and apartheid, poverty is not natural. It is man-made and it can be overcome and eradicated by the actions of human beings... While poverty persists there is no freedom” (Mandela, 2005:2). The above two statements reveal the state and condition of the majority of countries and people in sub-Sahara Africa today. Current existing international data shows that sub-Sahara Africa is the only region in the world where the number of people living in extreme poverty has almost doubled, from 164 million in 1981 to 314 million in 2005. Thirty-two of its 47 countries are among the world’s 48 poorest nations (World Bank, 2005). In addition, the FAO report of 2002 showed that approximately 842 million people were undernourished between 1999 and 2001 globally. Of this number, 10 million were in industrialised countries, 34 million in countries in transition, and 798 million in the developing world (FAO, 2002). These pieces of information indicate that poverty and food insecurity are among the leading problems in sub-Saharan Africa. The HIV/AIDS pandemic is another socio-medical problem in the region, and it has had a devastating effect on the socio-economic and demographic structure of the region. UNAIDS estimates in 2005 revealed that sub-Saharan Africa has just 10% of the world’s population, but is home to more than 60% of all people living with HIV/AIDS (PLWHA) - some 25.4 million. According to these estimates, in the year 2004 alone, 3.1 million people in the region became newly infected, while 2.3 million died of AIDS (UNAIDS, 2005).

Nigeria is one of the countries hardest hit by HIV/AIDS in the world, with about 3.5 million people currently living with HIV infection. In addition, heterosexual contact has been identified as the main route of HIV transmission in the country (FMHSS, 1992). Thus, since the early 1980s, several studies had been conducted on sex workers and the sex industry in Nigeria (Akinnawo, 1995; Caldwell, Caldwell & Orubuloye 1992; Caldwell, 1995; Esu-Williams, 1995; Näänen, 1991; Orubuloye, Caldwell & Caldwell, 1991; 1992; 1994). These studies and many others identified the significant role played by sex workers in the rapid transmission of HIV infection among the Nigerian populace. The principal objective of this study is to complement the existing knowledge about sexual behaviour of female sex workers in Nigeria. This was done by examining the role of hunger and food insecurity in motivating young Nigerian females to enter into the sex industry. In addition, the study investigated the impact of these identified factors on the sexual behaviour of female sex workers in Lagos metropolis, especially regarding the practice of safe sex and consistent use of condoms within the context of HIV/AIDS. In view of these stated objectives, this paper is sub-divided into four major sections. The first section contains information about the background to the study. In the second section, the research methods adopted in the study are described. Findings of the study are presented in the third section, while section four contains discussion of the major findings of the study.

Background to the study
This section provides detailed information about the socio-economic context of the study, by focusing on food insecurity in Nigeria, as well as the prevalence of HIV/AIDS in the country, including among commercial sex workers.

Poverty and food insecurity in Nigeria
It is important to note that the need for food is topmost in the hierarchy of needs. Thus, achievement of food security is an essential step to overcome poverty in any given country. Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life (Mohammed, 2003). Globally, there is enough food for all, but existing empirical data and estimates show that millions of people in developing countries are undernourished. Specifically, each year about 18 million people, mostly children, die from starvation, malnutrition and related causes (Hinrichsen, 1997). In addition, an estimated two billion people in developing countries suffer malnutrition and dietary deficiencies some 840 million of them are chronically malnourished (FAO, 1995;
Thus, a high proportion of people in developing countries suffer from food insecurity.

It is evident that food insecurity exists when people are undernourished as a result of the physical unavailability of food, lack of social or economic access to adequate food, and/or inadequate food utilisation (Mohammed, 2003). Food-insecure people are those individuals whose food intake falls below their minimum calorie (energy) requirements, and those who exhibit physical symptoms caused by energy and nutrient deficiencies resulting from an inadequate or imbalanced diet. Thus, food insecurity is conceptualised in this paper as the consequence of inadequate consumption of nutritious food. The problem of food insecurity is especially pronounced in sub-Saharan Africa. For example, projections by experts of the International Food Policy Research Institute (IFPRI) in 1997 showed that by the year 2020, nearly 70% of people suffering from food insecurity will live in sub-Saharan Africa and South Asia. The projections further reveal that by the same year, every third person in sub-Saharan Africa is likely to lack food security (Pinstrup-Anderson, Pandya-Lorch & Rassgrn, 1997).

In Nigeria, the most populous country in Africa, the majority of people within the country are food-insecure, due to the high poverty level and the poor performance of the Nigerian agricultural system. Poverty is a plague afflicting many people in Nigeria, and is regarded as one of the symptoms or manifestations of underdevelopment (CBN/World Bank, 1999). According to Sanni (2000), poverty is the main cause of hunger and malnutrition, which are aggravated by rapid population growth, and policy inadequacies and inconsistencies. Poverty is a vicious cycle that keeps the poor in a state of destitution and utter disillusionment. As argued by Okuneye (2001), the conventional notion depicts poverty as a condition in which people are below a specified minimum income level and are unable to provide or satisfy the basic necessities of life needed for an acceptable standard of living. Often, the poor are known to have an inadequate level of food consumption and they are limited in growth and brain development (Aluko, 1975).

Existing empirical national data in Nigeria show that the extent of poverty in the country has increased since 1980. Thus, the proportion of the poor increased from 28.1% in 1980 to 65.6% in 1996, and the estimated population of poor Nigerians increased from approximately 18 million people in 1980 to 67 million in 1996 (FOS, 1999). Even with the advent of democracy about seven years ago in the country, the proportion of the poor remain steadily high, if not increasing, due to the newly introduced economic reform policies that have resulted in high rates of unemployment, increases in fuel price and a very high inflation rate. Recent data from the Development Index of UNDP report showed that about 90.8% of Nigerians live below the poverty line of $2 per day (UNDP, 2006). Thus, the majority of Nigerians are poor, and they lack physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs. In fact, recent estimates by the FAO show that between 5% and 20% of Nigerians are undernourished (FAO, 2000).

It is essential to examine briefly the performance of the Nigerian Agricultural System in recent years, in order to know whether it has been able to produce sufficient food to make the average Nigerian food-secure. Agriculture was the backbone of the Nigerian economy up to the time of independence in 1960. With the discovery of oil and over dependence on oil revenue, its contribution to the national revenue declined from 80% in 1960 to 1.5% in 1995. However, it still continues to be the main source of employment in the economy, employing about 70% of the active labor force. Its contribution to the GDP, although lower than at independence, was nevertheless estimated to be in the range of 39% in 1996 to 40.4% in 1999 (Mohammed, 2003). Agriculture therefore remains a major non-oil contributor to the GDP in Nigeria.

Okuneye (2002) identified many problems confronting Nigerian agriculture. These problems have had significant negative effects on the production and distribution of food in the country. Thus, from the productive point of view, there is not sufficient availability of food to sustain the developmental efforts of the populace. In view of this situation, the Nigerian government relies heavily on the importation of food, in order to meet basic domestic food needs in the country. For example, food imports continued to rise in value in Nigeria from 3.47 billion in 1990 to N113.63 billion in 2000. In terms of relative importance, food imports as a percentage of total
Article Original

Food insecurity, HIV/AIDS pandemic and sexual behaviour of female commercial sex workers in Lagos metropolis, Nigeria

Imports rose from 3.5% in 1991 to 11.8% in 2002 in the country (Okuneye, 2002).

However, despite the increase in the importation of food into Nigeria, the majority of people in the country are not food-secure from the point of view of distribution and market price. The prices of food are so high because Nigeria has an inflationary economy. In the past three decades, the inflation rate has skyrocketed, so that food prices are beyond the reach of the majority of the people in the country. Thus the majority of the people in Nigeria are living below the poverty line and there are high levels of food insecurity in the country.

HIV/AIDS in Nigeria

The first case of AIDS was reported in Nigeria in 1986, and since then the number of persons infected with HIV and those who have developed AIDS has been rapidly increasing in the country. For example, in 1992, 267 new AIDS cases were reported in the country, and the number rose to 917 by September 1993 (WHO, 1993) and 1,490 at the end of 1994 (FMHSS, 1995). Specifically, data from the national HIV sentinel survey indicate a rapid transition from near zero prevalence in 1990 to 1.4% in 1992, 4.5% in 1996 and to 5.8% in 2001 in Nigeria (NASCP, 2002; NIMR, 2000). The current estimates show that 3.47 million people were living with HIV infection in Nigeria in 2002, which placed Nigeria third after South Africa (5 million) and India (3.9 million) with the highest number of infected adults in the world (UNAIDS, 2002). The epidemic continues to claim the lives of adults in the prime of their working and parenting lives, thereby decimating the workforce, fracturing and impoverishing families, and orphaning and shredding the entire fabric of Nigerian communities. Thus, Nigeria is one of the countries hardest hit by the HIV/AIDS pandemic in the world.

In Nigeria, HIV affects all age groups, but it is more pronounced in the prime age of life: teenagers (15-19 years) and young adults (20-29 years), where the rate of infection ranges from 6 to 6.5% respectively. Among other population sub-groups in the country, data from the national HIV sentinel survey revealed highest prevalence (34.0%) of HIV infection among commercial sex workers (CSWs) in the year 2002 (NASCP, 2002). This information justifies the need to have deeper knowledge about the sexual behaviour of commercial sex workers in the country on the one hand and the nature of the entire sex industry on the other hand.

Research methods

The study population is female sex workers in Lagos metropolis, Nigeria, who can be categorised into four different groups on the basis of occupational context of the job. Goldstein identified these four groups in 1979: a “street-walker” solicits business on the street; a “call girl” solicits clients over the phone, men either coming to her home or being visited by her; a “house prostitute” is a woman who works in a private club or brothel; while a “massage-palour prostitute” provides sexual services in an establishment supposedly offering only legitimate massage and health facilities (Goldstein, 1979). Basically, there are three types of prostitutes in Nigeria. These are “house prostitutes”, “street-walkers” and “corporate prostitutes”, the latter being young women in new generation banks. These women are normally put on the treasury desk with a specific saving target per a month. As marketing officers of the new generation banks, they have to do everything possible including offering sex, to get businessmen and politicians to save huge amount of money in their banks. However, the new guidelines on re-capitalization of banks in Nigeria may have reduced the proportion of corporate prostitutes in the country. Thus, this study focused on “full-time house female prostitutes” who work in brothels, continually involved...
in prostitution and deriving their main income from it. The study was conducted between June and July 2003.

