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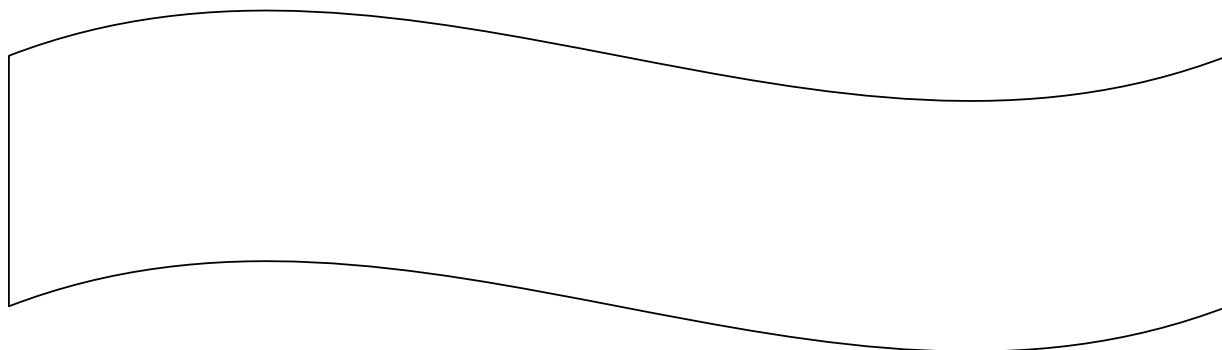
Addis Ababa, ETHIOPIA P O Box 3243 Telephone +251115 - 517700 Fax: +251115 - 517844

Website : [www.africa-union.org](http://www.africa-union.org)

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**SOCIO-CULTURAL DETERMINANTS AND IMPACT**

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## EXECUTIVE SUMMARY

### I. Background and Methods

This paper discusses the principle social factors affecting the slow progress towards the control and eventual elimination of HIV/AIDS, TB and malaria in Africa. The terms of reference call for a broad approach, and the paper discusses the way that health-related behaviour is influenced by socio-cultural factors. The overall scope of this paper is very wide. However, AIDS presents unprecedented challenges to African leaders, and a major focus of this paper is on the social and cultural issues relating to HIV prevention. The paper draws on existing documents and publications.

### II. Poverty Reduction and Health

At the international level, emphasis is now being placed on addressing poverty and social conditions. The NEPAD Health Strategy emphasises the need to develop stronger pro-poor health policies. Furthermore, developed countries are increasingly committed to Poverty Reduction Strategic Plans (PRSP), the extended Highly Indebted Poor Countries (HIPC) initiative and to the debt cancellation announced by the G8, the World Bank and the International Monetary Fund (IMF). These macro-level approaches, if successful in reducing poverty and inequality, will eventually have a positive impact on the health of the poor in Africa. However, raising overall GNP may have little effect on the health of the poor if the increased wealth is not re-distributed and inequalities reduced.

Defining, identifying and reaching the poor, is less straightforward than it might at first appear. Many definitions of poverty are used internationally. These range from assessments based on household income and/or consumption, to community-identified definitions. The World Bank uses income as the key measure of poverty by distinguishing between 'the poor', who live below a \$2 a day poverty line and the 'extreme poor', who live on less than \$1 a day. It has been estimated that 30-40% of the poor in sub-Saharan Africa are chronically poor, being individuals who have been poor for at least over five years, and perhaps for a lifetime, and who often pass their poverty on to their children.

### III. Service Demand and Supply

When people fall ill decisions about whether and where to seek treatment are made. Cultural-based knowledge about disease causation is weighed against knowledge about the western-derived approaches applied at the local clinic or hospital. Ethnicity and minority status affect decisions about where people seek treatment. When marginalised people feel excluded from services, for example, if the staff and most of the users in a clinic speak a different language, they are more likely to avoid that service. For the very poor, migrants, and internally displaced people, affordability is often the main criterion in decisions as to whether and where to seek treatment. It is estimated that a poor family living in malaria-affected areas may spend up to 25% or more of its annual income on prevention and treatment.

It is estimated that out-of-pocket payments exceed 25% of total expenditure in over three quarters of sub-Saharan African countries. A number of approaches to cost sharing and health insurance have been tried with variable results, but fail to adequately address the needs of the poor. There is mounting pressure for governments to remove user fees altogether. Reducing, or cutting, the cost of accessing health care through a well-planned, financed and implemented strategy would increase coverage for the three diseases, and greatly benefit the poor.

There needs to be greater accountability within clinics and hospitals. Simple measures, such as the display of prominent notices listing the prices of services and commodities and any exemptions, should be put in place in all health facilities. However, it should be recognised that health staff are more likely to solicit informal payments from service users when their salaries, and related morale, is low. With donors providing many African countries with large amounts of ARVs and other drugs to treat AIDS, it is important to focus on issues of accountability and transparency in the distribution of these life-saving medicines.

#### **IV. Preventing Illness**

Health education and Information Education and Communication (IEC) are approaches that seek to inform people about disease causation and prevention. Underlying such health education, is the premise that erroneous beliefs can be changed and that, as a result, new, health-promoting behaviour will be adopted. A range of mass media has been employed in order to communicate health messages: radio, TV, newspapers, magazines, billboards. The Behaviour Change Communication (BCC) approach, often linked to social marketing campaigns, focuses advertising campaigns on individuals within specific demographic groups in order to persuade them to buy a certain product such as insecticide treated nets, a condom brand or to adopt a particular behaviour, such as sexual abstinence. The advertising campaigns draw on the expertise of commercial advertising that appeal to image and lifestyle. If culture or beliefs are found to be a barrier to the desired behaviour change, the campaign will address these issues.

