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# SOUTH-SOUTH COLLABORATIVE PROGRAMME

**OCCASIONAL PAPER SERIES**

**Poverty, HIV and AIDS : Implications for  
Southern Africa in the Global Capitalist  
Architecture**

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# About the South-South Tri-Continental Collaborative Programme

The South-South Tri-continental Programme is a scholarly collaboration for Research, Training, Publishing, and Dissemination, between the Council for the Development of Social Science Research in Africa (**CODESRIA**); the Asian Political and International Studies Association (**APISA**); and the Latin American Council of Social Science (**CLACSO**). The Programme was established as a reaction to the need, identified by scholars in the South, to reorient theoretical and methodological frameworks of the dominant development discourses; and to improve the organization of Southern research infrastructures. The Programme aims at reviving cooperation and collaboration among scholars of the global South working in the broad field of the social sciences. The collaboration was entered into with the specific aim of sustaining knowledge exchange between scholars on the three continents as a long-term initiative. At the core of this collaboration are the objectives of


deepening intra-South networking

contributing a South perspective towards the transformation of the Social Sciences on a global scale

producing alternative theoretical and methodological approaches of knowledge building

Networking and dialoguing take place in the different International Comparative Seminars that the partners set up annually on a rotational basis. For each International Seminar, **CODESRIA**, **CLACSO** and **APISA** select representatives from their respective continents. Each themed Seminar brings together a total of no more than twelve senior scholars who have been working on the thematic area identified for the Seminar, and are recognized as leaders in such area of scholarship. The small number of participants is meant to enable close, thorough discussion of issues, with a view to producing scholarly publications that not only make audible the voices of the South in the global arena, but effectively advance scientific scholarship.

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## Introduction

This paper discusses the issues concerning HIV and AIDS within the context of capitalist development in Southern Africa. Southern Africa is the epicenter of the HIV and AIDS pandemic and coupled with growing poverty in Africa in general, there is need to understand the trajectory of Southern Africa in the present phase of global capitalist development. The paper is contextualised in post-adjustment Southern Africa in which all the countries have adopted and implemented economic structural adjustment programs of various sorts, all of which share common features such as liberalization of capital, labour and commodities and services. The paper raises issues about research, directions for future intervention so that there are better understandings of processes for containing, reducing and mitigating the effects of HIV and AIDS in Southern Africa.

This paper analyses the trends and likely impacts of HIV and AIDS in the Southern African region. It raises conceptual questions about poverty, social organization, political and economic development in the face of demographic, social and economic challenges generated by HIV and AIDS. The paper examines the political and economic thinking that has contributed to the development and entrenchment of poverty in the context of the crisis related to infection with HIV and AIDS. It describes the experiences of some of the countries that have tried to deal with HIV and AIDS, pointing out the historical issues that have contributed to the infection of people with HIV and critically analyzing areas in which intervention has been attempted. The paper concludes by pointing out the gaps in knowledge about HIV and AIDS within Africa, the possibilities for dealing with the challenges of poverty and under- development in this millennium, using HIV and AIDS interventions as a point of entry into this debate.

HIV and AIDS manifested in Southern African countries in the mid nineteen eighties, coinciding with the structural adjustment policies which were being pushed by the International Monetary Fund, the World Bank and related regional development banks. The major components of these policies were the contraction and de-legitimisation of state structures in development, the dominance of foreign and international institutions in economic decision- making and the consequent loss of sovereignty in decision making in the

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political and social arenas too. In Southern Africa, there has been some modest success in economies such as those of Botswana and South Africa where growth has been sustained but the failure to cope with and mitigate HIV and AIDS shows the lack of depth in development, governance and mobilization of populaces in the face of a common and major economic, social and political threat manifested through HIV infection and its consequences.

### **The context: Poverty and HIV in Africa.**

Poverty in Africa has increased in the past two decades whereas in other parts of the world, it is declining. Africa's share in global income poverty increased from 217 million in 1987 to 291 million in 1998 and to over 300 million by 2005. Half of the continent is poor and the proportion of poor people increases if one uses a definition of poverty that includes income poverty, ill health, illiteracy, isolation and incapacity. In Africa poverty has increased together with inequality between the poor and the non-poor. Country data show that by 2015, 380 million people in Africa will still live in extreme income poverty. (Human Development Report: 2006) The SADC Human Development Report of 1998 showed that women are poorer than men in the SADC. Africa needs economic growth of at least 7% per year to meet poverty reduction targets. Thus, poverty is increasingly Africanised and to some extent, feminised.

Johnson (1997) argued that in South Africa, trade liberalization that is promoted during adjustment would likely increase income inequality through shifting production to skill-intensive and capital-intensive processes and goods. In 1997, all the provinces in South Africa were forced to reduce their expenditures in health and education to achieve government's aim of budget deficit reduction from 4,1% of GDP in 1997/98 to 3% in 1999/2000. As a result of these measures, poverty deepened in South Africa, and in the Western Cape, urban unemployment amongst unskilled black women rose from 41,5% in 1995 to 76,3% in 1999. Official statistics showed that in urban areas, the proportion of black households earning less than R800 increased from 51,8% in 1996 to 58,8% in 1999. In South Africa, unemployment increased from 29% to 42% between 1995 and 2002.

The other SADC countries have not fared much better. In Zimbabwe, during the structural adjustment period, starting in 1991, public expenditure on education declined by 30%. Sachikonye observed that

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de-industrialisation occurred as the variety of goods manufactured in Zimbabwe declined in the face of cheaper imports. Unemployment rose from 20% of the workforce in 1982 to 32% in 1996 and declined further to over 70% by 2005. Kanyenze (1999) noted that formal sector employment declined from an annual average of 2,5% in the pre-adjustment phase to 1,5% during 1991-1997, the years of adjustment. Poverty increased from 40,4% in 1990 to 63,3% in 1996, six years into the adjustment program. Consumption declined by 37% between 1991 and 1996 and average real wages fell by 33% despite increased productivity. Salaries accounted for 57% of GDP in the mid nineteen eighties but by 1997, only 39% of GDP was accounted for by salaries. Wealth shifts occurred throughout the adjustment period so that by 1996, profit share accounted for 63%, an increase of 41% during the mid nineteen eighties. Until 1989, Zimbabwe was a lower middle-income economy with an average growth rate of 4,1% per annum but descended fast into a poor country by 1997.

Southern Africa is riddled with some of the highest social inequalities in income and wealth and these inequalities fuel social and political violence. In South Africa, the Human Development Report (2006) notes that the richest 20% have a human development index rank of 101 places above the poorest 20%. South Africa has some of the highest rape incidences in the world while crime and violence in South Africa are also very high. Thus, gross inequalities have led to lack of social integration and cohesion and fuelled HIV and AIDS in Southern Africa.