Two locations where there are high concentrations of female sex workers were identified and sampled for the study. These areas are Ikeja in Ikeja Local Government Area (LGA), and empire area at Surulere LGA. Purposive sampling technique was used to select both the locations and brothels in the two locations for the study. Quantitative and qualitative research methods were utilised to achieve the objectives of the study. In the quantitative phase, a total of 400 questionnaires were distributed equally in the two locations, 380 of which were returned for further analysis. After initial screening, only 320 questionnaires were found useful for coding, data entry into computer and statistical manipulations. Thus, this number (320) form the total sample used in the analysis of quantitative data in the study. The sex workers used in the study were recruited with the help of hotel managers and gate keepers (leading prostitutes usually called madams). The hotel managers in each of the sampled hotels were first contacted; they later introduced the research team to the gatekeepers. The gatekeepers helped in the distribution and retrieval of the questionnaires from those female sex workers who could read and write in English. Where the respondents could not read and write in English, a team of interviewers, which consisted of four female graduates, interviewed the respondents by interpreting the questions into “Pidgin English”, and wrote the responses down in the questionnaires. This method of recruitment helped greatly to secure adequate co-operation from the sex workers at the stage of data collection. The gatekeepers also nominated the sex workers used during qualitative in-depth interviews and they were interviewed either in English or “Pidgin English” in their respective hotels. A total of ten such interviews were conducted.

The survey questionnaire consisted of 65 questions, which were sub-divided into different sections, such as the socio-economic background of the respondents and their parents, their sexual behaviour, knowledge about HIV/AIDS, use of contraceptive methods, rate of conception and induced abortion, and reasons why the respondents joined the sex industry. The in-depth interview guide also consisted of the major sub-sections of the survey questionnaires in order to complement the survey data.

Regarding ethical issues, respondents were informed about the purpose of the study, which was purely academic in nature. Their consent was sought and obtained before the administration of the research instruments. In addition, the names of the respondents were not used, to ensure anonymity of their identities, and they were promised that the information they provided would be treated with confidentiality.

Statistical Package for Social Sciences (SPSS version 10.0) was used to analyse survey data, while the in-depth interviews were analysed manually to complement the survey data after the full transcription of the ten tapes. Descriptive and inferential statistical methods were used to explain those factors that motivated female Nigerians into the sex industry, as well as those variables that determined their practise of safe sexual behaviour or consistent use of condoms within the industry.

**Results**

**Socio-economic background of commercial sex workers and their parents**

Data on educational status revealed that the majority of the sample (87.5%) were literate with at least primary level education. Specifically, 39.7% of the sampled commercial sex workers (CSW) had secondary education; 35.6% had primary education, 12.2% had post secondary level education, and 12.5% did not have any formal education. Information on current age of sampled commercial sex workers revealed that the majority of CSW (89.1%) in the metropolis were youth below age 30 years. Specifically, the modal age group was 20-24 years with 42.5% of the respondents. This was followed by age group 25-29 years that had 30.3% of the respondents. The mean age of the respondents was 23.8 years. It is instructive to note that 16.3% of sampled sex workers were below age 20 years.

This shows that some of the female CSW in the metropolis are being recruited or initiated into the sex industry at very young age. Regarding current marital status, single females dominate the sex industry: 73.1% of the respondents were single, 14.7% were divorcees, while 5.6% had separated from their spouses.

Data on parental socio-economic backgrounds of the respondents showed that 59.4% of parents of the sampled female sex workers had marital disruption: 22.5% of their parents had separated, 15.6% had divorced, while 21.3% were widowed. 40.6 percent of
the CSW stated that their parents were married and still living together. The majority of the sample (74.4%) were from poor homes. In particular, 67.2% stated that their parents were poor, while 7.2% said that their parents were very poor. However, 22.2% of the respondents were from rich families and 3.1% reported that they were from very rich families. Data on types of apartment where the female sex workers grew up showed that 53.4% grew up in one-roomed apartments, 32.2% in two roomed apartments, while only 14.4% claimed to have grown up in mini flats or better apartments.

Factors that motivate female commercial sex workers to enter sex industry

The sex workers were asked about the major factors that influenced them to join the sex industry. The leading factors mentioned by the respondents as contained in Table 1 were peer influence and poverty. Specifically, 50.9% of respondents stated that their friends motivated them to join the sex industry, while 35.0% mentioned poverty. These two factors are interdependent and inter-connected. Responses from the in-depth interviews corroborated the significant role played by poverty and food insecurity as motivating factors for young girls to enter commercial sex in Nigeria. One of the female sex workers explained how she was introduced into the sex industry because of poverty:

I come from poor family you know... when I finished the free primary school in my village and I was about to die because of lack of food, I found the job as better option to starvation. The job has been helping me to care for myself adequately.

Likewise, other CSWs explained how hunger and poverty led them into the sex industry:

Immediately after my secondary school education, I came to Lagos primarily to look for a good white collar job. I couldn’t get anyone for about three years and my sister could not meet my basic needs any longer; even the three square meals, then I joined this business in order to offer what I have to get what I need. Sincerely, since the time I joined this business, I have never begged for money again, I can feed myself and send some money to my parents.

I joined sex industries out of necessity and as you know, necessity is a mother of invention. There was no money to train or provide initial capital which I need to start business. Without job, can anybody eat? I joined the industry to raise the initial capital to start my own business. Immediately, I am able to get it, I will leave this industry. I don’t really like this job.

The above responses indicate that food insecurity was a major factor that motivated women into commercial sex in Lagos. Other motivating factors mentioned by sex workers were death of husbands and divorce, but these factors were mentioned by fewer than 15% of respondents.

Knowledge about HIV/AIDS and use of condoms

Since the first case of AIDS in Nigeria in 1986, different intervention programmes have been designed and implemented to educate different population groups in the country about the disease. Diverse information, education and communication (IEC) materials have been developed on how HIV is being transmitted. Table 1 provides a summary of the knowledge and practices of sex workers regarding HIV/AIDS and condom use.

### Table 1. Percentage Distribution of Commercial Sex Workers by Factors That Attracted Them into Prostitution, Knowledge about HIV/AIDS and Use of Condoms

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>What factors motivated you into prostitution? (first option mentioned)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty</td>
<td>112</td>
<td>35.0</td>
</tr>
<tr>
<td>Friends</td>
<td>163</td>
<td>50.9</td>
</tr>
<tr>
<td>Death of husband</td>
<td>6</td>
<td>1.9</td>
</tr>
<tr>
<td>Divorce</td>
<td>12</td>
<td>3.8</td>
</tr>
<tr>
<td>I just love it</td>
<td>27</td>
<td>8.4</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>Have you ever heard of HIV/AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>What is the most common way of contracting HIV infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>262</td>
<td>81.9</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>53</td>
<td>16.6</td>
</tr>
<tr>
<td>Sharing of sharp objects</td>
<td>5</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>Do you know of the male condom?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>How often do you use the male condom?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>79</td>
<td>24.7</td>
</tr>
<tr>
<td>Sometimes</td>
<td>149</td>
<td>46.6</td>
</tr>
<tr>
<td>Depends on the client's choice</td>
<td>75</td>
<td>23.4</td>
</tr>
<tr>
<td>Don't use condom at all</td>
<td>17</td>
<td>5.3</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>If a client refuses to use condoms, will you accept him?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>245</td>
<td>76.6</td>
</tr>
<tr>
<td>No</td>
<td>75</td>
<td>23.4</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
</tbody>
</table>
transmitted, methods to be adopted to prevent contracting HIV, and the need to care for PLWHA. Many communication channels (radio, TV, printing materials, oral) have been used to disseminate information about the pandemic in the country. Thus, nearly everybody, especially people in urban centres, are believed to have heard about HIV/AIDS.

CSW were asked whether they had heard about the existence of the HIV/AIDS pandemic. Not unexpectedly, knowledge about HIV/AIDS was 100% among sex workers in the metropolis; all had heard about HIV/AIDS. In addition, respondents were asked to mention the most common route of HIV transmission, and 81.9% identified sexual intercourse as the main route of HIV transmission. This information indicates that the majority of CSW in Lagos metropolis knew that they were vulnerable and susceptible to HIV infection.

The condom has been identified to provide protection against HIV and other sexually transmitted infections. Sampled sex workers were asked if they knew of the male condom. Answers, as indicated in Table 1, show that all knew of the male condom. But only 24.7% stated that they used the male condom regularly during sexual activity. Moreover, only 24.3% said they would not accept a client who refused to use a condom. Consequently, approximately 80.0% were highly vulnerable to HIV infection, because they do not practise safe sex or consistent use of condoms during sexual intercourse.

Prevalence of sexually transmitted infections (STIs) among sex workers
Knowledge about the existence of STIs was nearly universal among CSW, as can be seen from Table 2 below. Specifically, 92.5% of respondents indicated that they knew that STIs exist. Of those, 58.1% mentioned HIV/AIDS, while 27.7 and 8.7% mentioned gonorrhea and syphilis respectively. Thus, the knowledge of HIV/AIDS was higher than that for other sexually transmitted infections in the metropolis.

Data on prevalence of STIs show that 51.6% of the sampled female sex workers had contracted at least one form of STI in the course of their sex work. The most prevalent STI was gonorrhea, with 76.7% prevalence among ever infected C SW. This was followed by syphilis (21.1%), while 2.4% stated that they were living with HIV/AIDS.

Health seeking behaviour of the sex workers in Lagos metropolis was relatively poor: about 39.9% of the infected sex workers stated that they visited a modern hospital for the treatment of the infection, some visited native doctors, while a significant proportion (43.0%) relied on self medication by purchasing drugs from a chemist.

Prevalence of induced abortion among female sex workers
Data on level of conception among the sex workers (see Table 3 below) revealed that 59.1% of the sample had been pregnant in the course of their work, and 99.5% of those pregnancies were aborted through induced abortion. Only 45.7% of the abortions were done in modern hospitals through D & C, while others (54.3%) were either done by drinking of local concoctions or by self medication through purchase of drugs from the chemist.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you heard of any STIs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>296</td>
<td>92.5</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>6.6</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>Mention the STI you have heard often (first option mentioned)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>172</td>
<td>58.1</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>82</td>
<td>27.7</td>
</tr>
<tr>
<td>Syphilis</td>
<td>25</td>
<td>8.5</td>
</tr>
<tr>
<td>No response</td>
<td>17</td>
<td>5.7</td>
</tr>
<tr>
<td>Total</td>
<td>296</td>
<td>100.0</td>
</tr>
<tr>
<td>Have you ever contracted a STI since you started this job?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>165</td>
<td>51.6</td>
</tr>
<tr>
<td>No</td>
<td>155</td>
<td>48.4</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>If you have contracted any STIs, kindly mention one you have contracted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>126</td>
<td>76.4</td>
</tr>
<tr>
<td>Syphilis</td>
<td>35</td>
<td>21.2</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>100.0</td>
</tr>
<tr>
<td>How did you treat the sexually transmitted infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bought drugs from chemist</td>
<td>71</td>
<td>43.0</td>
</tr>
<tr>
<td>Visited native doctor</td>
<td>27</td>
<td>16.4</td>
</tr>
<tr>
<td>Visited modern hospital</td>
<td>65</td>
<td>39.4</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Factors affecting consistent use of condoms by female sex workers

In the previous section of this paper, it was established that poverty and food insecurity played significant roles in motivating young Nigerian women into the sex industry. Responses during in-depth interviews revealed that these same factors were responsible for the low level of condom use among CSW. One of the participants stated that:

I know HIV infection exists and it can be contracted through sexual relationship. I also know the infection can be prevented by regular use of condoms. But let me tell you the truth, many of our customers especially the regular ones are not always ready to use condom. Since many of us are into this business principally to make money in order to keep soul and body together, we have to allow them without the use of condom. I personally allow them and many of my friends in the business usually do. There is nothing we can do about it. We cannot help the situation we need to survive.