Yet, despite well-thought out and rigorously applied campaigns aimed at behaviour change, progress is slow. Sustained behaviour change is a complex individual process, determined by not only by individual choice, but also by the extent to which social conditions enable choice. Constraints relate to the interaction of the individual with the wider social structure. The individual may not be, or feel, able, to change his or her behaviour because of their position within society, or because they cannot afford to financially. Poor and other marginalised groups, such as disadvantaged minorities, migrants, refugees and internally displaced persons, are less able to effect behaviour change than better off people. It has been estimated that amongst marginalised groups in poor countries, information about health risks changes the behaviour of one in four people, at most.

#### **V. Gender and Power**

Lack of personal autonomy and disempowerment undermine the ability of individuals to avoid illness and to access effectively treatment. In Africa, women enjoy less personal autonomy, and lower incomes than men. Female disempowerment impacts particularly on the spread of HIV/AIDS. In Sub-Saharan Africa 57% of adults living with HIV are women aged between 15 and 49 years of age, while young women (15-24) are three times as likely to be infected as men of the same age. Barriers to HIV prevention for these young women derive from both a lack of knowledge about HIV transmission and the inability to change behaviour in order to avoid infection. Data from 35 countries in Sub-Saharan Africa show that young men were 20 times more likely to have correct knowledge on HIV than young women.

Many women find it impossible to negotiate condom use, and fidelity to their partner may offer no protection, as data from Zimbabwe and South Africa show. Among women surveyed in Harare, Durban and Soweto, 66% reported having one lifetime partner and 79% had abstained from sex until at least the age of 17. Yet, 40% of the young the young women were HIV positive, despite having remained faithful to one partner. Gender-related violence makes women even more vulnerable to HIV. Sexual coercion occurs within relationships, as rape by relatives or strangers, within crisis situations where the might of military personnel prevails, or where people are displaced due to a humanitarian crisis. For the occurrence of risky (for both men and women) sexual acts involving unequal partners to be reduced, either women must be empowered, or men need to reconsider the power dimension of their relationships with women. Initiatives that seek to increase female autonomy should be intensified, but more attention now needs to be shifted to male sexuality and sexual behaviour.

Sexual behaviour arises out of cultural values that shape sexual responses and legitimizes male dominance and sexual rights. It has been argued that African men suffer from 'cultural entrapment' in relation to their sexuality and relationships with women, and therefore need empowering so that they can adopt new sexual behaviour that protects them, and their partners, from HIV.

Social change, much of it resulting from migration, has also affected sexual relations and family life in ways that have impacted negatively on both men and women. During colonial times, in many countries, men arriving in newly developed urban areas, in mines or plantations encountered women, also newly arrived, who provided commercial sexual services. Hence, contemporary, urban sexual culture, including commercial sex, is a way of dealing with migration and family separation that dates from mass

male migration during the last century. Male migration, family breakdown and the effects of high mortality from AIDS have combined to produce a large number of female-headed households in both rural and urban areas. As household heads, women are more likely than men to be poor and vulnerable to ill health in general, and to HIV in particular. Migration and family separation also impacts negatively on male health, especially in relation to HIV and sexually transmitted infections.

Globally males account for about 60% of deaths from TB. However, surveys show that both the prevalence of infection with the bacillus that causes TB as well as active TB disease is comparable between males and females until the age of 15 years. After the age of 15 it is thought that different social mixing patterns, leading to greater or lesser exposure to infection, by men and women may account for the difference.

## **VI. Changing Culture**

Culture is considered to be part of the precious heritage of a nation or ethnic group, and is seen as part of an unchanging tradition that stretches back into the past. Yet, cultures change, adapt, develop and decline. Cultures have also always been subject to outside influences, exchanging, absorbing and adapting new elements.

Within the health sector, culture is often viewed as a barrier to positive behaviour change or to treatment seeking. Behind the label of 'cultural beliefs' lie implications of conservatism and ignorance. Adherence to culture is seen as resistance to change. It is important that health workers respect the culture of the users of their services, especially in relation to ethnic minority groups, and people following different religious beliefs and practices. Meeting the needs of semi-nomadic pastoralists presents particular challenges to health service providers. Religion is closely linked to culture. A minority of people in Africa adhere to traditional culture-specific religions, while the majority identify themselves as Christians or Muslims. Religious teachings and moral precepts have a direct bearing on health behaviour and are listened to by an enormous number of people and adhered to by many. Religious leaders are powerful opinion leaders. Yet, in many countries, there is only limited engagement between the health sector and religious leaders.

Across Africa, cultural expression is thriving in the areas of fashion, music, art, including street art, film and TV. With increased movements of people, urbanisation and new information technology providing unprecedented access to images and sounds from across the continent and beyond, new popular cultural forms are emerging that blend African and imported elements. Political leaders and health promoters should tap into popular youth culture, transmitting positive messages through youth media. Existing good-will ambassadors for malaria, TB and HIV prevention should be joined by celebrities, such as African footballers or rappers and DJs, who have high credibility with youth.

With increasing numbers of young people born in cities, youth culture for many is an important part of their identity and a major influence on behaviour. Of particular concern is the recent spread of heroin injecting in a number of African countries. Harm reduction approaches reduce the sharing of injecting equipment and therefore HIV risk, and promote drug-abstinence and safer sexual practices amongst groups of injecting drug users. The emergence of sub-cultures of heroin injectors in many parts of Africa, serve as a reminder that, in order to tackle HIV effectively, new social and cultural trends must be recognised and responded to with appropriate and timely interventions.

## **VII. Mitigating the Social and Economic Effects**

AIDS was declared a development crisis by the World Bank in 2000, and in 2003 the AU recognised AIDS as a 'cross cutting issue'. AIDS overburdens health and social systems and hinders educational development. In some countries, thousands of teachers are dying from AIDS. Agricultural and industrial production is also negatively affected as large numbers of the workforce fall ill. In many countries of sub-Saharan Africa, as families and communities are struggle to cope with HIV and AIDS, their local social support systems are strained, just as the educational and health services provided by their governments are under stress.