### **HIV and AIDS in Southern Africa.**

While HIV and AIDS affect the world, its magnitude in sub-Saharan Africa is the most pronounced in the world. Africa is also the least developed continent in material terms, disempowered, colonized and struggling to control her resources for her people's benefit. By the year 2 000, 23,3 million people were already infected with HIV. Thus, 70% of the world's infections with HIV were concentrated in Sub-Saharan Africa, an area with only 10% of the world's population. According to UNAIDS, 12 million people had died of AIDS in 2 000, 25% of them children. By 1998, AIDS was the largest killer, affecting nearly double the numbers of people dying from malaria and nine times the numbers of people dying from tuberculosis (TB). Women

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are more infected than men in Sub-Saharan Africa, indicating that the previous demographic dominance of women over men might be in the process of reversal.

Southern Africa, in all Sub-Saharan Africa, is the region most affected by HIV and AIDS. HIV and AIDS pose the greatest challenge to development in Southern Africa since in 1999, it affected about 25% of 15-49 year olds, the most productive age groups in Zimbabwe and Swaziland, 35,8% in Botswana, 23,57% in Lesotho, 19% in Zambia, South Africa, and Namibia, 15 % in Malawi and 13,2% in Mozambique. In South Africa, 4,2 million people were infected and the national prevalence rate for 1999 was 22,4%. Prevalence rates tend to be lower amongst the older age groups in general. Parent to child transmission varies across countries.

Jackson (2 002) states that the HIV and AIDS epidemic in Southern Africa is characterized by heterosexual and to a lesser extent, homosexual infection, parent to child transmission, intravenous drug use with infected needles, infected blood and blood products, bodily fluids and secretions and contact through open wounds. Poor treatment of sexually transmitted diseases increases the risks of HIV infection because of the breakage of skin and membranes, allowing the virus to enter the bodies of people especially amongst young girls. Women run higher risks of infection than men because of their physiology, which is characterized by larger surface areas comprising membranes that can be broken or abraded during vaginal sex. Anal sex is riskier than vaginal and oral sex because of the greater degree of membrane abrasion that is likely to occur especially if the person producing the body fluids is in their most infectious phase, usually just after initial infection or when they are in fully blown AIDS. .

Parent to child transmission is very high because of pre-natal exposure of babies during delivery as well as through breastfeeding. Fathers' infection may be passed to the mothers and then to the babies hence the increasing use of the terms 'parent to child infection'. Although anti-retroviral therapy is available in the west, the costs of the drugs are still relatively high and anti-retroviral therapy is still largely unavailable to the majority of infected people who cannot afford to pay for them at the market or subsidized prices in Southern Africa. State provision is not feasible in many SADC countries that have high rates of poverty, low or negative

economic growth. Only Botswana, a country with a high growth rate has a viable public program for anti-retroviral therapy. South Africa and Namibia also have public programs that are being rolled out. The other SADC countries have inadequate public programs that fall far short of need. Only those citizens with high incomes are able to access anti retroviral drugs through private medical insurance. The reluctance of drug companies to subsidise treatment and drugs complicates the problem, raising issues of concern for human rights. In South Africa, the Treatment Action Campaign had to resort to legal means to force pharmaceutical companies to allow drug production as a response to an humanitarian emergency. The gap created by governments in Africa in HIV and AIDS policy and practice has been filled by international aid agencies, creating leverage for them to shape policies on HIV and AIDS in Africa.

Table 1 below shows the regional HIV and AIDS statistics as of December, 1998.

Country	Adult prevalence rate	No. of people living with HIV and AIDS	Estimated no. of orphans
Botswana	25,1	190 000	25 000
Lesotho	8,4	85 000	8 500
Mozambique	14,2	1 200 000	150 000
Namibia	19,9	150 000	7 300
S. Africa	12,9	2 900 000	180 000
Swaziland	18,5	84 000	7 200
Zambia	19,1	770 000	360 000
Zimbabwe	25,8	1 500 000	360 000
Total/Average	12	10 805 000	2 214 000

**Source:** Compiled by Whiteside and Sunter from UNAIDS epidemiology sheets.



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There are specific characteristics in the countries of SADC with respect to HIV and AIDS. While the region has some of the highest figures in the world in terms of infection (Jackson, 2002) it must be noted that these countries have different profiles with Zambia, one of the SADC countries with early explosion of HIV and AIDS experiencing a drop in infection amongst youths. The Ministry of Health in Zambia reported that Zambia had high TB infection rates with 70% of the population infected in 1999. Botswana and Kwa Zulu Natal in South Africa have experienced a plateau of infection levels amongst antenatal women at 30%. According to Whiteside and Sunter (2 000), HIV prevalence in Francistown, Botswana, rose to just over 40% in 1996 and has not risen further since that time. Generally, the Department of Health in South Africa noted that the prevalence of syphilis amongst antenatal clinic clientele had fallen by over 50% in all age groups due to treatment for sexually transmitted infections. It must also be noted that South Africa has the highest incidence of rape in the world, with a reported incidence of 240 women per 100,000 per year. Given the underreporting of rape worldwide, the incidence of rape in South Africa is likely to be much higher, raising questions about gender relationships, poverty, women's disempowerment and violence.


### **South Africa**

South Africa has a relatively well-developed surveillance and documentation system so that the trajectory of the HIV and AIDS epidemic can be understood and tracked well. There are variations in the rates of infection and prevalence in South Africa. The table below shows the provincial breakdown of the pandemic using data from ante-natal clinics.

**Table 2 showing the provincial breakdown of HIV/AIDS prevalence (%) amongst women attending antenatal clinics in South Africa.**

Province	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
KZ-Natal	1,6	2,9	4,8	9,6	14,4	18,2	19,9	26,9	32,5	32,5
Free State	0,6	1,6	2,9	4,1	9,2	11,0	17,5	20,0	22,8	27,9
Mpumalanga				12,2	16,2	15,8	22,6	30,0	27,3	
Gauteng				6,4	12,0	15,5	17,1	22,5	23,8	
North-West				6,7	8,3	25,1	18,1	21,3	23,0	
E.Cape				4,5	6,0	8,1	12,6	15,9	18,0	
Northern				3,0	4,9	8,0	8,2	11,5	11,4	
N.Cape				1,8	5,3	6,5	8,6	9,9	10,1	
W.Cape				1,2	1,7	3,1	6,3	5,2	7,1	
S.Africa	0,8	1,4	2,4	4,3	7,6	10,4	14,2	17,0	22,8	22,4

Whiteside and Sunter (2 000) state that the AIDS epidemic in Africa seems to have a natural ceiling of about 30% for the adult prevalence rate. In South Africa, the national antenatal prevalence rate stood at 22,8% in 1998 and 22,4% in 1999. A recent study commissioned by the Nelson Mandela Foundation showed that by 2005, HIV prevalence increased with age from 3,3% in children between 2 and 14 to 16,2% in adults between 15 and 49. Amongst people over 50, HIV prevalence was estimated to be 5,7%. However, variations by province show that KwaZulu-Natal, Mpumalanga and



Free State have the highest HIV prevalence in South Africa while the Northern and Western Cape provinces have the lowest. (South African National HIV prevalence, HIV incidence, Behaviour and Communication Survey: 2005) The gendered character of HIV is very pronounced in South Africa with HIV prevalence increasing dramatically amongst young females, peaking at 33,3% in the 25-29 age group. In men, HIV prevalence peaks at 23,3% in the age 30-34 and 35-39 age groups.