Another female sex worker argued as follows:

It is dangerous to be talking of condoms to each and every customer. They will just abandon someone and go to another sex worker who is ready to do it without a condom. What we normally do is to charge higher price for those customers that want to go in without a condom relative to those ones that can use a condom.

One of the participants explained the role of food insecurity in her attitude toward the use of condoms as follows:

Why are you talking about consistent use of condoms with clients during every sexual intercourse? Let me tell you, I joined sex industry in 1989 out of frustration. By then, I had no job, no food to eat and no money to take good care of myself. It was as if I would die because I lacked basic things of life. I have been in this business for about 14 years now; I live on daily income. From the money I used to make in a day, I pay the rent, buy clothes and buy my daily food. My regular customers don’t use a condom, I will not even ask them to use it. They normally pay me very well. In addition, if any occasional customers can pay very well, I will not bother him with the use of a condom. I need money to eat and to look better to attract more customers.

The above responses show that the sex industry in Nigeria is highly competitive, in urban centres. Thus, each of the female sex workers strives to maximise their daily income, and they will do anything to achieve this objective. Poverty and food insecurity made many of the sex workers join the sex industry; these same factors hinder consistent use of condoms and the practice of safe sex by female sex workers in the sex industry in Lagos.

Initiatives of sex workers in Nigeria to influence the sex industry in the country

Various activities had been introduced to make the sex industry safer in Nigeria. One of these is the association of sex workers, known as Nigeria Vulnerable Women Association (NIVWA). The group consists of HIV positive and negative female sex workers who have come forward to give sex workers a face, resist the stigma and discrimination meted out to them by society, and to fight the violence and injustice they suffer at the hands of their clients, the police, and other law enforcement agents. The mission of NIVWA is “to ensure that deprived and marginalised women

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have ever been pregnant in the course of this job?</td>
<td>189</td>
<td>59.1</td>
</tr>
<tr>
<td>Yes</td>
<td>131</td>
<td>40.9</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
<tr>
<td>If you have been pregnant, how many times?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once</td>
<td>104</td>
<td>55.0</td>
</tr>
<tr>
<td>Twice</td>
<td>57</td>
<td>30.2</td>
</tr>
<tr>
<td>Thrice</td>
<td>20</td>
<td>10.6</td>
</tr>
<tr>
<td>Four times</td>
<td>5</td>
<td>2.6</td>
</tr>
<tr>
<td>Five times</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
<td>100.0</td>
</tr>
<tr>
<td>Have you ever had an induced abortion in order to remain in business?</td>
<td>188</td>
<td>99.5</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
<td>100.0</td>
</tr>
<tr>
<td>How many times have you had induced abortion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once</td>
<td>101</td>
<td>53.7</td>
</tr>
<tr>
<td>Twice</td>
<td>46</td>
<td>24.5</td>
</tr>
<tr>
<td>Often</td>
<td>41</td>
<td>21.8</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>100.0</td>
</tr>
<tr>
<td>How did you carry out the induced abortion(s)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchased drugs from chemist</td>
<td>49</td>
<td>26.1</td>
</tr>
<tr>
<td>Drank some local concoction</td>
<td>53</td>
<td>28.2</td>
</tr>
<tr>
<td>D&amp;C in modern hospital</td>
<td>86</td>
<td>45.7</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>100.0</td>
</tr>
</tbody>
</table>
especially sex workers are given the recognition and support they deserve, such as protection of the law, acceptable living/working conditions and access to healthcare and other social services that are available to every other Nigerian citizen. This will be achieved through research, advocacy, information sharing, and capacity building. The three objectives of the association are: (1) to raise awareness on the health and welfare needs of female sex workers in Nigeria; (2) to create awareness in the general public about violence and injustice inflicted on sex workers and other vulnerable women in Nigeria; (3) to ensure that the economic and psychosocial needs of vulnerable women and their children are addressed. This association was formed in 2005. It is expected that adequate utilisation of the association and the objectives of the association by local and international agencies in the country will make government and the general public more sensitive to the plight of sex workers, and thereby make sex work safe in Nigeria.

Conclusion and recommendations

The number of people living with HIV/AIDS continues to grow in Nigeria. Heterosexual contact is the major route of HIV transmission in the country. This study indicated that poverty and food insecurity contributed to many young female Nigerians joining the sex industry. Since existence determines essence, as argued by Karl Marx, the struggle for food security and victory over poverty influences the majority of the sex workers in the metropolis not to use condoms regularly during sexual intercourse. Specifically, most of the sex workers would accept sex without a condom if they deal with their regular customers or where clients would pay more. On the basis of the findings of this study, it is important for the Nigerian government to improve local production of food, in order to meet the basic food needs of the Nigerian populace. In this need could be met, poverty levels would invariably be reduced, which would contribute to the control and prevention of HIV/AIDS. The proportion of young female Nigerians joining the sex industry would be drastically reduced, while those who prefer working in the sex industry would be able to negotiate more effectively for the use of condoms. This would be possible if they were sure of meeting their basic daily food needs even if they turned down a client who refused to use condoms. Invariably, the rate of HIV transmission would decline among CSW in particular and among the general populace in the country at large. In addition, there is a need to intensify HIV/AIDS prevention programmes among sex workers in the country. They need to be educated about the fact that regular clients and those who can pay more for sex without condoms do have other sexual partners, and they are potential carriers of the HIV virus. Thus they need to protect themselves always, especially in the course of their work in the sex industry. Combinations of these two recommendations will go a long way toward halting and reversing the rapid transmission of HIV in Nigeria.

References


Federal Ministry of Health and Social Service (FMHSS, 1992). Bulletin Epidemiology 9, 10-16.


Food insecurity, HIV/AIDS pandemic and sexual behaviour of female commercial sex workers in Lagos metropolis, Nigeria

Canberra: Australian National University.
LETTER TO THE EDITOR

Knowledge about HIV/AIDS and policy knowledge in a South African state hospital

A Dijkstra, E Kangawaza, C Martens, H Boer, JJ Rasker

INTRODUCTION
Sub-Saharan Africa is the epicentre of the HIV/AIDS epidemic. With about 5.6 million people living with HIV/AIDS (PLWHA) in 2004, South Africa has the largest number of PLWHA in a single country (Shisana et al., 2005; UN AIDS, 2003; UN AIDS, 2006). It is expected that in the coming years the number of PLWHA will increase in South Africa.

Medical staff involved in the hospital care of HIV/AIDS patients in South Africa, especially nurses and doctors, are confronted with a number of problems. Due to the presumed dangers of HIV infection during patient care, medical staff may experience stress when caring for HIV/AIDS patients. Adequate knowledge about HIV/AIDS is an important means to reduce stress and could result in better care and improve information to the general public (Hall & Shisana, 2003; Horsman & Sheeran, 1995; WHO, 2005).

In 1992 the National AIDS Committee of South Africa formulated a policy aimed at preventing HIV/AIDS. A review of this policy was conducted in 1997. Based on the strengths and constraints found, the South African National HIV/AIDS plan 2000-2005 was designed (AIDS Foundation South Africa, 2005; Garbus, 2002). The purpose of this plan was to provide a broad national framework aimed at four priority areas: a) prevention and treatment; b) care and support; c) research, monitoring and evaluation; and d) human and legal rights (Department of Health South Africa, 1999). Based on the National HIV/AIDS plan, hospitals can adapt their hospital HIV/AIDS policy to the requirements of the hospital (Garbus, 2002; Zelnick & O’Donnell, 2005). A hospital HIV/AIDS policy helps employees living with HIV/AIDS to understand what support and care they will receive, and a prevention programme may limit the spread of HIV/AIDS; they also assist a hospital in planning/managing for the impact of HIV/AIDS and, ultimately, save money. Counselling programmes for medical staff include information about protocols used in the treatment of PLWHA, infection control programmes, and precautions taken during the treatment of PLWHA.

In South Africa a great majority of PLWHA are treated in state hospitals (Shisana et al., 2005). However, to date little is known about the practical use that medical staff make of hospital HIV/AIDS policy in state hospitals in South Africa, as well as their knowledge about HIV/AIDS in general.

Objectives
The objective of this pilot study was to get insight into the knowledge about HIV/AIDS of medical staff (everybody involved in the hospital care of HIV/AIDS patients, but especially nurses and doctors), as well as their knowledge about and practical use of current hospital HIV/AIDS policy and counselling programmes in a South African state hospital.

Allard Dijkstra is physiotherapist working at the Rehabilitation Centre "Roessingh" Enschede, the Netherlands. At the time of the study he was a student at the University of Limpopo in Garankuwa, South Africa, in receipt of a research scholarship provided by Delta Beurzen. He is currently specialising in paediatric physiotherapy at Avans Plus.

Evelyn Kangawaza is internist and specialised in HIV/AIDS at the Dr. George Mukhari Hospital, University of Limpopo, MEDUNSA, Gauteng, South Africa. She is also a lecturer in internal medicine at the Limpopo University. She had a 2nd degree at the University of Pretoria and a diploma in HIV/AIDS management at the college of medicine of South Africa.

Caroline Martens, physiotherapist, Enschede, The Netherlands. At the time of the study she was a student at the University of Limpopo in Garankuwa South Africa, in receipt of a research scholarship provided by Delta Beurzen.

Henk Boer is associate professor at the Faculty of Behavioural Sciences, Department of Psychology and Communication of Health and Risk, University of Twente. He has carried out research in South Africa on the psychological correlates of HIV prevention behaviour and on the role of communication in shaping social norms related to condom use. He is interested in applying psychological knowledge to improve our understanding of HIV prevention behaviour among adolescents in Africa.

Johannes J. Rasker is specialist Internal Medicine and Rheumatology, Professor at the Faculty of Behavioural Sciences, Department of Psychology and Communication of Health and Risk, University of Twente. He has cooperated in epidemiologic studies with COPCORD and is past Secretary-General of the International League of Associations for Rheumatology (ILAR).

Correspondence to: Johannes J Rasker, University Twente, Cubius Room C-229, PO Box 217, 7500 AE Enschede, The Netherlands, e-mail: jjrasker@utwente.nl
Methods
The participants in this study were members of the medical staff from the Dr. George Mukhari Hospital, a large state hospital with 3008 employees, located in Tshwane, South Africa. From the medical staff a stratified sample of 100 persons was selected, according to the actual percentage of each discipline working in the hospital, and invited to participate in the study. A questionnaire was developed after pre-testing, which asked participants to indicate their gender, age and occupation in the hospital, and whether they knew someone close to them with HIV/AIDS. Participants were also asked about their actual and perceived HIV/AIDS knowledge, and about their actual and perceived HIV/AIDS policy knowledge. Their opinion was asked about current counselling programmes.