By 2004 it was estimated that 14 million children under the age of 15 had lost one or both parents to AIDS; 82% of these children live in sub-Saharan Africa. The death of parents creates many painful experiences for children. These include: economic hardship; lack of love and attention; withdrawal from school; psychological distress; loss of inheritance; increased abuse and risk of HIV infection; malnutrition and illness; stigma and discrimination. An even larger number of children are vulnerable to HIV because of poverty, hunger, armed conflict, harmful child labour practices and sexual abuse by adults. As AIDS continues to impact on communities and countries, undermining the social fabric, the vulnerability of children is set to increase. Poor urban children, including street children, have joined sub-cultures that may be centred on drug use, but also provide mutual support and comfort. These sub-cultures should not be ignored as peer pressures and norms will operate and may increase or decrease vulnerability to HIV. While in most African cities more male children live on the streets, girls are at risk of sexual abuse through their work as domestic servants.

In some countries members of the armed forces have rates of HIV infection between double and five times that of the general population. In addition, soldiers may spread their HIV to the civilian population or during duties as peace keepers in other countries. However, it has also been argued that there is evidence to show that HIV is not necessarily spread by soldiers, and that many countries that have suffered civil wars over 10 or more years' duration have lower rates of HIV than their neighbours. However, regardless of the relationship between war and HIV transmission, countries should ensure that their troops have the knowledge and means (condoms) to prevent the spread of infection. Improved services for treating soldiers with AIDS should also be developed. Such measures will improve the health, and therefore the capabilities of the armed forces, as well as increasing morale. Hence, HIV prevention and AIDS treatment within the armed forces are in a nation's best interests.

#### **VIII. New Strategic Approaches**

Broad recommendations are outlined with the intention of provoking thought and reaction, and to stimulate new ideas about how society and culture affect the health of Africans.

- 1) Civil society and government partnerships should be fostered in order to enhance accountability and transparency of health expenditure, particularly in relation to ARVs.
- 2) High level male leaders are respectfully called upon to set an example to other men, by examining their own sexual behaviour, the culture (both traditional and modern) of which it is a product, and rectifying any conduct that exploits or harms women.
- 3) One important barrier to health care access is the attitude of health workers towards either all service-users or towards particular ethnic groups or the poor. Training programmes and refresher courses for health workers should have an added component about the importance of inclusion, especially for the poor, and respect for other cultures and religions.
- 4) Serious engagement with religious leaders is required. This should be on the level of serious theological debate within Christianity and Islam, and address the interface of morality and doctrine with health promotion. Once national-level leader, such as Archbishops, independent church leaders, Chief Kadhis and Imams have been engaged in debate and deliberation, the results should be disseminated to the regional level, and the debates continued there.
- 5) A shift in thinking away from perceiving 'culture' to be a conservative and tradition-bound barrier to health seeking behaviour, and towards embracing popular culture as a medium for reaching and communicating with youth is called for.
- 6) Recruiting youthful African celebrities from the entertainment and sports world to raise awareness about the prevention and treatment of the three diseases.
- 7) Injecting drug users are an emerging group in a number of towns and cities across the continent. Harm reduction measures for IDU should be part of HIV prevention in affected countries.

## I. SECTION 1: INTRODUCTION

### (a) Background to the paper

1. This paper highlights and discusses the principle social factors affecting the slow progress towards the control and eventual elimination of HIV/AIDS, TB and malaria in Africa. The scope of the paper is wide and a broad approach is taken, while at the same time taking into account social and cultural diversity. The analysis focuses on social and cultural determinants of health related behaviour for both prevention and treatment of malaria, TB and AIDS, in relation to behaviour change and barriers to treatment seeking. The wider socio-economic constraints, such as poverty and gender relations, affecting the ability of individuals and families to adopt practices that promote their health are discussed. Ways to work towards the overcoming of some of these barriers are suggested. The Terms of Reference for this paper call for a very wide interpretation of 'social and cultural factors' that includes migration, human rights, access to services, accountability, transparency and confidentiality.

2. In relation to health issues, the term 'culture' usually denotes beliefs about illness causation and norms influencing health related behaviours. Hence, culture is often viewed as a conservation force and as a barrier to change. In this paper, a conceptual shift towards viewing African cultures and sub-cultures as modern and youth affirming is suggested. Such a change will enable a greater engagement with popular culture and new partnerships for raising awareness about the three diseases and the promotion of prevention and treatment initiatives.

3. All health-related behaviour is influenced by socio-cultural factors. Hence, the overall scope of this paper is very wide. However, AIDS presents unprecedented challenges to African leaders to not only improve health delivery systems to tackle this disease, but also to address the social issues that are both the cause and effect of the spread of HIV. Both prevention and treatment are important. However, in support of the WHO/AFRO Regional Committee Resolution on the "Acceleration of HIV prevention efforts in the African Region" that calls on Member States to declare 2006 a year for Accelerating HIV Prevention<sup>1</sup>, a major focus of this paper is on the social and cultural issues relating to HIV prevention.

4. The paper raises pertinent, and possibly controversial, issues in relation to social and cultural aspects of the three diseases. Although it draws on existing reports, papers and books, the paper is not intended as a comprehensive review of social and cultural factors. Neither does it seek to present a synthesis of best practice in relation to the application of social factors in relation to health interventions for the three diseases. A number of new approaches to tackling the three diseases are outlined in the final section of the paper. These are intended to stimulate ideas and debate amongst leaders across the continent. These approaches should be adopted in addition to, and in conjunction with, the best practices identified in other documents. Some of the approaches may already have been adopted in some countries, but require more intensive efforts.

### (b) Method

5. Given the scope of the paper, the potential pool of reference material is vast. Due to time constraints, there has been no opportunity for a systemic literature search, even in relation to the issues that are raised in the paper. Therefore, recent papers that refer to Africa, present African case studies, and discuss the key emerging issues in relation to the prevention, treatment, care and support of the three diseases have been selected.<sup>2</sup>

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<sup>1</sup> Resolution AFR/RC55/R6. Acceleration of HIV Prevention in the African Region. 25 August 2005. Maputo, Mozambique.