In South Africa, it is notable that some provinces are registering a slower increase in infection but the relatively high prevalence rates in the economically strong provinces is still disturbing. Contrary to the trends in other countries such as Zimbabwe and Malawi, there is little difference in the urban and rural infection and prevalence rates in South Africa. This indicates a broader spread of the epidemic in South Africa in general. This may partly be due to the higher levels of infrastructural development in South Africa, which allows the population high mobility, more intensive interaction and a greater variety of mixes of populations within the polity.

Life expectancy in South Africa declined from 53.4 in 1975 to 49 in 2005.

### **Swaziland**

Swaziland, like other SADC countries, has a high prevalence of HIV and AIDS, having reached the epidemic stage where demographic and social structure change and many elderly people are left with little or no support in caring for orphans, sick children and other dependents. According to Mlipha (2002) the 7<sup>th</sup> sentinel sero-surveillance survey of 2 000 found that that amongst antenatal clinics attendees, HIV and AIDS infections stood at 34.2%, sexually transmitted infections at 50.2% and tuberculosis at 78.6% respectively. It is estimated that 25% of the total population was HIV positive, bearing in mind that there is inadequate diagnosis, failure to seek hospital services and poor health data collection in the health institutions.

As in other SADC countries, infection is mainly through heterosexual sex and is concentrated in the 20-49 year age groups, which accounted for 52% of all reported HIV and AIDS cases between 1987



and 1999. Parent to child transmission is also quite high and is driven by the male sexual privilege, promiscuity, polygamy and failure to deal with sexually transmitted infections and to institute vigorous preventative programs amongst the groups most at risk of infection. Life expectancy has been shortened from 60 prior to the epidemic to 33 in 2 005, a loss of 27 years of productive work for an average Swazi person living during the epidemic.

### **Botswana**

Botswana has one of the highest infection and prevalence rates in SADC as indicated above. Botswana is and has been a labour supplying economy to South Africa since the nineteenth century. According to SAfAIDS (1999) 25% of the sexually active population were infected both in urban and rural areas in Botswana. . There are internal variations in infection within the country as indicated before. Whiteside and Sunter (2 000) indicated that Francistown in Botswana had registered an HIV prevalence rate of over 40% by 1996 and that this rate had, most likely, peaked and stabilized since then. By 1999, there was no significant difference in infection rates between men and women. This is a real difference with other countries where more women than men are infected. Life expectancy in Botswana has declined dramatically from 56,1 years in 1975 to 36,5 in 2005.

### **Zimbabwe**

Zimbabwe has a high prevalence rate of HIV and AIDS of about 17% of those in the 25-49 age group infected. According to the National AIDS Coordination Programme, between 1990 and 1995, antenatal clinic attendees had prevalence rates of 7,7% and 43,9% for rural areas and 12,3% and 67,1% for urban areas. Robinson and Marindo's projections, based on the 1992 census indicated that in 2 000, 66%-73% of deaths were due to AIDS. Foster et al (1997) indicated that by 2 001, 16%-22% of maternal orphans under 18 were a result of AIDS-related deaths. In 1998, the Central Statistics Office indicted that 1 in 70 households in Zimbabwe, was headed by a child. By 2001, it was estimated that 3% of Zimbabwean households were child-headed because of the deaths of parents.

Gender gaps also tend to facilitate infection with HIV. Mataure and Renton (2002) in Zimbabwe, lack of literacy affects the success of


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community responses to prevention programmes. In Zimbabwe, adult illiteracy stood at 9,6% for men and 20,1% for women in 2000, concentrated amongst older women. Older women are less likely to acquire written information that may be useful in preventing infection by HIV. The link between illiteracy and economic opportunities has long been documented through National Manpower Surveys since 1985 and lack of literacy disadvantages less literate women in the better-paid sectors of the labour market. In addition, citing UNAIDS studies in Africa and Latin America, Mataure and Renton (2002) argue that amongst 15-19 year olds in 17 African and 4 Latin American countries, better educated girls tend to postpone their sexual debut in comparison to their less educated counterparts. The proportion of sexually experienced 18year olds was 24% lower amongst girls with secondary school education than amongst girls with primary schooling. People with more education were also more likely to use condoms during casual sex in order to protect themselves from HIV. Thus, higher schooling made a big difference in reducing girls' risk to infection.

Southern Africa has also experienced settler colonialism, the erosion of native cultures and the social and economic dispossession of the native people in the economies of these countries. In contrast to West Africa where infection rates are much lower, Southern Africa faces huge challenges in development as a result of the pandemic. This issue will be discussed in the paper in greater detail, challenging the Southern African community to link cultural, social and economic analyses in crafting development solutions for the region.

### **Economic issues 1Economic issues**

The paper raises questions about HIV and AIDS and the prospects of economic development. In the first place, the trends described in most HIV and AIDS literature focuses on infection and mortality amongst the economically active age groups amongst both men and women. SAfAIDS (2002) featured an article on how HIV affects African business. The issue of attracting foreign investment to the region as relatively cheap labour supplies are threatened by infection, was raised. It may well be that the competitive advantages of Southern Africa as a region with relatively cheap



labour, are lost as labour illness reduces productivity, savings and profitability for employers and investors in specific sectors. In addition, job losses by the infected create even more poverty as breadwinners erode savings and eventually leave or lose jobs and die. The costs of anti-retrovirals, whether borne by the state or by employers increase labour costs and erode social and other investment, especially by states.

It may not be immediately clear how HIV and AIDS will impact Southern Africa as the epidemic unfolds. However, the impacts are mixed, with some sectors such as large-scale mining experiencing relatively low impacts. For example, the diamond economy in Botswana is capital rather than labour intensive so that its development will not be heavily influenced by the infection and deaths of semi-skilled and unskilled mine labour. However, other sectors such as transport and other services may be more affected since they depend on both skilled and unskilled labour.