Findings
A total of 58 questionnaires were returned (response rate 58%). The sample included 44 nurses (76%), seven doctors (12%) and seven (12%) other hospital staff, including a social worker, a physiotherapist, an occupational therapist, a speech therapist and a psychologist. The mean age of the participants was 38 years (range: 22 - 54 years). There were eight men (14%) and 47 women (81%). The gender of three participants was unknown. Non-respondents were nurses (33/77, 43%) and doctors (14/21, 67%).

Of the participants 70% (40/57) knew someone close with HIV/AIDS, while 30% (17/57) did not know of anyone close to them with HIV/AIDS. The mean VAS-score on perceived HIV/AIDS knowledge was 76. Nineteen participants (33%) indicated complete confidence in their perceived HIV/AIDS knowledge, with a score of 100. Among these 19 participants were 17 nurses (90%). Six participants (10%) had no confidence in their perceived HIV/AIDS knowledge, with a score of 0. The actual HIV/AIDS knowledge question, in which participants were asked to indicate the meaning of the abbreviation AIDS, was answered correctly by 91% (53/58) of the participants (Table 1). The question assessing knowledge of routes of infection was answered correctly by 83% (48/58) of the participants. Further analysis indicated that 26% of the participants (15/58) had incomplete basic HIV/AIDS knowledge, as indicated by lack of knowledge of the meaning of the abbreviation AIDS and routes of infection. The analysis also indicated that 87% (13/15) of these were nurses. Remarkably, there was a discrepancy between perceived and actual knowledge; of the participants (19/58) who scored themselves a 100 on perceived knowledge, 37% (7/19) actually scored lower than 100. Participants who knew someone with HIV/AIDS did not differ in their level of knowledge of HIV/AIDS (75%) from those who did not know someone with HIV/AIDS (76%).

Perceived and actual knowledge of hospital HIV/AIDS policy
The mean VAS-scores of perceived knowledge of the hospital HIV/AIDS policy were: among nurses 49, among doctors 69, and among other disciplines 56. The mean for the total group was 48. Of the participants 71% (41/58) indicated that they knew where to go in case of a possible work related HIV infection (Table 1). The question whether HIV/AIDS was a notifiable disease in South Africa was answered correctly (‘not a notifiable disease’) by only 53% (31/58). Of the participants, 66% (38/58) did not treat or deal differently with HIV/AIDS patients, but they were aware of the dangers. A further 28% (16/58) of the participants did not treat HIV/AIDS patients differently at all, and 7% of the participants (4/58) did treat / deal differently with HIV/AIDS patients. It appears that less than a quarter (24%) had a 100% score on the three questions.

Hospital HIV/AIDS counselling programme
Of the participants, 88% (51/58) indicated that they were aware of information from the counselling programme, such as information leaflets, posters and other means of HIV/AIDS education (Table 1). However, 36% (21/58) indicated that the accessibility and availability of HIV/AIDS counselling in the hospital was insufficient. The majority, 85% (49/58), stated they used part of the counselling programme, but 72% (42/58) found that not enough counselling was done in the hospital.

Discussion
To our knowledge this is the first study performed in South Africa by a South African HIV/AIDS specialist regarding knowledge about HIV/AIDS and HIV/AIDS policy among medical staff in a South African state hospital. Of the participants 41% scored themselves average or lower (< 50) on perceived HIV/AIDS knowledge. More than a quarter of the
participants (26%) appeared indeed to have incomplete basic HIV/AIDS knowledge. Thus, our study indicated a rather poor level of HIV/AIDS knowledge, which is compatible with Shisana and Simbayi (2002, 2005) who found that only 33% of medical staff had received some training on the transmission of HIV. Moreover, nurses around the world have repeatedly reported a knowledge deficit regarding HIV/AIDS (Andersson et al., 2004; Horsman & Sheeran, 1995; Lewis & Gray, 2003).

In this study, 72% of the participants stated that not enough counselling was done in the hospital. According to this study, 38% of the respondents indicated that the information on HIV/AIDS was not accessible to everyone. Although most participants (85%) stated that they had used HIV/AIDS counselling programmes, a majority of 72% stated that not enough was done to train the medical staff. These findings imply that the current efforts regarding HIV/AIDS workplace counselling are insufficient. The results of this study are comparable to recent studies concluding that awareness of hospital HIV/AIDS policies in the workplace is poor (Shisana & Simbayi, 2002).

Only 53% of the participants correctly indicated that HIV/AIDS was not a notifiable disease in South Africa. There would be some advantages if HIV/AIDS would become a notifiable disease, as it is in most parts of the world. One can imagine that formal knowledge and awareness of the problem would increase among health authorities, both economically and socially. Making HIV/AIDS a notifiable disease could also stimulate the acceptance and treatment of HIV/AIDS patients, and officials would respond adequately to try and prevent the spread of HIV/AIDS and improve patient care (Shisana & Simbayi, 2002). However, since the majority of HIV/AIDS infection is among poor people, introduction of registration of the disease would be difficult in South Africa. The often inadequate infrastructure and communication in many of the townships may be a severe barrier to HIV prevention and may make it difficult to start HIV/AIDS notifications (Cock, M borin gacha & M arum, 2002; Fenton, 2004; H ogan et al., 2005; Mukherjee et al., 2003; Parker, Easton & Klein, 2000).

A number of other factors may have contributed to the low level of knowledge among hospital staff, including limited woman’s rights in African countries, stress caused by high work pressure, stigma, and economic and infrastructural conditions (Deacon, Stephney & Prosalendis, 2004; Desapriya, 2004; Hogan et al., 2005). In a recent study, 43% of health care workers reported that stigma existed in health care, and 44% stated that stigma affected the performance of their duties (Shisana & Simbayi, 2002). HIV/AIDS related stigma leads to a vicious circle with isolation of and discrimination toward people with HIV/AIDS,

### Table 1. Overview of Items from the Questionnaire and Percentages Correct Answers for Doctors, Nurses, and Other Disciplines in a State Hospital in South Africa

<table>
<thead>
<tr>
<th>Item</th>
<th>Doctors (n=7)</th>
<th>Nurses (n=44)</th>
<th>Other (n=7)</th>
<th>Total (n=58)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does AIDS stand for?</td>
<td>100%</td>
<td>89%</td>
<td>100%</td>
<td>91%</td>
</tr>
<tr>
<td>How does one get HIV/AIDS?</td>
<td>86%</td>
<td>82%</td>
<td>86%</td>
<td>83%</td>
</tr>
<tr>
<td>HIV/AIDS is a notifiable disease.</td>
<td>71%</td>
<td>48%</td>
<td>71%</td>
<td>53%</td>
</tr>
<tr>
<td>Do you know where to go once infected?</td>
<td>86%</td>
<td>70%</td>
<td>57%</td>
<td>71%</td>
</tr>
<tr>
<td>Do you treat PLWA differently?</td>
<td>57%</td>
<td>61%</td>
<td>100%</td>
<td>66%</td>
</tr>
<tr>
<td>Aware of counselling programmes?</td>
<td>86%</td>
<td>89%</td>
<td>86%</td>
<td>8%</td>
</tr>
<tr>
<td>Information on HIV/AIDS is accessible.</td>
<td>86%</td>
<td>61%</td>
<td>43%</td>
<td>62%</td>
</tr>
<tr>
<td>Do you participated in counselling?</td>
<td>86%</td>
<td>82%</td>
<td>100%</td>
<td>84%</td>
</tr>
<tr>
<td>Enough is done on counselling for medical staff.</td>
<td>57%</td>
<td>25%</td>
<td>14%</td>
<td>28%</td>
</tr>
</tbody>
</table>
increase of the workload of nurses, and a negative influence on adequate care and treatment (Deacon et al., 2004; Horman & Sheeran, 1995; Parker et al., 2000; Smit, 2005). Financial and political support of the South African government seems to be necessary to overcome HIV/AIDS stigma (Desapriya, 2004; Mukherjee et al., 2003; R uger, 2004; Sidley 2004). (We added Dixon to the reference list. Sidley was indeed 2004).

The hospital in which our study was performed is a state hospital in South Africa, with many HIV/AIDS patients and relatively good facilities. Patients in the hospital came from within and outside the district. Since South Africa is one of the most developed countries in Africa, the situation in other African countries may be comparable or even worse (Buve, Bishikwabo-N Sarhaza & M utangadura, 2002).

Conclusions
More than a quarter of the medical staff in a state hospital appear to have insufficient knowledge of HIV/AIDS and hospital HIV/AIDS policy. Moreover, half of medical staff did not know that HIV/AIDS is not a notifiable disease. The medical staff was also not confident in working with the current hospital HIV/AIDS policy. Education of medical staff may be insufficient due to several factors, including lack of accessibility to information, lack of training and counselling, and lack of knowledge about HIV/AIDS policy.

Recommendations
Medical staff should be educated regarding HIV/AIDS, for an effective HIV/AIDS prevention programme and adequate care and treatment of PLWHA. It may be advisable for current HIV/AIDS counselling programmes to be evaluated for their effectiveness. We recommend that hospital HIV/AIDS policy and counselling programmes are developed in co-operation with community based organisations (U N A I D S 2005) and all disciplines in the hospital, especially nurses. Sufficient attention should be given to making HIV/AIDS a notifiable disease, which is an important step in overcoming the challenges facing patient care for HIV/AIDS in South Africa (Shisana et al., 2002).

Acknowledgements
We thank the medical staff of the Dr. George M ukhari Hospital for their cooperation in the study and the Hospital Board for their cooperation in conducting the study. The researchers AD and CM received a Delta Research Scholarship.

References
About 520 delegates from all over Africa and 21 countries attended the conference. This report and policy brief summarises the key findings and suggested policy options that emerged from rapporteur reports of conference proceedings including the following themes: (1) Orphans and vulnerable children, (2) Treatment, (3) Prevention, (4) Gender and male involvement, (5) Male circumcision, (6) People living with HIV/AIDS, (7) Food and nutrition, (8) Socioeconomics, and (9) Politics/policy. Two (11.8%) of the 17 OVC projects from the three countries were classified as best practice interventions. Of the 83 abstracts that were accepted at the conference, only 7 (8.4%) were dealing with antiretroviral therapy (ART). There has been tremendous effort by various organisations to provide information about prevention of HIV/AIDS. Information received by adolescents has been effective in increasing their knowledge, but without positive sexual behaviour change. The conference noted the contribution of gender discrimination and violence to the HIV epidemic and the different risks that men and women face in relation to the epidemic. Social scientists need to study the deep cultural meanings attached to male circumcision among different ethnic groups to be able to guide the debate on the latest biomedical findings on the protective effect of circumcision against HIV. Palliative care and support is crucial for coping among people living with HIV/AIDS (PLWHA) in order to deal with medical and psychological issues. Researchers from several countries have helped researchers to explore alternative ways of examining poverty in the context of HIV and AIDS. Policy frameworks which are likely to succeed in combating HIV/AIDS need to be updated to cover issues of access, testing, disclosure and stigma. In general, the conference was successful in identifying innovations in access to prevention, treatment and care in HIV/AIDS.