<sup>2</sup> Thanks to Ellie Bard, Georges Ki-zerbo, Steve Jones, Chris Atim, Sylvia Meek and Stephanie Simmons for providing articles that are cited in this paper.

## II. SECTION 2: POVERTY REDUCTION AND HEALTH

### (a) Macro Level links Between Poverty and Health

6. The links between poverty and ill health are widely known and increasingly well understood. At the international level, greater emphasis is now being placed on addressing poverty and social conditions. The NEPAD Health Strategy emphasises the need to develop stronger pro-poor health policies. Furthermore, developed countries are increasingly committed to Poverty Reduction Strategic Plans (PRSP), the extended Highly Indebted Poor Countries (HIPC) initiative and to the debt cancellation announced by the G8, the World Bank and the International Monetary Fund (IMF). These macro-level approaches, if successful in reducing poverty and inequality, will eventually have a positive impact on the health of the poor in Africa.

7. However, raising overall GNP may have little effect on the health of the poor<sup>3</sup> if the increased wealth is not re-distributed and inequalities reduced. The WHO Commission on the Social Determinants of Health has been setup to review evidence, raise debate about health inequalities and recommend policies with the goal of improving the health of vulnerable people. This approach focuses on the relationship between absolute deprivation and health, as well as the social gradient within countries. Hence, greater socio-economic inequality within countries correlates with worse health outcomes for those of low social status relative to the high status, wealthy groups.<sup>4</sup> These data indicate that redistribution of resources is an important factor in improving overall health outcomes.

### (b) Defining Poverty

8. Until macro-economic approaches aimed at poverty reduction take effect, the challenge for the health sector is to better address the barriers to access for poor people. However, defining, identifying and reaching the poor, is less straightforward than it might at first appear. Many different definitions of poverty are used internationally. These range from definitions based on household income and/or consumption, to community-identified assessments. The World Bank uses income as the key measure of poverty by distinguishing between 'the poor', who live below a \$2 a day poverty line and the 'extreme poor', who live on less than \$1 a day.

9. Other definitions emphasise the fact that poverty has many dimensions, in addition to lack of income. These include:

- lack of productive resources to sustain livelihoods
- limited or no access to basic services such as water, health and education
- hunger and malnutrition
- increased morbidity and mortality
- living in an unsafe or insecure environment
- poor or no housing
- lack of participation in social, cultural and political life
- social discrimination or exclusion.<sup>5</sup>

10. Hence, insecurity and vulnerability can be experienced on a number of different fronts simultaneously, so that different aspects of poverty reinforce each other. For example, chronic ill-health can affect an individual's ability to participate in social and community activities, which could lead to social exclusion.

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<sup>3</sup> O'Farrell, N. 'Poverty and HIV in sub-Saharan Africa.' *Lancet* 2001; 357: 636-637.

<sup>4</sup> Marmot, M. 'Social Determinants of Health Inequalities.' *Lancet* 2005; 365: 1099-104

<sup>5</sup> Green, C. 'Increasing the Access of the very poor to drugs and treatment in the health sector: an Overview.' Unpublished discussion paper, PATHS, Nigeria. July 2005.

11. It has been estimated that 30-40% of the poor in Sub Saharan Africa are chronically poor (between 90-120 million people), and that over a third of the Sub Saharan African chronically poor live in Nigeria, the most populous country on the continent. The chronically poor are individuals who have been poor for a long time, at least over five years, and perhaps for a lifetime, and who often pass their poverty on to their children. The chronically poor are often concentrated amongst:

- People living in certain geographic locations (e.g. remote rural areas, urban slums and conflict zones)
- disadvantaged social groups (e.g. tribes, ethnic groups, castes, refugees)
- disadvantaged people in households (e.g. elderly, women, children)
- poor health (e.g. disability, serious ill-health, stigmatised ill-health such as TB, or HIV/AIDS)
- socio-economic position: (e.g. bonded, indentured labour, migrant labour)
- household composition (e.g. female headed households, households headed by widows or orphans)

12. Other individuals and households move in and out of poverty, perhaps seasonally, and from time to time may be unable to pay for basic services, including health care. These are the 'transient poor', who if faced by a severe health shock, could move into a state of chronic poverty.

### III. SECTION 3: SERVICE DEMAND AND SUPPLY

#### (a) Treatment-Seeking Decision Making

13. When people fall ill decisions about whether and where to seek treatment are made. Symptoms and their severity are assessed and the likely cause of the illness speculated upon. Cultural-based knowledge about disease causation is weighed against knowledge about the western-derived approaches applied at the local clinic or hospital. A decision about the likely cause may be reached that directs people to either the traditional or bio-medical sectors, or to a particular specialist practitioner. Across the continent, these decisions are made by individuals and families living in conditions that permit some choice: there is a small private health clinic within walking distance; the services in the government health facility are known to be adequate, but drugs sometimes run out; the local traditional healer charges modest fees and has a good reputation. Ethnicity and minority status also affects decisions about where people seek treatment. When marginalised people feel excluded from services, for example, if the staff and most of the users in a clinic speak a different language, members of the minority group are more likely to avoid that service<sup>6</sup>. When alternative choices are limited or non-existent, factors relating to exclusion reduce the overall demand for services and increase the burden of disease. For the very poor, migrants, and internally displaced people choice between service providers may be a luxury, and affordability is often the main criterion in decisions as to whether to seek treatment.