Therefore HIV and AIDS development needs to be analysed in tandem with economic and policies that are premised on attracting foreign or local investment and the increasing costs of reproducing labour in high HIV prevalence countries. Thus, only those countries that make the greatest efforts at preventing or minimizing infection are likely to maintain or increase their competitive advantage in the regional labour markets. It is therefore surprising that the bulk of macro-economic discussion in Southern Africa today assumes an HIV and AIDS-free context, creating doubt about its potential for development within the region.

Arndt and Lewis (2 000) argued that by the year 2010, the level of GDP in South Africa could be lower by 17% due to HIV and AIDS. In other economies, labour supplies and productivity in agriculture and industry are likely to be significantly affected, raising major questions about technology, industrial strategy, and growth with HIV and AIDS. HIV and AIDS also call for major shifts in human resource investment from younger to older people at lower risk of infection, to children before they reach the ages of infection, to technologies that do not require physical strength and can be utilized by older women, children, the chronically sick and ailing.

## Food Security and Agriculture

The question of food security and its relationship to HIV and AIDS was brought once more to the fore by the drought that ravaged Southern Africa in 2 001- 2002. In the SADC, there are countries that have traditionally been food insecure because of their climates, topography and soils, which make them unable to grow sufficient food crops to feed themselves. Countries such as Botswana and Malawi have traditionally imported food to meet the needs of their populations. However, a new twist was added to the SADC and African food policies through structural adjustment programs of the international financial institutions. In the SAPs, the focus on tradable goods with export potential, were privileged over food production. This neo-liberal market thinking with respect to food led many countries such as Zimbabwe, Malawi and Zambia to liquidate their reserve grain stocks and to earn foreign currency to service their debt through the sale of this grain.

As has been indicated by Gaidzanwa (1985) food in the form of maize in the sub-region, tends to be a low value and high bulk crop with poor earnings especially during non-drought years, in comparison to other goods. Therefore, food exports are not very profitable. However, food imports during droughts and famines are very expensive because when countries experience high demands for grain during droughts at the same time, the costs tend to be high for the importing countries. Zimbabwe was caught on the wrong foot at the beginning of her SAP in 1990-1991, when the drought of 1992 occurred with no food reserves in the country. Malawi was also in the same position in 2 001 when the drought occurred. Zimbabwe had just embarked on a land reform program, which also disrupted maize production in 2000-2001. Maize prices have increased by more than 300% in Zambia and Malawi. Coming in 2 002, when SADC countries were experiencing the growth of the HIV and AIDS pandemic, the need for a regional food policy could not have been better illustrated. Given the dominance of market policies in the region after 1990, people living with HIV and AIDS are more vulnerable because of their potential for experiencing diminishing incomes and competing expenditure on drugs, food and other necessities that people without HIV do not experience. While de Waal (2006) that the poor handling of HIV and AIDS in most African countries has not precipitated famines, riots and political revolts, the slow starvation, growing poverty and diminished capacity for self-provisioning are no less pernicious despite their relatively muted character.

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In addition, the importance of good nutrition in strengthening immune systems of the infected and delaying the onset of fully blown AIDS is critical. There is therefore, a need for revised food policies that do not only address food needs from the perspective of uninfected people but also take into account the differing and changing food needs of people who are infected. Such changes would also necessitate the development of different policy assumptions about food entitlements by different people, the organization of food production, availability, affordability and accessibility. In any case, the market-led food policies of the SADC make it difficult for impoverished and infected people to access nutritious food. Given the accelerating development of child-headed, grandparent-headed, destitute and orphaned households, the market approach to food will need to be revisited and other bases for food production will need to be devised so that production is improved, costs lowered and access differentiated by need and ability to pay for the food.

The issues of food security and agriculture are closely intertwined because of the agro-economic bases of many SADC economies. For example, Zimbabwe, Malawi, Zambia, Mozambique, Namibia and Tanzania, depend on primary agricultural products for their export earnings and for their domestic industries. HIV and AIDS pose a big threat to agriculture in the SADC. As indicated by Kadzandira (2002) on Malawi, the high attrition of extension staff, from the public into the private sector, after the cessation of extension worker training in 1995, is likely to push agriculture into crisis. Kadzandira's survey in Malawi indicates that there is now 1 extension worker per 2 040 families. Bota et al (2 001) quoted in Kadzandira, indicated that 25% of the extension workers in one study had had sex outside their marital homes in the month preceding the survey.

In a CARE-Malawi study by Kaul Shah (2 002), 22%-64% of households in the project area had been affected by chronic illness or death of a member and 23% of respondents had left their land fallow and 26% had changed their crop mix in response to the effects of HIV/AIDS. The illness, rituals around death and funerals drew people from their agricultural work and threatened their economic and social activities, resulting in erosion of incomes, property and livelihoods. Agricultural productivity also declined in 72% of the CARE study households.

Ncube (1999) and Munyombwe et al (1999) recorded similar impacts



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in small field studies conducted in Zimbabwe. Ncube's study in Gweru/Shurugwi district, found that extension workers spent 10% of their working time per month attending funerals. Land was increasingly not cultivated due to labour shortages and death of family members, shortage of agricultural inputs due to the death of an income earner and lack of draught power and farm implements because of sale to cover medical and funeral expenses.

Manyombwe et al (1999) found that HIV and AIDS negatively affected livestock extension programs amongst the villagers and extension workers in their study sites in Mashonaland East. Frequent funeral attendance disrupted dipping of cattle, increased absenteeism at dipping and placed more livestock at risk. Sales and slaughter of draught and production animals increased in the survey areas while greater responsibility for animals was placed on children who often could not give accurate information on livestock. Given these findings, there are many issues that are raised with respect to the future of agriculture in the SADC region. Small-scale agriculture has traditionally depended on the labour of women and children and the issues raised by the HIV and AIDS epidemic need to be tackled with speed.

Kwaramba (1998) found that in a communal and a small-scale farm, the death of an adult due to AIDS resulted in a 61% decline in the marketed output of maize. For cotton, the decline was 47% in magnitude. Thus, the loss of an adult has dire consequences for a household and the negative impacts may be magnified as the orphaned children, widow or widower fall victim to other social and economic pressures relating to death rituals, failure to use land productively, premature dropping out of school by the children, labour shortages and social isolation in their communities. These findings together point to a need to focus on some of these issues at the macro-level so that coherent policy responses that have a realistic basis, can be crafted.