Keywords: Summary, policy, social aspects of HIV/AIDS, Kisumu conference, 2007

RÉSUMÉ

Environ 520 délégués du continent africain et 21 pays ont assisté à cette conférence. Ce rapport et dossier politique présente le compte-rendu des résultats clés et des options de la politique suggérées qui ont émergées des bilans de débats de la conférence. Entre autres les thèmes suivants ont été abordés : (1) les Orphelins et les Enfants Vulnérables (OEV), (2) le traitement, (3) la prévention, (4) le sexe et la participation des hommes, (5) la circoncision des hommes, (6) les personnes vivant avec le VIH/SIDA, (7) les aliments et la nutrition, (8) les socio-économies et (9) la politique. Deux (11,8%) de 17 projets d’OEV ont été portés sur la thérapie antirétrovirale (TAV). Pas mal d’organisations ont fait des efforts énormes afin de mettre à disposition des renseignements sur la prévention du VIH/SIDA. Les renseignements reçus par des adolescents se sont avérés efficaces à augmenter leur savoir sans pour autant changer leur comportement sexuel. Les débats ont fait constat du rôle de la discrimination de sexes et celui de la violence sur l’épidémie du VIH et les risques auxquels les hommes et les femmes font face vis-à-vis l’épidémie. Les sociologues doivent étudier le sens culturel associé à la circoncision des hommes parmi des différents groupes ethniques afin de diriger des débats sur les résultats biomédicaux plus récents liés à l’effet protecteur de la circoncision contre le VIH. Les soins et le soutien palliatifs sont primordiaux aux personnes vivant avec le VIH/SIDA pour pouvoir faire face à leur condition et pour qu’elles puissent faire face aux aspects médicaux et psychologiques. Les résultats de plusieurs pays ont aidé les chercheurs à découvrir d’autres voies d’étudier la pauvreté dans le contexte du VIH et du SIDA. Les cadres politiques qui ont une chance de réussite dans le combat contre le VIH/SIDA doivent être mise à jour afin d’aborder les questions d’accès, du dépistage, de révéler son statut et de la stigmatisation. En général, la conférence a réussi à identifier les innovations d’accès à la prévention, au traitement et aux soins du VIH/SIDA.

Mots clés: Résumé, politique, aspects sociaux du VIH/SIDA, conférence de Kisumu.
1. Orphans and vulnerable children (OVC)
Professor Leickness Simbayi presented an overview of the development, implementation and progress as well as lessons from a 5-year programme whose objective was to develop best practice OVC interventions in Botswana, South Africa and Zimbabwe. The initiative brought together six organisations in the three countries - one national implementation grant maker to coordinate the delivery of OVC interventions, and one research organisation in each country - under the auspices of the Social Aspects of HIV/AIDS Research Alliance (SAHARA) network. The project was implemented at 17 sites in the three countries – as depicted in Table 1 below.

Lessons learnt and policy implications: The use of implementation research networks such as SAHARA to conduct multi-country and multi-site research projects is useful for providing scientific evidence for use in both OVC policy and programme development, both on an individual national basis and regionally.

Moira Ngaru described care and support for OVC in farming communities through the Farm Orphan Support Trust (FOST) in Zimbabwe. The vision of the project is to get “all orphans’ rights realised” by proactively increasing the capacity of communities to respond to the orphan crisis and ensuring that systems are in place to protect and care for OVC. In farming communities, FOST has developed a holistic intervention that builds the capacity of the community to respond in sustainable ways, by developing support networks in communities, access to education, home-based care (HBC), development of “Kids Clubs”, alternative livelihood skills, and supporting child-headed households.

Lesson learnt: The most effective and sustainable way to protect and support OVC on farms is building community capacity, developing meaningful livelihoods, keeping parents alive and healthy, enhancing psychosocial support systems, and building the resilience of children themselves, rather than pure material support.

Ella Mohamadi described important aspects of Bana ba Keletso (BBK) Child care project in Molepolole, Botswana. As a response to the increasing numbers of OVC, the community of Molepolole started a joint intervention to provide care and support to OVC through a comprehensive approach of establishing a counselling centre and a child care programme to reduce the psychosocial effects of orphanhood.

**TABLE 1. OVERVIEW OF OVC INTERVENTIONS BY COUNTRY AND GRANT MAKER, PROJECTS AND SITES WITH A BRIEF DESCRIPTION**

<table>
<thead>
<tr>
<th>Country and grant maker maker</th>
<th>Projects and sites</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana, Masiela Trust Fund</td>
<td>Bana ba Keletso</td>
<td>Community child support</td>
</tr>
<tr>
<td></td>
<td>Motse wa Tsholofelo</td>
<td>Child care for OVC</td>
</tr>
<tr>
<td></td>
<td>Mother’s Union Centre</td>
<td>Preschool orphan care support</td>
</tr>
<tr>
<td></td>
<td>Little Friends Centre</td>
<td>Day care centre</td>
</tr>
<tr>
<td></td>
<td>Kgodi Song Centre</td>
<td>Early childhood education for OVC</td>
</tr>
<tr>
<td>South Africa, Nelson Mandela Children’s Fund</td>
<td>Matjhabeng OVC JV</td>
<td>Comprehensive OVC support</td>
</tr>
<tr>
<td></td>
<td>Tapologo OVC project</td>
<td>Household support for OVC</td>
</tr>
<tr>
<td></td>
<td>Child Welfare NW</td>
<td>Community child welfare</td>
</tr>
<tr>
<td></td>
<td>Liketsi Eseng Dipuo</td>
<td>Community empowerment project</td>
</tr>
<tr>
<td>Zimbabwe, Family AIDS Caring Trust</td>
<td>Midlands Aids Service Org</td>
<td>Community OVC support</td>
</tr>
<tr>
<td></td>
<td>Farm Orphan Support Trust</td>
<td>PSS support for farm orphans</td>
</tr>
<tr>
<td></td>
<td>DevAid People-People</td>
<td>Preschool and youth-friendly corner</td>
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<td>Ndzeve Centre</td>
<td>Education/support - deaf children</td>
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<td>Tyinyunjy Babili Trust</td>
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<td>FACT N’yang</td>
<td>Education and PSS for orphans</td>
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<td>Practical Action</td>
<td>Community-child support</td>
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<td>Batsirai Group</td>
<td>Integrating microfinance in OVC</td>
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Lessons learnt: BBK is an integrated community based programme, with interventions that focus on educational support for preschool children and out of school youth, psychosocial support through counselling, camps, kids clubs, home visits, skills building and play, community educational outreach, provision of material support, and training of caregivers and volunteers on child care. Of the 6,310 orphans registered with the Department of Social Services, 520 of them are from BBK. The project is sustainable because of the high level of community involvement. There is networking and collaboration with other stakeholders to reduce unforeseen duplications of programmes and to expedite resource mobilisation.

Hilda de Bees described interventions for OVC at Tapologo HIV/AIDS project in Rustenburg, North West province. The community based care model uses four leading principles: community ownership, children's rights, child protection and child participation. The programme recruited 20 Community Care Workers (CCW) and two Community Care Coordinators (CCC) at two sites.

Lessons learnt: CCW identified 200 households with about 377 OVC, where they provide psychosocial counselling, management of grants, identification and dealing with violence against children, and sexual abuse. They also provide food parcels, when available, and support income generating activities at the local community centre such as knitting, sewing, gardening, fence-making, etc.

Policy implications: Introduce and educate tribal authorities and other community structures on OVC models to reinforce the capacitation and institutional strengthening of the community to care for their own children. It is also important to foster a sense of ownership of the programme by the broader community. It is important to provide training on care for carers and to support counselling from the social worker, debriefing and individual emotional counselling.

Geoffrey Setswe, presented a study on elements of good practice OVC interventions in 17 projects in three southern African countries. This study evaluated 17 OVC interventions in Botswana, South Africa and Zimbabwe, to determine if they were “best”, “good” or “promising” OVC practices, using a combination of reading, observing, talking and review. Researchers visited each of the OVC projects and observed how the projects were implemented, took field notes and reviewed same. They also read and reviewed annual progress reports which were submitted by project managers over the five year period. A documentary review was also done on a presentation and/or poster using ten-point criteria.

Evidence generated: Two of the 17 projects were classified as best practice, four were good practice and 11 were classified as promising practice OVC interventions. None of the projects were classified as poor practice OVC interventions. Deciding what is “best” is not easy. Best practices can vary over time, as new evidence and new possibilities emerge, and from place to place, depending on available resources and infrastructure. What is “best” also depends on what people want.

2. Treatment

Of the 83 abstracts that were accepted at the 4th SAHARA conference as papers and posters, only seven (8.4%) dealt with antiretroviral therapy (ART), five of which were papers and two were posters. This was disappointing considering the amounts of money allocated for ART.

Table 2 below shows innovations in HIV/AIDS treatment, which included a description of gender distribution of patients on ART, clinical outcomes of patients on ART, adherence to ART, innovations in ART treatment, access to socio-economic support, factors that influence access and utilization, and an approach to delivery of ART services. Innovative methods were used to study access and treatment with ARVs. The three case studies on access to ART are valuable in studying new interventions such as the introduction of ARVs; two cross-sectional surveys on adherence to ART will help new programmes to understand factors that influence PLWHA to adhere to treatment; and a systematic review on gender distribution and clinical outcomes of patients on ART gives a broader picture of who is on treatment and whether it is effective or not. Three of the studies were from researchers in West Africa and two each from researchers in southern and east Africa. Five of the studies were targeting PLWHA on treatment, one study targeted the general community using a nongovernmental ART service, while another focused on increasing access to children receiving ART.
A systematic review of gender distribution and clinical outcomes of patients on ART in southern Africa found that the median age of patients in the studies ranged from 33 to 39 years, with females exceeding 60% of patients on ART in most of the study locations. The latter finding was not surprising, but researchers believe there is need to identify factors facilitating accessibility to treatment by women (Muula et al.).

A cross-sectional survey among 98 men and 109 women receiving ART to determine adherence to ART in Dakar, Senegal found that 58% of them were adherent, but there were differences in the levels of adherence according to variables and treatment protocol. Social characteristics such as having children, or being a housewife and not planning to have a child in the next year, were associated with adherence (Sow et al.).

A case study of innovations in the treatment and access to socio-economic support in Guinea-Bissau found that the distribution of condoms was on-going and increasing, and most of those infected were still waiting for treatment. The key challenges in providing HIV/AIDS treatment services were limited resources, lack of capacity for implementation of the national strategy, and lack of necessary equipment (Mendez).

Obinge and colleagues described access to HIV care and treatment through partnership using a children's club approach, to meet the needs of children and to help them cope with their situation. Feedback received from the children after every meeting made it possible to adjust the programme to address the needs of the children, and many beneficiaries reported positive therapeutic outcomes.