14. Decisions concerning where to access treatment can have far reaching effects for households. The expenses of dealing with catastrophic illness can plunge households into poverty<sup>7</sup>. It is estimated that a poor family living in malaria affected areas may spend up to 25% or more of its annual income on prevention and treatment.<sup>8</sup> The economic costs of TB are also steep, as families may lose the income of a breadwinner as well as having to pay for treatment. For example, a study in Uganda found that the average income lost, based on a period of nine months without work was US\$161.<sup>9</sup> Indeed, there is concern about the indirect costs of TB treatment in poor settings. Hence, while the cost of TB treatment has fallen, the high costs of accommodation, special nutrition and transport may push families into

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<sup>6</sup> Jones, C and Williams, H. 'The Social Burden of Malaria: What are we measuring?' *American Journal of Tropical Medicine and Hygiene*. 71(Suppl. 20, pp156-161, 2004.

<sup>7</sup> NEPAD Health Strategy

<sup>8</sup> The Abuja Declaration on Roll Back Malaria in Africa.

<sup>9</sup> WHO *The Economic Impacts of Tuberculosis*, Geneva, 2000

poverty. In Zambia, for example, it has been estimated that non-medical costs were double the actual treatment costs.<sup>10</sup>

(b) **Affordability, Accessibility and Quality of Services**

15. Until poverty reduction strategies take effect, health services must be made more accessible and affordable to the poor if malaria, TB and HIV/AIDS are to be tackled effectively. Increasing service access for the poor is the responsibility of not only governments, but also of health partners such as NGOs, mission-run services and the private and traditional sectors.

16. One of the single biggest sources of financing health care is out-of-pocket payments. It is estimated that out-of-pocket payments exceed 25% of total expenditure in over three quarters of sub-Saharan African countries.<sup>11</sup> Since the 1980s and 1990s increase in user fees in government run health facilities have made it increasingly difficult for the poor to access services. A number of approaches to cost sharing and health insurance have been tried with variable results, but fail to adequately address the needs of the poor. A range of community- level financing schemes has sought to put in place effective mechanisms that provide a safety net for the poor. These include deferral and exemption schemes, vouchers schemes and community-based health insurance.<sup>12</sup> Coverage has remained low and vulnerable households are often excluded.<sup>13</sup> These schemes are controversial and expert opinion is divided over their desirability and to the extent that they are viable at any scale.

17. NEPAD is calling for the ending of 'fee for service' at the point of delivery<sup>14</sup>. Indeed within Africa there is mounting pressure for governments to remove user fees altogether. Such a measure would certainly make access easier for the poor and increase overall demand for health services. It has been done in South Africa and Uganda. In the Ugandan case, the removal of user fees increased clinic usage by 120% and reduced health expenditure in for poorest quintile. However, a recent study in Uganda has shown that with the abolition of user fees in government facilities, the incidence of catastrophic health expenditure amongst the poor did not fall. The suggested explanation for this continued level of expenditure by the poor is the frequent unavailability of drugs in government health facilities, and a possible increase in informal charges by health workers.<sup>15</sup> For the abolition of user fees to make a big difference to the poor, it will be necessary to ensure that health facilities have a good supply of drugs. If this is not the case, service users will be referred to pharmacies or other private drug sellers, who may operate with minimal regulation with regard to drug safety and price. Hence, unless such the abolition of user fees is carefully planned and budgeted for, rapid increases in utilisation cannot be adequately managed<sup>16</sup>.

18. Reducing, or cutting, the cost of accessing health care through a well-planned, financed and implemented strategy would increase coverage for the three diseases, and greatly benefit the poor. A main focus should be improving maternal and child health services and making them more accessible. Ante-natal care is particularly important as a means of reaching pregnant mothers who can then be initiated into IPT programmes for malaria prevention, and offered HIV tests to identify women who can then be recruited into programmes that prevent mother to child transmission.<sup>17</sup> Accessible under- fives clinics offering curative services are an important entry point for the prompt treatment of malaria. In

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<sup>10</sup> UNDP *Investing in Strategies to Reverse the Global Incidence of TB*. UN Millennium Project. Earthscan, UK and USA, 2005.

<sup>11</sup> McIntyre, D, Gilson, L., Mutiyambizi, V. *Promoting Equitable Health Care Financing in the African Context: current challenges and future prospects*. EQUINET Discussion Paper, No. 27. 2005.

<sup>12</sup> Partners for Health ReformPlus *An Overview of Community-Based Health Financing*. 2004.

<sup>13</sup> McIntyre, D, Gilson, L., Mutiyambizi, V. *Promoting Equitable Health Care Financing in the African Context: current challenges and future prospects*. EQUINET Discussion Paper, No. 27. 2005.

<sup>14</sup> NEPAD Health Strategy.

<sup>15</sup> Xu, K, Evans, D. B. Kaduma, P, Nabyonga, P. O. O., Nabukhonzo, P., Aguilar, A. M. 'Understanding the impact of eliminating user fees: utilization and catastrophic health expenditures in Uganda.' *Social Science and Medicine* 62 92006) 866-876.

<sup>16</sup> McIntyre, D, Gilson, L., Mutiyambizi, V. *Promoting Equitable Health Care Financing in the African Context: current challenges and future prospects*. EQUINET Discussion Paper, No. 27. 2005.

<sup>17</sup> UNAIDS/WHO AIDS Epidemic Update. December 2005

addition, high quality, affordable and accessible VCT centres and other services where HIV testing is carried out are the key to the scaling up of ARV provision, as well as being an important tool in HIV prevention programmes. In addition, VCT is an important entry point for the diagnosis of TB.

(c) **Transparency, accountability and rights to confidentiality**

19. From the service-user perspective, there may appear to be little difference between user fees and 'informal charges'. There needs to be greater accountability within clinics and hospitals. Simple measures, such as the display of prominent notices listing the prices of services and commodities and any exemptions, should be put in place in all health facilities. However, it should be recognised that health staff are more likely to solicit informal payments from service users when their salaries, and related morale, are low. Increasing health salary levels is an important step towards reducing levels of 'informal charges' and to increasing staff motivation to provide high quality services.