### **Social issues and possibilities for intervention**


HIV and AIDS raises many other issues related to social and political development within the region. There is a strong and proven correlation between HIV and AIDS, gender, sexual behaviour, literacy and education. Given the disparities in education, economic and social power between men and women in Southern Africa, the mortality of younger women leaves the older women as the backbones of most rural and poor communities. These women are



usually less educated and less literate than men in comparable age groups. UNAIDS studies in 17 African and 4 Latin American countries show that better educated girls tend to postpone their debut into sexual careers and the percentage of sexually experienced girls at 18 was 24% lower amongst girls with secondary school education than amongst girls with only primary school education. In addition, people with more education were more likely to protect themselves by using condoms for casual sex. Thus, older women who generally have less education are also disempowered not only with regard to coping with orphans but also with participation in HIV and AIDS prevention measures as informed resource persons, leaders, policy brokers, proposal writers and fund-raisers. (Mataure and Renton, 2002) They are also less empowered to resist traditional practices that pre-dispose men and women to infection with HIV. Thus, in addition to disempowerment with respect to negotiating about sex and sexuality, the gender imbalances prevalent in the region drive the epidemic and pose an economic, social and political threat to the cohesion of these societies.

Economic, social and political programs such as home-based care for HIV and AIDS patients, orphan care and the mobilization of rural communities will not be sustained at present quality as younger men and women's populations are eroded by illness and death due to AIDS while older women bear an increasing burden for economic, social and political development. As observed by Action-Aid in Zimbabwe, the slender capacity base for skills building concentrates skills in a few hands as literate people who stay alive become the focus of many types of training and responsibility in communities ravaged by HIV and AIDS.

In political terms, the concentration of power, influence and skills in many communities will be less conducive to good governance, transparency and democracy because only those who are alive and able will have time and energy and some education, can meaningfully participate in the social and economic processes in their communities and nations. The gender dimensions of these emerging inequalities are manifold as the evidence from Southern Africa shows. The care burden placed on women immediately takes them out of the social, political and economic arena as men are scarcely involved in home care programs throughout Africa. As has been documented by many PLWA and activists and organizations such as Panos, the needs of men who are infected are neglected because of the lack of involvement of men in caring for people affected by AIDS. The preponderance of women as volunteers at




grassroots but not as office-bearers, policy makers and people with hands-on and direct experience of the problems of living with HIV and AIDS, exacerbates the insensitivity, ineffectiveness and poor focus of many HIV program in Southern Africa.

There is therefore need for a policy shift in terms of empowering women. So far, many programs have focused on childbearing women. These types of programs include Safe Motherhood Initiatives, focusing on women as reproducers of labour in SADC economies. There has been neglect of post-menopausal women, the very women who have the highest chances of surviving or avoiding infection, the ones who are supposed to care for orphans and provide volunteer care labour in communities, and the ones who perform unpaid domestic and poorly paid agricultural labour as casual, temporary and seasonal labour throughout Southern Africa. How will these women cope given the issues raised by Ncube and others with respect to technology in agriculture?

Barret et al (1996) observed that in Zimbabwe, the existing ploughs do not match the quality and characteristics of the draught animal and human users. Most cattle and donkeys are smaller than they were when the current plough was designed in the nineteen seventies. In addition, the ploughs assumed male use despite the fact that the real users were mainly women and older boys in rural Zimbabwe. Barret et al argued for the design of a lighter, smaller and more maneuverable plough that can be used by women, children and the sick. In addition, there is need to focus on alternative domestic animals for draught power since oxen are growing expensive and are speedier than other animals. Donkeys were suggested as alternative animals for draught purposes because they are tamer, lighter, less infested with ticks and diseases and generally easier to manage. Apart from draught animals, weeding technologies, manuring, fertilizer and pest chemicals need to be redesigned to make them cheaper effective so that sick, elderly and young people can use them. At the national level, there is need to link the food security issues to technological issues so that mass production of cheap food can be undertaken, freeing the people and communities living with HIV and AIDS from heavy work that could threaten their health further.


In countries such as Zimbabwe, where there have been attempts at radical economic and social transformation in land and agrarian sectors, the execution of the programs has generated many negative and some positive consequences. It still has to be worked out how the positive aspects of these changes can be sustained given the



infection of young men and women, the ageing and aged communal area populations, particularly middle aged women who constitute the bulk of the wage and non-wage labour force in commercial and communal agriculture in rural Zimbabwe. Evidence from the Ministry of Health's surveillance studies shows that infection is highest on commercial farms and mines in Zimbabwe where men have disposable incomes and can pay for casual sex. These are also the areas in which women are most marginalized, least educated and least served by health personnel and some of them depend on casual sex for incomes. In the other countries of Southern Africa, the linkage between high infection, disposable income and casual sex has been made with respect to transport workers particularly long distance drivers on specific regional routes that are heavily trafficked. (Jackson: 2002) Governments in the region still have to determine how, through their economic policies, they intend to deal with these problems in an integrated manner.

The gendered nature of infection, access to anti-retroviral drugs and care during illness and the gendered care burden, has driven men and women further apart in their approaches to dealing with HIV and AIDS. The linkage between infection and marriage has also undermined male-dominated monogamous marriage in Sub-Saharan Africa and in Southern Africa in particular. In South Africa, in the nineteen eighties, only 30% of marriages were formalized and female-headed households are significant in proportion to other types of households. In Zimbabwe, before the HIV and AIDS pandemic gathered momentum in the early nineties, Sunga (1989) and Gaidzanwa (1988) found that at least 33% of the households were female-headed. The high unemployment amongst men in Southern Africa, particularly in Zimbabwe and South Africa, also creates problems of crime, alcohol abuse, rape and other forms of physical violence. The gendered differences in power also indicate that Southern Africa entered the millennium with huge gender conflicts, which have been worsened, magnified and sharpened by HIV and AIDS.

Thus, the shape of future households in these economies is already changing as those areas with more women-headed households gain control over sexuality and related decisions simply due to the absence of men. In addition, the struggles over incomes have created new dynamics between men and women. The gender divide and its width undermine social, economic and political initiatives premised on the co-operation between men and women in the whole system.




The high incidence of HIV and AIDS in Southern Africa raises the problem of orphans, children under 15 who have lost a mother, father or both parents. According to SAfAIDS (2002), the countries most likely to be affected are Botswana (37%) Zimbabwe (34%) Swaziland and Namibia (32%) and South Africa (31%) Zimbabwe has a higher than continental average orphan rate at 17,6% with more than 75% of orphaned children losing their parents to AIDS. Ten countries in Sub-Saharan Africa have orphan rates higher than 15%. The problem of orphaned children also poses major challenges for social policy because apart from South Africa, there is no state-funded social security system, that that can cope with the present levels of orphan hood in Southern Africa. The Central Statistics Office in Zimbabwe (1998) noted that 35 000 households, that is, 1 in 70 households was headed by a child. In Kwa Zulu-Natal, it was estimated that there were 65 500 orphans by 2 000, most likely increasing to 500 000 by 2010.