In a cross-sectional survey of patients who started ART between 2004 and 2005, to document factors associated with adherence to ART in Pretoria, the 180 patients who consented to be interviewed had a mean age of 36.7 years, 68.8% were female, 86.7% were unemployed, 73.9% had high school education and 77.8% were single (Malangu).

Nduta and colleagues found a significant relationship between age, marital status, ethnicity, religion, main occupations and current engagement of PLWHA, in accessing and utilising ARVs.

An integrated approach to ART delivery at the Christian Health Association of Kenya runs ART programmes at 255 sites, 25 hospitals and health centres. It includes training in ART, onsite mentoring, and training of community health workers to support home based care programmes. Community outreach for ART increased access and adherence to ARV treatment.

Conclusion: The 4th SAHARA conference was a missed opportunity for programmes to share research and progress on implementing ART programmes.
was disappointing that less than 10% of all abstracts accepted at the conference focused on ART. However, these few presentations and posters were helpful in sharing innovations in HIV/AIDS treatment. Programme implementers should be trained and supported to share research and progress on implementing ART programmes at conferences.

3. Prevention
There has been tremendous effort by various organisations to provide information about prevention of HIV/AIDS. However, despite these efforts, a large segment of the population is still being excluded from accessing information on the basis of their disability. The use of mass communication to provide information about HIV/AIDS has serious implications for prevention, since it does not consider the needs and limitations imposed on individuals due to disabilities. Persons with disabilities do not have correct and adequate information about prevention, treatment and care of HIV/AIDS, due to the methods used in mass communication by service providers. It was reported that experts estimate that persons with disability are about five to ten years behind the general population in knowledge and awareness about HIV/AIDS. The low knowledge of facts about HIV/AIDS among persons with disabilities is as a result of conventional methods of using print and electric media for mass communication which are not accessible to persons with disabilities. These conventional methods do not take into account that persons with disability require the use of other media such as sign language, symbols and Braille.

This paper discusses the implication and the use of mass communication in promoting the participation of persons with disabilities in HIV/AIDS prevention, treatment and care. The use of mass communication by various stake holders to disseminate information about HIV/AIDS through print, electric and verbal media requires proper functioning of auditory, visual and cognitive processes. These processes are usually impaired in persons with disabilities and therefore, they are marginalised socially and isolated from the general society. As a result of this marginalisation, information and education on HIV/AIDS largely bypasses the members of the disability community. Although studies have shown that information is one of the strongest tools for fighting HIV/AIDS, persons with disabilities continue to be limited in accessing information due to media used in mass communication.

National and institutional policies on HIV/AIDS should recognise the needs of persons with disabilities, and provide information through accessible disability-friendly communication channels, such as talking computers, to allow them to participate in activities leading to the prevention and care of HIV/AIDS. Various stake holders providing information about HIV/AIDS should adapt communication tools that would enable persons with disabilities to make use of the silent television set, invisible radio, indecipherable newspaper, and the unconfident parent and siblings (Edward Kochung).

Evidence generated: Information plays a key role in influencing adolescent sexual behavior. Studies undertaken indicate that information received by adolescents has been effective in increasing their knowledge, but without positive sexual behavior formation and change. The aim of the study was to determine the characteristics of information sources that influence adolescent sexual behavior. The study revealed that peer and media were the main sources of sexuality information, compared to FBO and parents. Peers followed by media had most of the desired characteristics such as listening, availability and openness, whereas parents were said to be knowledgeable as compared to other sources. The study showed that parents (46%) were the most preferred source, yet they had fewest of the preferred characteristics. Parents were considered to be judgmental and lacked privacy, and therefore rated among the least used source. The source of information and sexuality practice were found to be related, as those who sought their sexuality information from peers were more likely to have engaged in sex, while those who received their information from parents were less likely to have engaged in sex. The researcher concluded that each source has a unique characteristic that affects the behavior of adolescents, and that there is a need to look at opportunities for parents to gain the knowledge and skills they need to enhance the desired characteristics to effectively communicate with their adolescents about sexuality for a positive health outcome among adolescents. The research also recommended the need to enhance peer
and media as most used sources, to make them effective in sexuality information provision (Olayo & Kaseje).

The dilemma of married couples in disclosing HIV/AIDS status was also reported at the conference. A study conducted on the experiences of VCT funded by USAID, reported that men and women who came for the testing did not come together as couples but alone. After testing they found it difficult to share their results with their spouses for fear of being blamed for having several sexual partners (Nsabagasani & Yoder).

A study was conducted to evaluate the effectiveness of abstinence and faithfulness among youth (ABY) interventions in five African countries. The abstinence programmes encourage unmarried individuals to abstain from sexual activity and only protect themselves from exposure to HIV and other sexually transmitted infections while “be faithful” programmes encourage individuals to practise fidelity in marriage and other sexual relationships, as a critical way to reduce risk of exposure to HIV. It was found that to obtain the best evidence of effectiveness of the ABC intervention, it is essential to involve the evaluation team in the design of the plan, and to train them on the methods of the evaluation (Setswe).

Policy implications: Many people are not familiar with the scientific terminology, technical details and other information about HIV/AIDS. Moreover, there is a need for visual communication so that it can be more effective, understandable and interesting. Scientoons, a new class of science cartoons, which combine scientific information with humour, provide a very effective and powerful tool to tackle this communication challenge. Scientoons with their unique communication power are used worldwide. Scientoons have been very successfully used for creating awareness about HIV/AIDS in India and abroad (Kumar). Moreover, counselling should include discussion of sexual relationships, so that the risks of HIV transmission may be reduced. VCT clients need to be followed up to help them negotiate sharing sero-status with spouses.

4. Gender and male involvement

The contribution of gender discrimination and violence to the HIV epidemic, and the different risks that men and women face in relation to the epidemic, was reported at the conference. These require some consideration in the development of intervention strategies. However the papers presented made it clear that both men and women need to be informed of the interventions directed at each other, to be able to support their partners.

One of the key sessions at the conference dealt with sexual and partner violence. A sample of women attending a primary health care clinic in Limpopo province South Africa reported emotional abuse in 22% of cases, physical intimidation in 20% of cases, and physical abuse in 17% of cases. Of importance 50% implied that it was difficult to initiate talking about this, and wanted health care professionals to ask about it or investigate it further. Given that there were many more participants requesting this action from health professionals than reporting abuse, it is likely that the 17% is a considerable undercount and that there is a need to feel safe in reporting forms of abuse (Papa Gallo Sow).

Another survey in South Africa also reported levels of partner violence at 21%, with 17% of women raped. Violence was reported as coming predominantly from partners, family members, and friends. Jealousy was seen as the major reason for violence from partners. Men also reported experiences of violence from older men and women, and also on occasion from their peers (Pengpid & Peltzer).

Alternative protection technologies that are under the control of women were raised as important. Attitudes towards the diaphragm were investigated among female sex workers. The researchers found high levels of acceptability from the women and their male clients, who were often not even aware of the use of the diaphragm. However partners were concerned that they were excluded from decisions making. Of importance is to establish what protection diaphragms offer in relation to STDs (Okal et al.).

PMTCT constitutes an important intervention to protect children from infection and is primarily directed at women. Research found that awareness and informed knowledge regarding the programme was low amongst men, and requires further input from health workers towards men. Women attending the programme also need to be skilled to educate men (Onyango et al.).
VCT is a potentially powerful prevention tool, but it requires either that partners test together or that they are prepared to disclose to each other, especially in the context of marriage. A study found that men and women tend to test separately and that those who do test positive find it difficult to disclose this to their partner, with only about half of the sample being prepared to reveal their results to their partner. Efforts need to be introduced to facilitate partners being able to attend VCT together and to be able to talk to each other about positive results (Nsabagasani & Yoder). A similar ignorance of information was shown in relation to nosocomial infection in the DRC, thus requiring additional input (Bukondo & Disashi).

5. Male circumcision

Social scientists need to study the deep cultural meanings attached to male circumcision among different ethnic groups, to be able to guide the debate on the latest biomedical findings on the protective effect of circumcision against HIV. According to Professor Cheikh Niang of the Institute of Science and Environment, Cheikh Anta Diop University, Senegal, African social scientists should look beyond the evidence of trials conducted in Kenya, Uganda and South Africa on the protective effect of male circumcision, and ‘reconceptualise’ the findings to fit into African cultural perspectives. Niang was contributing to a roundtable discussion on the preventative impact of male circumcision on HIV at the conference. He argued that to promote male circumcision as a Western-type biomedical hospital procedure would not be widely accepted and supported. All African ethnic groups have deep cultural and spiritual meanings attached to circumcision, and these should be uncovered and reintegrated into African sexual life, in order to get wide acceptance of circumcision as a protective measure against HIV and AIDS.

Prof Agot Kawango from the Department of Microbiology and the project coordinator of the Kenyan study on the protective impact of male circumcision on HIV released in February 2007, kicked off the discussion, emphasising the importance of the social acceptance of male circumcision, especially in areas where circumcision is not a cultural practice. Three studies have now shown remarkably consistent findings on the protective effect of male circumcision against HIV/AIDS: the Orange Farm randomised trial conducted in South Africa (60% protective effect), the Kisumu study (59% protective effect) in Kenya, and the Rakai study in Uganda (51% protective effect). None of the studies showed that circumcision was harmful. He said for circumcision to be accepted as a means of protection, there were key social aspects that need to be resolved, including:

- How to communicate the benefits, while also explaining that circumcision is not 100% effective.
- The cost aspect: the willingness to pay in communities where circumcision is not a cultural or religious obligation.
- Access: what level of health facility and cadres of personnel should do circumcisions?
- Can traditional circumcisers be trained to provide safe circumcision?
- How to encourage young men to go to health facilities.
- How to identify qualified circumcisers and educate parents and sons on how to find or identify them.
- Wound care and after-care.

Adera Osawa, the deputy secretary general of the Luo Elders – a community that do not practice circumcision – said there were strong cultural emotions against circumcision, and some ‘very derogatory words’ were used for someone who is circumcised. But because AIDS is ‘a very dreaded disease that scares us all’, he said the Luo community did not challenge the scientific findings. ‘We as the Luo Council cannot force people to accept it [circumcision], as a policy. We don’t reject people who do it, but accommodate them.’

In one of the sessions, Professor Leickness Simbayi, a research director at the Human Sciences Research Council, suggested before governments consider male circumcision as a potential public health policy and HIV prevention strategy, it would be prudent to wait for the results of long-term follow-up studies of the Kenya and Uganda studies, due in 2009. He said the long-term 60% protection offered by circumcision should first be established before this could be made public policy. He presented a South African study that was based on a further analysis of data obtained from the first national population-based survey of HIV/AIDS conducted in South Africa in 2002, consisting of a sub-sample of 3025 men over 15 years.
Most of the papers demonstrated that areas covered for palliative care services include hospitals, hospices, schools, home based care, community centres, use of motorbikes to reach patients in unreachable areas, open air treatment, programmes such as road side mobile clinics, and the rural AIDS home care programme. A multi disciplinary approach is used with a good referral system established. Involvement and participation of communities in palliative care is visible in countries such as Uganda, Kenya and Canada. Palliative care is cost effective, improves quality of life and saves life.