20. With donors providing many African countries with large amounts of ARVs and other drugs to treat AIDS, it is important to focus on issues of accountability and transparency in the distribution of these life-saving medicines. However, more information about the eligibility criteria and cost of ARVs needs to be made more easily available to people living with AIDS and to the general public. These measures are necessary to address the irregularities that have occurred with respect to the roll out of ARVs in a number of countries. Requests for 'top up' payments from health staff and drug leakages onto the open market have undermined efforts to reach '3X5' target, and will continue to do so, unless greater accountability is achieved. There is a possible role for the NEPAD Peer Review System in monitoring the roll out of ARVs, while finance and health ministries should take measures to improve drug supply monitoring systems. Organisations of people living with AIDS and other civil service groups can also play an important role in holding governments accountable for the drug supplies that they receive from donors such as PEPFAR and the GFATM.

21. Stigma is the cause and effect of secrecy and denial<sup>18</sup>. Although more attention has been placed on AIDS as source of stigma, TB is also a stigmatizing disease, both in its own right as and in association with AIDS. In relation to AIDS, fear of stigma limits the efficacy of HIV testing programmes because people are scarred of breaches of confidentiality or gossip concerning their status. Such fear causes treatment delays and undermines prevention efforts. It is vital that high quality voluntary counselling and testing services are made more widely available, and that these services maintain high standards of confidentiality. Confidentiality should be seen as the right of users of VCT services. At the same time, if stigma is to be reduced a move must be made towards viewing AIDS as 'just another illness'. This conceptual change will only happen when effective treatment is more widely available; treatment can only be offered to people who have been tested for HIV. Hence, improved treatment and VCT are linked interventions that will contribute towards reducing the stigma and discrimination experienced by many people living with AIDS.

**IV. SECTION 4: PREVENTING ILLNESS – PLACING THE RESPONSIBILITY ON THE INDIVIDUAL AND FAMILY**

(a) **Knowledge, belief and behaviour**

22. Health education and Information Education and Communication (IEC) are approaches that, with greater or lesser sophistication, seek to inform people about disease causation and prevention. Underlying much health education, is the premise that erroneous beliefs can be changed and that, as a result, new, health-promoting behaviour will be adopted. A range of mass media have been employed in order to communicate health messages, including radio, TV, newspapers, magazines and bill-boards. Ministry of Health workers play their part by carrying out health education in clinics and by showing

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<sup>18</sup> Rankin, W. W., Brennan, S., Schell, E., Jones, L., Rankin, S. H 'The stigma of being HIV-positive in Africa.' PLoS Medicine, 2005; 2(8):702-4.

videos to waiting service-users. All these techniques are by now familiar aspects of daily life across the continent.

23. Anthropologists are often consulted by the designers of health interventions about beliefs held by a specific social or cultural group that may be creating barriers to the adoption of a particular health promoting behaviour<sup>19</sup>. For example, it is widely documented that in East Africa beliefs about *ndege* type illnesses sometimes prevent parents from taking their children for early treatment for malaria.<sup>20</sup> In the case of insecticide treated nets (ITN), it is important that parents of young children believe that mosquitoes cause malaria and that a net will protect their offspring against bites. Often malaria-type symptoms are attributed to other causes by people drawing on theories of disease causation that derive from traditional medical systems<sup>21</sup>. Such beliefs are usually culture-specific and limited to a particular geographical location. Barriers to acceptance and use of ITN for other reasons may also occur. These may derive from dislike of sleeping under nets, for example due to heat<sup>22</sup>, or concerns about the level of poison in the insecticide dip. Through effective communication such fears can be addressed and coverage of ITN increased<sup>23</sup>. Once local health beliefs and problems with acceptability with ITN have been effectively addressed, the issue of access and affordability is also pertinent.

24. At times concerns within a community about specific health initiatives develop into widespread rumours, for example about condoms being ineffective or even being 'spiked' with HIV.<sup>24</sup> These rumours should be addressed as expressions of health knowledge or beliefs that run counter to information provided by biomedical health promoters. The existence of rumours points to resistance to the unconditional acceptance of health messages by the community, and therefore to the limitations of the approach of imparting knowledge to change beliefs, and therefore behaviour.<sup>25</sup>

25. The Behaviour Change Communication (BCC) approach, often linked to social marketing campaigns, focuses advertising campaigns on individuals within specific demographic groups in order to persuade them to buy a certain product such as insecticide treated nets (ITN) a condom brand or to adopt a particular behaviour, such as sexual abstinence. Hence, parents of young children are encouraged to buy ITN, while young urban dwellers are targeted as potential consumers of condoms, and teenaged girls are told that abstaining from sex is 'cool'. The advertising campaigns draw on the expertise of commercial advertising that appeal to image and lifestyle. If culture or beliefs are found to be a barrier to the desired behaviour change, the campaign will address these issues. For example, in East Africa the importance of 'trust' between sexual partners may inhibit condom usage<sup>26</sup>,<sup>27</sup>. Socially marketed condoms in Kenya are branded as 'Trust'.

26. In Uganda Straight Talk Foundation (STF) was created to contribute to the improved mental, social and physical development of Ugandan adolescents (10-19 years) and young adults (20-24 years) and keep them safe from HIV and STI infection and early pregnancy. STF aims to increase the understanding of adolescence, sexuality and reproductive health and to promote the adoption of safer

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<sup>19</sup> Jones, C and Williams, H. 'The Social Burden of Malaria: What are we measuring?' *American Journal of Tropical Medicine and Hygiene*. 71(Suppl. 20), pp156-161, 2004.

<sup>20</sup> Heggenhougen, H K, Hackenthal, V. and Vivek, P. *The Behavioural and Social Aspects of Malaria and its Control (TDR/STR/VOL/030)*. UNDP/ World Bank/ WHO/ TDR, 2003.

<sup>21</sup> Mwenesi H A, Harpham T, Marsh K and Snow R W (1995) 'Perceptions of symptoms of severe childhood malaria among Mijikenda and Luo residents of Coastal Kenya. *Journal of Biosocial Science* 27, 235-244.