The magnitude of the incidence of orphanhood calls for novel and creative responses to the HIV and AIDS problem. Mupedziswa (1998) has described the existing responses, namely, institutionalizing children, sibling care, and elderly volunteer and grandparental care. However, all these responses have limited utility given the problems being experienced by volunteers, elderly people, public budgets and children in households without adults. In countries such as Zimbabwe where the number of orphans nationally has reached the 1 million mark, the limits to such strategies have been reached. As things stand, relatives, neighbours and friends are no longer able to take in orphans, related or unrelated in many localities. The sustainability of many of these interventions still has to be proven and the evident problems of neglect, sexual and other types of abuse of orphans raise many trenchant questions.

Gaidzanwa (2007) has found that in 20 of the households that she studied in a village Uzumba Maramba Pfungwe, two are child headed or child-managed because the grandmother is no longer able to control and direct the grandchildren or because there are no relatives willing to stay with and supervise the children even from a distance. In this village, traditional and other authorities have to step in to persuade neighbours and friends to volunteer to look after orphans or to supervise them when relatives are no longer willing and able to do so.


The over-burdening of the few males, who are still functional in many male-dominated communities where male labour migrancy into towns is common, also has to be considered. In the UMP village



studied by Gaidzanwa over five years from 2000, amongst the 20 households, there were only four men who were relied on by the extended families to intercede for elderly people, widows, divorcees and others in distress. During the study period, two of these men died and only two are left. They are now responsible for helping orphans procure death certificates, birth certificates for school, drought relief, state aid for schooling and so forth. These men also have their own households to look out for. One of them is a headman and has to attend the chief's meetings every week. They are now not able to cope and the village laments the death of one of the men who used to be very efficient in helping the distressed. There is also a crisis in the chieftainship because the men who have survived are not traditionally eligible so there may come a time when the women have to be considered. Alternatively, the chieftainship has to be forfeited to another family whose turn to assume it has not come. Thus, even the customary and traditional norms around power and relationship have been shaken to the core as a result of HIV and AIDS and the lacklustre state responses to the pandemic in its early stages.

Thus, new ways of conceptualizing relationships between the state, communities and children have to be devised because as the laws stand in many SADC countries, children do not have legal capacity to carry out many functions, many of which have legal consequences. Thus, orphaned children already fall outside the protection of the laws simply because they have no legal capacity as children and cannot rely on many adults to mediate between them and the state. Orphans, especially those who head households, have to leave school, work and deal with adults who are also heads of households on an equal basis, in the communities in which these orphaned children live. The international conventions on children's rights have already been rendered redundant by the realities in poor and orphaned children's lives in Southern Africa. The protection of vulnerable children has to be re-conceptualised, taking into account the lived experiences of children orphaned by AIDS and other reasons.

There are other issues that are raised by HIV in organizing communities, education, health delivery and other services. Public schooling also needs to be reorganized to include elderly women who are caretakers and caregivers to orphans, other adults and communities. Poor and orphaned children often fall outside the public schooling system because they cannot afford fees, levies, uniforms, books and other necessities, even basic ones, for




schooling. According to UNAIDS, in Zambia, 1300 teachers died of AIDS in the first ten months of 1998, representing more than twice the number of teacher deaths in 1997 and equaling 66% of all teachers trained annually. The infection of teachers with HIV and the attrition of teachers because of poor pay, has forced many teachers out of the public schooling system into private schools, the non-governmental sector and emigration in many countries in Southern Africa. Other alternatives such as home schooling, involving grandparents and their grandchildren may need to be explored in order to assure poor children and adults affected by HIV and AIDS of education and training in a cost-effective manner. Alternative education may be necessary to increase the capacity of elderly people to cope with orphans and to carry the care burden in many communities where NGOs, the state and other partners are willing to make resources available.

In the uniformed services, an area which has traditionally absorbed men from the peasantry and working classes, the levels of infection are quite high. Panos in a report authored by Foreman (2002) noted that in many African countries where AIDS has been present for more than ten years, HIV prevalence amongst soldiers may be as high as 50%-60%. In Zimbabwe, the estimated prevalence of HIV was 50% amongst soldiers in 1998 until compulsory testing was introduced. This has implications for peacekeeping and other operations in which soldiers, some of them infected with HIV, stay away from home for months or years on end and have opportunities to infect the people or be infected by them, in host countries which are often in turmoil. Concerted efforts need to be made to ensure that HIV and AIDS education for prevention is focused on these sectors to prevent the export and importation of HIV infection between countries, some of them already experiencing dislocations through wars, conflicts and instability.

The social instability that has built up in Southern Africa especially after colonisation has undermined the utilization of effective cultural responses to HIV and AIDS. Anthropologists and historians for have documented the migrant labour system throughout the region over a century. Van Onselen (1980) First (1983) Mayer (1961) Sachikonye, (1998) Little (1973) , Barnes and Win (1992) Ramphela (1986) The decomposition of the gender systems in Southern Africa has occurred in the context of industrialization, national liberation wars, civil conflicts , growing poverty and sustained inequalities in most SADC countries. These social phenomena have been extensively documented and the studies on mining, labour mobility and HIV





infection have focused on the housing of workers away from home, the separation of spouses and children, institutionalized casual commercial sex and changed sexual norms. Makumbe (2 002) Moodie (1994) and studies sponsored by SADC/FESARTA/GTZ/CBRTI (2003). The dislocation of the households, growing poverty with increased infrastructural development and population mobility, have all fuelled the upheaval, creating a conducive environment for the rapid spread of HIV in Southern Africa.


In global terms, Southern Africa's terms of entry into the world economic system are decidedly disadvantageous. Apart from the stigma of HIV and AIDS, there is the historical aftermath of settler colonialism and imperialism, manifesting themselves through the resurgence of the aggressive championing interests of affluent and dominant multinationals and nations by international financial institutions and capital worldwide. The resistance to land and agrarian reform in Southern Africa by the west, is a manifestation of that problem. The divisions over NEPAD, the problems relating to unresolved transformation in South Africa, the largest economy, all focus international attention on the region. The location of strategic minerals in this region also creates pressures on Southern Africa to deal with internal issues, namely HIV and AIDS, gender divides which drive the epidemic and undermine economic, social and economic development. HIV and AIDS unite and coalesces all these issues in ways that call for immediate resolution. Only then can Southern Africa participate meaningfully in the global capitalist economy as an integrated region with social and political structures that can be joined to sound economic policies to generate sustained economic growth and development for the region.

There has to be renewed mobilization of the state and other players to mount a meaningful response to HIV and AIDS beyond receiving ready-made, one-size fits all solutions to HIV and AIDS that have little chance of working in the long term. Like the uniform structural adjustment programs that take little account of individual countries' and regions' experiences, responses to HIV and AIDS need to be tailor-made to individual country circumstances for maximal and sustainable positive impact.