Some problems and challenges with palliative care include:

- Generally there is still poor accessibility and utilisation of palliative care services such as home based care, due to stigma, since communities are not adequately equipped to deal with terminal illness, death and dying. Utilisation of hospice services such as home based care are not fully utilised, e.g. in South Africa due to stigma toward people using services and the community health workers. In Uganda palliative care is fully effective; nurses prescribe morphine and help in managing and helping patients.
- Palliative care is stigmatised, therefore support comes late for PLWHA, leading to high mortality rates.
- There is a need to have more trained nurses and community health workers (CHW). CHW play a crucial role in linking communities and formal health care systems.
- Access to resources such as space, ART, chemotherapy, radiotherapy for palliation, staff, and pain alleviating drugs are still a problem.
- National policies on palliative care need to be developed or revised, e.g. legislation on stocking, dispensing and prescribing opioids or narcotics is still a barrier in many African countries.
- Lack of funding and resources.
- No incentives, recognition and motivation for CHW.

Way forward and policy implications:

- There is a need to do more advocacy, awareness, education, policy review, research projects, needs assessment, capacity building through training, facilitation and supervision, collaborations and partnerships, strategies on scaling up palliative care services, community mobilisation, implementation
of national strategy, stigma reduction and changing attitudes towards PLWHA.

- Palliative care should be structured according to the culture and needs of communities - this is called "culturally appropriate care".
- There is a need to develop expertise in communities, and affirm communities to care for themselves.
- There is also a need to build in more psychological support in models of care.

7. Food and nutrition

Mainstreaming HIV/AIDS in development programmes was seen to be a big concern, that came with many questions such as: is there any difference in nutritional requirements between men and women?, what is the ability of good nutrition to delay HIV progression?, without adequate nutrition is there any need for ARVs intervention?

The papers presented appear to focus on ensuring food security for all, whether HIV infected or not, because it is believed that this makes it easier for ART intervention. This includes the establishment of kitchen gardens where people will be able to grow their own crops. There were discussions on nutritionally superior indigenous vegetables, especially the bitter vegetables that are viewed as medical. Having the right information on nutritional requirements prior to the intervention can help ensure the right nutritional status. Another option that was presented at the conference was camels' milk, which is also proven to be nutritious and rich in phytochemicals. However, in food intervention, the concern primarily lies in nutrition education especially in the era of HIV/AIDS, where recommendations for nutritional requirements for those living with HIV are needed (Owino & Konyole).

Policy formulation on how to fill the gaps to encourage production of enough, nutritious foods was also presented at the conference. Giving farmers a subsidy was presented as a policy option that would increase the production of nutritious food. It starts with the provision of safe drinking water and reduces cross-contamination in cases of replacement feeding; and also focuses on fortifying food, especially if the government can subsidise and ensure proper quality control, by doing the processing centrally through social marketing and seeking private public sector partnerships. A policy framework (government intervention) is needed to mainstream these issues by allowing small-scale agriculture in the urban centres. This was seen as practical, as compared to rural communities who do farming as a seasonal activity and prefer to do it on a large scale. A policy should also emanate to clarify the roles of nutritionists, identify the problem and then advocate for the need for such positions (Owino & Konyole).

Some services support what they think is the core service and should be de-linked from the health facilities, with nutrition integrated more into health service provision. HIV further complicates the issue of malnutrition, and people with knowledge should embark on outreach programmes to deliver the message more, and this should also include partnerships and networking. Nutrition and HIV policy formulation in Kenya has been slow; this is probably because the current parliament has few (2) nutritionists who have tried to mainstream HIV and nutrition issues into the policy. Nutrition and dietetics bill was presented to have reached second stage of debate, to address issues like supplements used without control. Regulation is needed to eliminate the inadequate supplements. The regulation of education was shown to be significant in order to help channel right information to the people. Research presented at the conference shows that adequate nutrition can help postpone the progression of HIV/AIDS and emerging issues on nutrition and HIV especially among children is necessary to avoid complications (Owino & Konyole).

Policy intervention should be introduced to help such urban cases to enhance the capability of IGAs and allow the provision of ARVs as a package. It was noted at the presentation that linking with agricultural extension people would help the nutritionists to channel efforts towards the targeted production. Food distribution should also not only target one sector but the whole population. The changing face of HIV/AIDS and other nutritional related diseases has caused an increase in demand, because of growing recognition of the important role of nutrition. On the other hand, all farmers whether small or large scale, should have credit access, and clean and safe drinking water available. Communities should also have access to...
nutrition education. Land ownership still has loopholes and contributes to food insecurity, since there is land-grabbing and so production for the household is reduced. Policy gaps exist to control the mushrooming of dubious manufacturers, especially of products with unconfirmed nutritional benefits. Implementation of some of the policies should be followed up to ensure practicality, and adjustments made accordingly.

8. Socioeconomics

Professors Dan Kaseje (Kenya), Cheikh Niang (Senegal) and John Seager (South Africa) convened a symposium to present preliminary results of a SAHARA multi-country study being carried out in South Africa, Kenya and Senegal on the socio-economic impacts of HIV and AIDS. The study was funded by the governments of the Netherlands (DGIS), United Kingdom (DFID), Canada (CIDA) and the Ford Foundation. Quantitative studies were reported for Kenya and South Africa, and a qualitative exploration of the nature of poverty for Senegal. The quantitative studies utilised similar semi-structured questionnaires, which were administered to 600 households in rural Kenya and 300 households in a peri-urban area in South Africa.

The symposium began with the presentation of a conceptual framework developed to assist in understanding the dynamic nature of the relationship between HIV infection and poverty (Seager & Ganyaza-Twalo). The framework explored the relationships between HIV and poverty at the various stages from initial infection, through AIDS, to death. The model identified both how poverty contributes to risk of initial infection and how negative feedback loops related to illness and death exacerbate poverty.

The next paper, interactions between poverty and HIV/AIDS at the household level (Seager & Ganyaza-Twalo), explored methodological challenges in identifying HIV-affected households, and categorised households using both known HIV status (volunteer PLWHA) and proxy indicators for HIV impacts, such as young adult deaths from typical opportunistic infections, and presence of orphans within the household. The study then explored the relationship between several composite indicators of socioeconomic status and household HIV status in a peri-urban area of Cape Town. Significant relationships were reported between HIV and asset depletion and hunger. Funeral costs were a substantial economic shock to households, equivalent to about one to two years income in a poor household, but were offset for the majority of households by access to insurance (formal or informal).

The Kenyan study was carried out in a rural sub-district and was presented in four components study background and demographic information (Oyui et al.); impact of HIV/AIDS on economic impacts and spending patterns (Kaseje et al.); impact of HIV/AIDS on food and nutrition security (Ariga et al.); and coping mechanisms for economic shocks (Owii et al.). Background data included an absolute poverty rate of 65%, food poverty of 55%, and HIV prevalence of 35% (KDHS, 2003). The study identified HIV-affected households using health facility records and an informed consent procedure. Control households were selected from two immediate neighbours. Disease staging (available from clinical records) was used to provide a "quasi-longitudinal" study design, i.e. assessing impacts from early to late stage disease. Relative to control households, the index households spent a greater proportion on food and health care, and less on investments, education and house construction or repairs. Decrease in asset ownership over the past six months was related to stage of disease, with 8.8% of stage 1 households having decreased asset ownership, rising to 18.2% by stage 4 and dropping to 11.8% for households experiencing a death (stage 5). HIV-affected households planted and harvested significantly less maize than control households. The index households also kept less livestock. Both results may be indicative of the affected households avoiding labour-intensive activities and selling off livestock to meet medical and other essential expenses. Hunger was significantly more frequent in index households. In response to adult deaths, a greater proportion of HIV-affected households used social support from relatives as a coping strategy, unlike the control households who depended on the sale of assets or cereals. The analysis showed that HIV-affected households experienced more economic shocks than non-HIV-affected households, and resorted to more desperate measures in response. Strategies for sustainable mitigation of the impacts of HIV among rural households should address food availability and affordable health care.
The final paper in the seminar was a qualitative assessment of the impacts of HIV/AIDS on families in Senegal (Niang). Niang argued that poverty needs to be re-conceptualised since it is understood differently in different cultures. In some languages, there is no direct translation of the word poverty, but rather an understanding of poverty as “a lack of something”. This lack may include economic capital, social capital, human capital or political capital. By way of illustration, a millionaire might be considered poor if he has no social capital or is “alone”. A lack of political capital was described as a state in which a person is described as one who “when he calls, nobody will come”. The emotional effects of illness may lead to depression, which can have direct economic impacts if the patient feels unable to work. Health seeking behaviour can be costly, especially when a PLWHA or their relatives become desperate and seek many different forms of care, including both western and traditional medicine. The death of a head of family often results in the scattering of his family members (wives and children) who go into other homes (remarriages, remarriage of widows and children). HIV/AIDS is affecting the size and the composition of families. Families with PLWHA (especially if the person is the head of this family) have relatively fewer children staying with them than families without PLWHA. Beside the fact that funerals impoverish families, they disturb children’s lives, because they are the first family members to sleep on the floor and leave their beds to visitors if they are not sent to neighbouring homes. Few people take the trouble to look after children on such occasions, and they may be overwhelmed with errands or housework, which can affect their school results. In traditionalist families, many people can share the same meals, even if they don’t live in the same compound. This is sometimes seen as a sign of wealth or social prestige. With AIDS, the number of people who eat together may decrease. The drop in the number of people who usually have meals together can be made sharper by stigmatisation, which leads to the relative isolation of families with an HIV-infected member. In conclusion, although Senegal has a low prevalence of HIV/AIDS in its general population, the socio-economic impacts of HIV/AIDS on infected and affected individual families are devastating. The ongoing research may lead to new suggestions on how to measure and how to make these impacts more visible.

The symposium offered a unique opportunity to compare results from several countries and to explore alternative ways of examining poverty in the context of HIV and AIDS. Further analysis is planned and the presenters will be seeking to publish several papers at the same time so that inter-country comparisons can be made.

9. Politics/policy

This section of the report is based on the presentations and discussions made by presenters who represent a mix of politicians and managers of organisations that deal with policy and other interventions on HIV/AIDS, including: The honourable Dr. Gerard Menya Simon, Ugandan MP, Christina van Furstenberg, UNESCO, The honourable Ms. Margaret Mensah-Williams, Namibian MP, The honourable Dr Bani Leon Bio Bigou, Benin MP, The honourable, Mr. Charley M boc, Cameroon MP, and Ms. Alloys Orago, National AIDS Council, Kenya

Perspective: The politicians emphasised the importance of scale and consideration of global trends in the fight against HIV. Globally 42 million people are infected, and 5 million are infected every year. 30 million have died already. Of these figures sub-Saharan Africa represents the highest proportion of those infected. The sad part is that while prevalence was declining in some states, in recent years it is increasing due to lack of resources and capacity. In some countries, government communicates with researchers regularly. As a result different governments have started introducing policies and laws to address socio-economic factors related to HIV/AIDS. However, African governments still need to synchronise evidence drawn from research with legislation and policy.