<sup>22</sup> Heggenhougen, H K, Hackenthal, V. and Vivek, P. *The Behavioural and Social Aspects of Malaria and its Control (TDR/STR/VOL/030)*. UNDP/ World Bank/ WHO/ TDR, 2003

<sup>23</sup> Minja, H and Obrist B (2005) 'Integrating Local and Biomedical Knowledge and Communication: Experiences from KINET Project in southern Tanzania.' *Human Organization* 64 (2): pp 157-165.

<sup>24</sup> Pfeiffer, J. 'Condom Social Marketing, Pentecostalism, and Structural adjustment in Mozambique: A Clash of AIDS Prevention Messages. *Medical Anthropology Quarterly* 18(1):77-103, 2004.

<sup>25</sup> Niehaus, I. and Jonsson, G. 'Dr. Wouter Basson, Americans, and Wild Beasts: Conspiracy theories of HIV/AIDS in the South African Lowveld. *Medical Anthropology* 24:179; 2005.

<sup>26</sup> Bujra, J. in Ed Caplan P. 'Risk and Trust: Unsafe Sex, Gender and AIDS in Tanzania' In Caplan, P. (ed.) *Risk Revisited* London: Pluto Press, 2000, pp59-83.

<sup>27</sup> Dilger, H. 'Sexuality, AIDS, and the lure of modernity: reflexivity and morality among young people in rural Tanzania.' *Medical Anthropology* 22:23-52, 2003.

sex practices. This is done through disseminating information on their health and bodies, child/human rights, HIV/STIs and life skills such as assertiveness, confidence building and decision-making. STF reaches its audience through English and local newspapers; radio broadcasts, workshops with teachers and health providers and school visits. This approach has been replicated around the region. STF has shared its experience in eight regional and similar publications to Straight talk and Young Talk are up and running in Tanzania, Kenya and elsewhere.

27. Schools also have a role to play in HIV prevention education and in the acceptance of people with AIDS. The approach should be rights based and designed to address stigma. This should begin at an early age and be sustained over time. However, for accurate information to be imparted to children in an appropriate manner, teachers must be trained, and working links with the health sector must be made.<sup>28</sup>

(b) **Social constraints on behaviour change**

28. Health education, IEC and BCC approaches all address their messages to individuals who then, hopefully, change their behaviour in a way that promotes their health, or that of their families or sexual partners. Such campaigns are valuable, tried and tested approaches. Yet, despite well-thought out and rigorously applied campaigns aimed at meeting targets for HIV and malaria prevention, progress is slow. Sustained behaviour change is a complex individual process, determined by not only by personal choice, but also by the extent to which social conditions enable choice<sup>29</sup>. Constraints relate to the interaction of the individual with the wider social structure. Thus, knowledge does not automatically lead to behaviour change. The newly acquired knowledge may clash with dearly held religious and cultural values and therefore be rejected before change is even contemplated. Alternatively the individual may not be able, or feel able, to change his or her behaviour because of their position within society, or because they cannot afford to financially. Hence, the poor and other marginalised groups, such as disadvantaged minorities, migrants, refugees and internally displaced persons are less able to effect behaviour change than better off people. It has been estimated that amongst marginalised groups in poor countries, information about health risks changes the behaviour of one in four people, at most.<sup>30</sup>

29. With TB particularly associated with poverty and deprivation, the ability of patients suffering from the disease to comply with therapy has been questioned by social scientists. Farmer argues that the inability of patients to comply with treatment is a far more important factor shaping their behaviour than health beliefs or the patient-provider relationship.<sup>31</sup> Similarly, it is noted that people who are economically and socially marginalised are least likely to be able to comply with treatment.<sup>32</sup>

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<sup>28</sup> UNESCO and other UN agencies, together with DFID, USAID and The World Bank. *HIV/AIDS and Education: A Strategic Approach* 2002

<sup>29</sup> Campbell C. and Mzaidume Y. 'How can HIV be prevented in South Africa? A Social Perspective.' *BMJ* 2002; 224; 229-232.

<sup>30</sup> Gillies, P. 'The effectiveness of alliances and partnerships for health promotion.' *Health Promotion International* 1991; 13: 1-21.

<sup>31</sup> Farmer, P. 'Social scientists and the new tuberculosis.' *Social Science and Medicine* 43 (1997) 347-358.

<sup>32</sup> Lienhardt, C., Ogden, J., Sow, O. 'Rethinking the social context of illness: interdisciplinary approaches to tuberculosis control.' In Gandy, M and Zumla, Z. (Eds.) *The Return of the White Plague: Global Poverty and the 'New' Tuberculosis*. London, Verso, 2003.

V. SECTION 5: GENDER AND POWER

(a) Autonomy, Power and Gender Relations

30. Inevitably, in a continent as socially diverse as Africa, there are large variations in gender relations. Many decisions about treatment seeking and the accessing of health services are made at the household level. In many cultural contexts across Africa, women have considerable autonomy. However, in some areas, notably in some conservative Muslim societies, women must seek permission from husbands before going to a health facility; while men must take responsible for providing money for transport and user fees. Alternatively, in some cultures women, if their husbands are absent, may be expected to ask permission of their in-laws before taking a child for treatment.<sup>33</sup> Hence, in women and child centred health interventions, where women have little autonomy, it is important to involve men because they are key decision makers and financial providers. Lack of personal autonomy and disempowerment undermine the ability of individuals to avoid illness and to effectively access treatment. In Africa, as across the rest of the world, women enjoy less personal autonomy, and lower incomes than men. This affects their ability to access care for malaria <sup>34</sup> and TB<sup>35</sup>

31. Female disempowerment impacts particularly on the spread of HIV. In Sub-Saharan Africa 57% of adults living with HIV are women aged between 15 and 49 years of age<sup>36</sup>, while young women (15-24) are three times as likely to be infected as men of the same age<sup>37</sup>. Barriers to HIV prevention for these young women are derive from both a lack of knowledge about HIV transmission and the inability change behaviour in order to avoid infection. Data from 35 countries in Sub-Saharan Africa show that young men were 20 times more likely to have correct knowledge on HIV than young women<sup>38</sup>. Efforts to ensure that young women and men have correct knowledge about sex and HIV transmission should be intensified.