### **Southern Africa, politics and the global AIDS industry.**

In view of the analysis outlined above, it is necessary to interrogate the problem of HIV and AIDS in Southern Africa in the context of the global discourses of development. Southern Africa in general and






South Africa in particular, has been viewed as the hub of industrialization, employment and a region to which migrants seek to be admitted. However, there is need to link the failure of Southern Africa to handle the HIV and AIDS pandemic to the application of neo-liberal economic, political and social thinking that marginalizes the state, making it less responsible and less accountable for crafting sustainable solutions for preventing infection and mitigating the impacts of the epidemic. The initial responses of these states such as Zimbabwe and South Africa were characterized by paralysis, denial of the existence and effects of the virus, thereby endangering the lives of the populace, many of whom had no idea about the virus and its effects if it infected them. This is a crisis of democracy and responsibility since these states were already in the grip of neo-liberal economic, political and social regimes that privileged the rich and connected who could cushion themselves from the effects of the virus.

Thus, HIV and AIDS are directly related to poverty since it is people who lack food, education, information, personal and political capacity who are most vulnerable to infection by HIV and whose progress into AIDS is accelerated. Southern Africa is likely to experience a slowing down of development and an erosion of whatever advantage she has in the global capitalist system because of attrition of workers, particularly the skilled ones who are needed to run the skill and capital intensive export production favoured under structural adjustment.

Given the threats to human and other development posed by HIV and AIDS, there has to be a concerted attempt to mount serious initiatives to prevent infection by and transmission of the virus since it is not viable to resort to treatment as the major or significant intervention at the present high costs of antiretroviral drugs, the lack of capacity of most governments to plan and implement sustained, effective and credible responses to HIV and AIDS.

The drug route poses threats of resistance, non-compliance and other complications relating to the management of chronic conditions in situations of shortage of qualified health personnel, laboratories and qualified researchers to track and adapt treatment to the development of the virus over time. In Southern Africa, there has been easy resort to imported interventions without a clear understanding of the anthropology of sexuality and relationships in many of the countries. Thus, the ABC (Abstain, Be Faithful and Condomise) messages are spectacularly difficult to swallow and/or inappropriate for populations living in poverty and in male-



dominated societies where children and women are economically dependent on men for land, urban housing, heavy labour and other resources needed to live. Poor people cannot abstain from sex indefinitely since they have more children for insurance and care in their old age. Male dominated cultures privilege male sexual adventurism so even if women are faithful to sexually promiscuous men, it will not help them avoid infection with HIV. The use of condoms may imply a breakdown of trust especially in marriage relationships where women have less volition than men in insisting on condom use.

Condom use also violates the pro-natalist norms of poor communities whose only assets and security are their children, relatives and families. These measures are difficult to propound and operationalise in the majority of cultures where people consider sex and childbearing as a right. In many cultures, sex is relational and a prerequisite for a legally valid marriage so hedging sex with barriers accentuates the lack of trust and breakdown in social cohesiveness that results from poverty.

In addition, the imposition of the political and social sensitivities, values and conditionalities of bilateral and multilateral institutions such as USAID under the Bush administration, erodes the efficacy of many of the programs to prevent infection with HIV. For example, faith-based and bi-lateral and multi-lateral organizations dictate what types of prevention they will fund regardless of the preferences of the recipients of the programs. Such organizations privilege abstinence-based prevention programmes for all regardless of the problems in operationalising abstinence for teens, single and other people who are not marriage worldwide. In the USA, 35% of state schools teach abstinence-based sex education and this has resulted in a 3% increase in teenage pregnancy in the 15 to 19 year group by 2007. In this group, teenage pregnancy had been in decline for 15 years. Amongst African American the teenage pregnancy rate increased by 7%, suggesting a strong link between poverty and teenage pregnancy in the USA. The Guttmacher Institute found that 86% of the decline in teenage pregnancies in the USA could be attributed to better contraceptive use and it was only amongst the 13-14 year olds that abstinence worked well to prevent pregnancy. Despite these data, the Bush administration, under the influence of right wing Christian fundamentalists who support the Republican party, have exported these abstinence-only messages to Africa, endangering the lives of millions of African teens and adults who are fed these messages as condom use and other contraception are

downplayed in the fight against HIV and AIDS.

The experiences of Lovelife in South Africa are instructive in this regard, suggesting that even the fight against HIV and AIDS has been and is being subordinated to the interests of cultural and political control and dominance by the North. Funding of health and anti-retrovirals has also been political regardless of the humanitarian reasons raised for supporting HIV and AIDS programmes. Brazil and South Africa had to resort to litigation in order to break the stranglehold of pharmaceutical companies over drugs needed for HIV and AIDS programs in the South. In addition, funding for HIV and AIDS and health is similarly politicized with differentiated funding to countries depending on their regimes' standing with the west. The table below shows the levels of financing of health and HIV and AIDS in East and Southern Africa.

<b>Country</b>	<b>Level of funding per person in US\$</b>
Uganda	362
Zambia	190
Swaziland	139
Botswana	104
Malawi	46
Lesotho	39
Zimbabwe	4

Source: UNAIDS, 2005.

It is ironic that despite the heavier funding of other countries, only Zimbabwe, in the SADC region has managed to reduce the levels of HIV prevalence, confounding the funders and supporters of the current funding policies in health and HIV in the SADC region. The first reports indicating reduced HIV prevalence in Zimbabwe (Gregson et al : 2006) were received with skepticism and disbelief. Initial reactions to HIV and AIDS decline in Uganda and subsequently, Zimbabwe, were dismissed as mere “emptying of reservoirs”, referring to the high mortality of people with AIDS and a resultant decline in HIV prevalence. A senior staffer in one major bilateral


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agency commented sarcastically in reference to reports on HIV and AIDS decline in Zimbabwe,

*“Do you need to have a dictatorship, state violence, bad governance and an economy that is melting down for HIV and AIDS to decline?”*

However, it is important to consider the reasons and contexts for HIV and AIDS declines in Zimbabwe and in Uganda. AIDS, generated relatively sexually and socially conservative societies in comparison to the rest of SADC because it heavily affected Uganda and Zimbabwe. According to the Zimbabwe Demographic and Health Survey of 2005-6, the median age of sexual debut of women then aged between 40 and 49 years was 18, rising to 19 for women in the 20-39 year age group. This is evidence of increased delay in sexual debut by younger women. Among men in the aged 20-39 years, the median age of sexual debut was 20.2 years in 2005-6. The median age of sexual debut stood at 21.8 years for women and 20.9 years for men with more than a secondary school education. In contrast, in other SADC countries such as South Africa, in 2005 the median age of sexual debut was 17years, with a trend towards earlier sexual debut by younger respondents. The delay in sexual debut, reduction in casual sex, and consistent use of condoms with casual partners also contributed to HIV and AIDS decline in Zimbabwe while in South Africa, the HIV pandemic is still unfolding.