Challenges: HIV and AIDS have negative impacts on the socio-economic conditions of most African states, which complicate struggles against inequality, poverty, unemployment and alcohol abuse. The epidemic has reduced development gains made in recent times. Most African states experience loss of skilled workforce. Women are the most affected and infected because of their vulnerability, exacerbated by socio-economic and cultural factors. Very few people take HIV tests despite governments’ free access policy to health care. There is still a lot of ignorance and lack of knowledge about government policy in most African states. As a result,
government laws seem to address the needs of parliamentarians rather than those of communities. People are left out of the legislation process. It seems that governments do utilise communities to implement their mandate. This problem is compounded by political and religious differences. In some states leadership remains a major challenge. As result efforts to combat HIV/AIDS are disjointed and uncoordinated. The civil society is not active enough to put pressure on governments to prioritise HIV/AIDS issues. Governments do not have sufficient funds to commission research. Accountability remains a problem, because some public programmes on HIV/AIDS are abandoned because of lack of funds or funds not used for the programmes but for other things.

Evidence generated: It seems initially most African states were doing well in reducing HIV infections. However, this trend has not been sustained. It seems that the increase in HIV infections may be attributed to reduced funding, and lack of communication of government policies. Most governments have begun introducing progressive interventions to curb intentional infection and abuses arising from HIV/AIDS. However, the laws still need to be integrated with results from research, best practices in Africa and comparative models successful elsewhere.

Lessons learned: Reduction in infection rates requires urgency, sustained interventions and communication. Parachuting programmes as once-off interventions does not help. PLWHA are vulnerable. In a social climate laced with discrimination, human rights abuses and historical problems, there is a need for more regulations to protect vulnerable groups, especially PLWHA. Government intervention is necessary to ensure that PLWHA are protected. Partnership with researchers is important in making scientific knowledge accessible to policy makers. In this way governments will draw lessons from best practices in the world, and also utilise local socio-cultural innovations to combat HIV/AIDS.

Policy implications: The purpose of the roundtable was to highlight major gaps in policy. Policy frameworks which are likely to succeed in combating HIV/AIDS need to be updated to cover issues of access, testing, disclosure and stigma. Generally, socio-economic environments fettered with religious and cultural beliefs need to be regulated to protect PLWHA. Religion and culture, when used unscrupulously, nurture discrimination and human rights abuses. The private sector needs to be brought on board in the fight against HIV/AIDS. They are an important role player in the economy. Without them the economies of different states may collapse.

It is refreshing to read *AIDS and the Ecology of Poverty* by Eileen Stillwaggon, as it tackles the topic of HIV/AIDS from a perspective that is not altogether forgotten but is not as prevalent as it should be. The 260 page book, extremely relevant for policy makers, researchers, students and those working in the field of HIV/AIDS, discusses AIDS beyond the behavioural perspective. What makes this book relevant is that Stillwaggon reminds us that there is more than the behavioural perspective; she shows us that our fixation on the behavioural has led us to policies that are not as effective as we hoped they would be.

In the text, Stillwaggon contends that current AIDS research, and ultimately interventions and policies, are predominantly based on behavioural perspectives concerning the spread of HIV. She argues that the spread of HIV is more complex than sex, and that there are many underlying co-factors that models such as AVERT, GOALS and STDSIM do not begin to incorporate. All three models were developed to evaluate the effectiveness of HIV prevention strategies and therefore support strategic planning but cannot be truly relied upon if they base their assumptions only on individual sexual behaviour. She argues that nutrition or malnutrition, malaria, leishmaniasis, helminthic and filarial infections, genital schistosomiasis, tuberculosis, and STDs, as well as economic and social conditions are all factors or co-factors that impact on the spread of HIV. These co-factors go hand-in-hand with poverty, and cause the body to be more susceptible to the HIV virus. Stillwaggon goes into detail regarding the above-mentioned co-factors, and shows with the use of examples, how they relate to increased HIV susceptibility. If these co-factors are controlled for, then the spread of HIV will decrease. The text shows us that HIV infection is associated with various social, economic and biological conditions, and therefore strategies to prevent new infections based on behaviour modification programmes alone will not be sufficient to stem the epidemic. Stillwaggon clearly points out that she does not call for current behavioural work to be abandoned, but argues that their effectiveness could be improved by taking the other co-factors into consideration.

In Part three, Stillwaggon explores the ‘Derailment of HIV/AIDS Research’ by discussing racial metaphors and individual bias in methodology. With regards to racial metaphors, we are shown that it is not extraordinary behaviour that distinguishes the third world from the first world but rather poverty. Due to such stereotypes (Western misconception of Africans), poor research, policy and interventions continue to be promoted. In discussing methodology, Stillwaggon details the problems of AVERT, GOALS and STDSIM which do not incorporate what is known about the complexity of HIV. As such, she suggests factors discussed in previous chapters to strengthen the models.

Part four examines the ‘Consequences’ of only looking at HIV/AIDS from the sexual behavioural viewpoint and explores HIV/AIDS policies and workplace interventions. The final part of the text explores ‘Solutions’. What is truly of benefit in this text is that the solutions to the co-factors that increase or promote HIV are already known, and even more important is that the infrastructure and the ability to make the solutions available to people already exist. The example of malnutrition due to parasitic infection that is given in the text, shows us that treatment and education for the infestation is available, yet worm infestation is overlooked for sexual behavioural modification interventions. If true epidemiological methodology, which is not obscured by the sexual behavioural school, were used, the co-factors and corresponding solutions
mentioned by Stillwaggon would come into play in the fight against HIV/AIDS.

This is not thinking ‘out-the-box’, because the perspectives have always been there, but merely lost by our fixation on the behavioural. Stillwaggon in AIDS and the Ecology of Poverty makes a convincing argument and as stated above, should be essential reading for all HIV/AIDS researchers, policy makers, students and others working in the field of HIV/AIDS. This text is useful in reminding one that it is not that behaviour is unimportant in understanding HIV/AIDS, but that it “explains so little about why poor people get sick.”

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Submission of papers

The Journal publishes contributions in English and French from all fields of social aspects of HIV/AIDS (care, support, behaviour change, behavioural surveillance, counselling, impact, mitigation, stigma, discrimination, prevention, treatment, adherence, culture, faith-based approaches, evidence-based intervention, health communication, structural and environmental intervention, financing, policy, media, etc.). While the emphasis is on empirical research (qualitative and quantitative), the journal also accepts theoretical and methodological papers, and review articles, which should not be longer than 8 000 to 10 000 words, as well as short communications, letters, commentaries and book reviews. Priority is given to articles which are relevant to Africa and the developing world and which address social issues related to HIV and AIDS. Special issues may deal with a specific topic, region or country. Submission of papers presented at the biannual International Conferences of HIV/AIDS and STIs in Africa and biannual Social Aspects of HIV/AIDS Research Alliance (SAHARA) conferences are especially invited.

Authors are requested to submit their original manuscript and figures with two copies and a matching disc to the Editor: Prof Karl Peltzer, Social Aspects of HIV/AIDS and Health, Human Sciences Research Council, Private Bag X 9182, Cape Town 8000, South Africa. Manuscripts can also be submitted by e-mail. Please create one folder (with the name of the corresponding author) for all word and figure files, and e-mail this to the editor at jahara@hsrc.ac.za

Submissions will be considered on the understanding that they comprise original unpublished material and are not under consideration for publication elsewhere (all authors are to sign on submission of the article), and the study(ies) on which they have been based have been subject to appropriate ethical review.

All submissions may be subject to initial assessment by the editor or appropriate Editorial Board members to determine their suitability for consideration by the Journal of Social Aspects of HIV/AIDS. Papers accepted for formal review will be sent anonymously to at least two independent referees.

Short biographic details of not more than 10 lines should be provided at acceptance of the paper for publication.

Manuscript preparation

General: Manuscripts must be typewritten, double-spaced with wide margins on one side of white paper. Good quality printouts with a font size of 12 are required. The corresponding author should be identified (include a fax number and e-mail address).

The reference style should follow APA guidelines: http://humanities.byu.edu/linguistics/Henrichsen/APA/APA01.html

Abstract and keywords: Supply an abstract (without subheadings) of up to 300 words and up to six keywords.

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AVIS AUX AUTEURS

Soumission d’articles

Le journal publie des communications en anglais et en français dans tous les domaines des aspects sociaux du VIH/SIDA (le soin, le changement du comportement, la surveillance comportementale, la consultation, l’impact, la réduction, le stigmate, la discrimination, la prévention, le traitement, l’adhésion, la culture, les approches basées sur la loi, l’intervention évidence-basée, la communication sur la santé, l’intervention structurale et de l’environnement, le financement, la politique, le média, etc.).

Bien qu’il mette l’accent sur la recherche empirique (qualitative et quantitative), le journal accepte des travaux théoriques et méthodologiques, les articles de revues d’une longueur d’entre d’environ 8 000 à 10 000 mots ainsi que des messages courts et des lettres. Nous donnons la priorité aux articles concernant l’Afrique et des pays en voie de développement et qui abordent des questions d’ordre social sur le SIDA. Des éditions spéciales pourraient aborder des sujets, des régions ou des pays particuliers. La soumission de communications déjà présentées à la conférence internationale bisannuelle de VIH/SIDA et de MST en Afrique et aux conférences des Aspects Sociaux de l’Alliance de R écherche du VIH/SIDA (SAHARA) bisannuelle est la bienvenue.

Les auteurs sont priés de soumettre leur manuscrit original et leurs données et deux photocopies et le texte sur disquette au rédacteur en chef: Prof Karl Peltzer, Social Aspects of HIV/AIDS and Health, Human Sciences Research Council, Private Bag X 9182, Cape Town 8000, South Africa. Les manuscrits peuvent également être soumis par courrier électronique. Veuillez créer un dossier (portant le nom de l’auteur) pour tous les fichiers textes et chiffres et l’envoyer au rédacteur en chef: jsahara@hsrc.ac.za

Les communications soumises seront acceptées à condition qu’elles soient originales et non publiées ailleurs (tous les auteurs sont priés de mettre leur signature sur la communication lors de la soumission) et que l’étude sur laquelle la communication est basée a subi un examen moral de recherche.

Toute communication pourrait être évaluée par le Rédacteur en chef ou par des membres du Comité de Rédaction afin de s’assurer de sa valeur scientifique avant d’être publiée dans le Journal des Aspects Sociaux du VIH/SIDA. Les communications déjà acceptées pour la publication seront soumises à au moins deux lecteurs indépendants pour évaluation.

Veuillez fournir des détails biographiques en environ 10 lignes une fois communication acceptée.

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