In contrast, Botswana still has a high and stable level of HIV prevalence and still has to register decline in HIV prevalence despite high mortality from AIDS. South Africa’s HIV epidemic has yet to stabilize so there is likely to be higher mortality in the next few years. Thus, while South Africa and Botswana have rolled out comprehensive anti-retroviral programs, Zimbabwe has not been able to do so because of economic and political sanctions, poor economic management and declining state resources to fund significant treatment programs, resulting in the foreclosure of treatment beyond a few thousand people who are able to fund their own treatment privately. Thus, prevention is the only possibility that could be pursued vigorously. According to Gregson et al (2006) the relatively high education of the Zimbabwean population and the good communications and health infrastructure could have facilitated HIV prevention through early control of sexually transmitted infections, social marketing of condoms, voluntary counseling and testing, television and radio dramas and the activities of the National AIDS trust Fund. Regardless of the social, economic and political crisis in Zimbabwe, it is quite likely that the social investment in health and education during the first decade of independence produced a dividend, which was reaped when the HIV and AIDS



epidemic unfolded in the late nineteen nineties. In addition, the national levy for HIV and AIDS helped to finance the initiatives of the state in the absence of significant funding to the state from donor sources. There is no doubt that with better political, social and economic management in the nineteen nineties and beyond, this dividend could have been larger and more significantly utilized. However, there is need to recognize that even in Zimbabwe, adult prevalence rates of 17% are still high and more still needs to be done to reduce HIV incidence and prevalence significantly.

It is necessary to re-think HIV and AIDS control strategies based on the experiences and sensitivities of the peoples of the South. HIV and AIDS present another terrain for the playing out of economic, political and cultural struggles between the North and the South. Given the neo-liberal approaches to state intervention, it is critical to craft strategies that are sustainable, workable, well-informed and democratic so that all the people affected and infected by HIV and AIDS can participate meaningfully in prevention and control of HIV and AIDS. The case of Zimbabwe and HIV illustrates some of the problems in social and political analyses linking various types and levels of funding of interventions with sustainable control of HIV and AIDS. High funding of HIV and AIDS interventions does not necessarily translate into effectiveness in the containment of HIV and AIDS. If anything, abundant 'political' funding by bilateral and multilateral institutions may derail more workable and sustainable interventions on HIV and AIDS. In Zimbabwe, the absence of anti-retrovirals in the public programs most likely galvanized the state to focus on significant investment in prevention and some palliative care, leaving some prevention and the drug options to the bilateral and multilateral agencies.

### **Emerging issues in the globalisation of HIV, its prevention and control.**


It has been assumed in most of the first generation of HIV and AIDS literature, that reactions, interactions and responses to HIV and AIDS can be standardized, facilitating the formulaic control of HIV and AIDS globally. However, it is becoming evident that social, economic and political issues contour the terrain in which HIV is contracted, transmitted, controlled and prevented. Thus, the formulae do not work out in the same way, generating disbelief, skepticism and denial of HIV and AIDS and their possible impacts on social, political and economic development in Africa. De Waal (2006) argues that African publics, politicians and policy makers have not prioritized HIV and AIDS

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prevention. Noting that AIDS activism has not challenged the legitimacy of African regimes for their denial or tardy responses to HIV and AIDS, de Waal observes that there has not been a political crisis as a result of the lack of coherence of the African response to HIV and AIDS.

This might be true but in economies that depend on agriculture and manufacturing, such as that of Zimbabwe, the loss of skilled and unskilled labour in households is felt throughout the system. In addition, dependence on international funding for HIV and health may grow and undermine the local efforts at prevention and control and create countervailing sources of authority, for better or for worse. The fads that are common in the interactions of donors and civil society sector are quite evident in the AIDS industry as the HIV issue becomes globalised, domesticated and 'mainstreamed'. Moving from ABC, to abstinence and fidelity only by some faith-based organizations such as the Roman Catholic church and Bush era initiatives, condom use only by liberal civic organizations and then treatment with a combination of abstinence, fidelity and condom use, depending on the circumstances, the changes are quite dizzying. Recently, male circumcision has gained ground as another intervention in HIV prevention. Male circumcision is usually performed as a religious, cultural and spiritually initiation practice in different cultures. Without its religious, cultural and social trappings and contexts, it is not likely to be as effective. According to the Zimbabwe Demographic Health Survey (2005-6) circumcised men, who were tested for HIV, had a slightly higher rate of infection with HIV (17%) than uncircumcised men (14%). Age analysis of the effects of circumcision showed that male circumcision has a slight protective effect among men under 25 but this effect disappears as the men age over 25. It is likely that in Zimbabwe, as in many societies where male sexual adventurism with a wide range of partners is accepted, the initial advantages of male circumcision are eroded as males enjoy the 'male dividend' as they age. The social, cultural and religious teachings that accompany male circumcision may be coupled with limited sexual mixing in many West African countries with traditions of polygynous marriage. Thus, the effects of circumcision in West Africa cannot be assumed to be the similar in Southern Africa where the anthropology of sex is quite different in content and context.

In many Southern African countries, HIV and AIDS are the business of bilateral and multilateral institutions and organizations, which sponsor the research, set the parameters and craft solutions to the



epidemic. The assumptions made about prevention, mitigation and control of HIV and AIDS are not necessarily based on the lived realities of many populations in Southern Africa. In addition, it is assumed that the interventions in Uganda and Senegal will have the same impact in Southern Africa despite the differences in social, economic and political cultures and characteristics. For example, condom use is usually inferred from volumes of condom sold or distributed. In cultures where politeness to donors is required to receive valued goods, condoms may be bought or accepted for use for completely different purposes from those intended by the distributors. For example, some researchers in Zimbabwe, in personal communications, noted that in Matebeleland South, condoms that are distributed by AIDS organizations, are often used for handling and processing mopani worms, which have sharp spikes. In Zimbabwe, some people, instead of buying expensive balloons for children's parties, people may use condoms instead.

Thus, it is necessary to interrogate the responses and practices involved in the HIV and AIDS industry because some of them represent incursions and restructuring of the most personal and intimate areas, the last frontiers of people's human experiences. The transfer of or appropriation of HIV and AIDS policy by international agencies as African states plead poverty or incapacity in order to access or exploit international AIDS funds results in the initiatives and responses to HIV and AIDS that leave Africans feeling totally excluded from initiatives that are meant to safeguard their very existences. There are many gaps in the knowledge about HIV and AIDS, about why some countries such as Botswana, with sound economies, good relations with western AIDS donors and good governance, have not managed to control HIV and AIDS, about why some practices such as male circumcision reduce infection with HIV in some instances but not in others. Africans must make greater efforts to participate and generate scientific knowledge about the biological, social, cultural and political contexts and factors affecting HIV and AIDS infections. African responses to HIV should extend the knowledge and capacities of Africans to research, debate and craft policies and programs that empower the infected and affected Africans.



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