32. Accurate information on HIV transmission enables some people to make informed choices about their own sexual behaviour, in terms of abstinence, fidelity or condom use. However, sexuality and associated sexual behaviour are determined by social structure, culture, power relations and moral values derived from religious doctrines. Some individual young women have the personal autonomy to make decisions about their sexuality, but many are overwhelmed by social forces beyond their control. Across the region, poverty causes some young women to trade sex for survival in a variety of arrangements, with a single partner or with multiple partners<sup>39</sup>. In addition, in some countries, men particularly target vulnerable young women as sexual partners, in the belief that, because of their youth, they are less likely to be HIV positive. Many women find it impossible to negotiate condom use, and fidelity to their partner may offer no protection, as data from Zimbabwe and South Africa show. Among women surveyed in Harare, Durban and Soweto, 66% reported having one lifetime partner and 79% had abstained from sex until at least the age of 17. Yet, 40% of the young the young women were HIV positive, despite having remained faithful to one partner.<sup>40</sup> Gender-related violence makes women even more vulnerable to HIV. Sexual coercion occurs within relationships, as rape by relatives or strangers,

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<sup>33</sup> Jones, C and Williams, H. 'The Social Burden of Malaria: What are we measuring?' *American Journal of Tropical Medicine and Hygiene*. 71(Suppl. 20), pp156-161, 2004.

<sup>34</sup> Heggenhougen, H K, Hackenthal, V. and Vivek, P. *The Behavioural and Social Aspects of Malaria and its Control (TDR/STR/VOL/030*. UNDP/ World Bank/ WHO/ TDR, 2003.

<sup>35</sup> Thorson, A. and Diwan, V. K. 'Gender and tuberculosis: a conceptual framework for identifying gender inequalities.' In Gandy, M and Zumla, Z. (Eds.) *The Return of the White Plague: Global Poverty and the 'New' Tuberculosis*. London, Verso, 2003.

<sup>36</sup> UNAIDS/WHO *AIDS Epidemic Update* December 2005

<sup>37</sup> Kim J. C. and Watts C. 'Gaining a foothold: tackling poverty, gender inequality, and HIV in Africa.' *BMJ* 2005; 331; 769-772.

<sup>38</sup> UNAIDS/WHO *AIDS Epidemic Update* December 2005

<sup>39</sup> Schoef, B. G 'AIDS in Africa: Structure Agency and Risk.' In (Eds.) Kalipeni E., Craddock, S., Opong, J. R. and Ghosh, J. *HIV and AIDS in Africa: Beyond Epidemiology* Oxford: Blackwell Publishing, 2004, pp 121-132.

<sup>40</sup> Meehan, A. et al. 'Prevalence and risk factors for HIV in Zimbabwean and South African women' XV International AIDS Conference. Abstract. MoPeC3468, Bangkok, 2004.

within crisis situations where the might of military personnel prevails, or where people are displaced due to a humanitarian crisis.<sup>41</sup>

33. For the occurrence of risky (for both men and women) sexual acts involving unequal partners to be reduced, either women must be empowered, or men need to reconsider the power dimension of their relationships with women. Programmes that aim to increase female autonomy and financial independence are underway in a number of countries<sup>42</sup>. These initiatives should be intensified, but attention now needs to be shifted to male sexuality and sexual behaviour.

34. Political leaders, the vast majority of whom are men, are respectfully urged to the lead in examining their sexual relationships with women and the extent to which they are exploitative or domineering. At the level of HIV prevention programmes, greater emphasis should be placed on working with men to confront the ways that sexual culture and their behaviour fuels HIV transmission, increasing risk to themselves as well as others. Sexual behaviour arises out of cultural values that shape sexual responses and legitimizes male dominance and sexual rights. Such attitudes make it difficult for women to refuse sex or negotiate condom use. It has been argued that African men suffer from 'cultural entrapment'<sup>43</sup> in relation to their sexuality and relationships with women, and therefore need empowering so that they can adopt new sexual behaviour that protects them, and their partners, from HIV. New interventions should encourage men to take responsibility for their own sexual behaviour and to consider the consequences that it has on themselves, their partners and the children they have fathered.<sup>44</sup>

(b) **The Effects of Migration on Family Life and Sexual Health**

35. Social change, much of it resulting from migration, have also affected sexual relations and family life, in ways that have impacted negatively on both men and women. Throughout the twentieth century, particularly in Eastern and Southern Africa, male migration patterns have contributed to the weakening, even breakdown, family stability, and provided an ideal milieu for the spread of first STIs, such as syphilis, and, since the 1980s, HIV.<sup>45</sup> Similar migratory processes also occurred in parts of West Africa. Hence, patterns of HIV transmission in Ghana and Cote d'Ivoire can be linked to the social consequences of mass labour migration<sup>46</sup>. During colonial times, men arriving in newly developed urban areas, in mines or plantations encountered women, also newly arrived, who provided commercial sexual services. Hence, contemporary, urban sexual culture, including commercial sex, is a way of dealing with migration and family separation that dates from mass male migration during the last century.

36. Male migration, family breakdown and the effects of high mortality from AIDS have combined to produce a large number of female-headed households in both rural and urban areas. As household heads, women are more likely than men to be poor. Women have lesser earning power and, as household heads, often have to take sole responsibility for the welfare of their own children, as well as siblings and other relatives. These women and the people they care for are particularly vulnerable to ill health in general and to HIV in particular.

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<sup>41</sup> Akeroyd, A. V. 'Coercion, constraints, and "cultural entrapments": a further look at gendered and occupational factors pertinent to the transmission of HIV in Africa.' In (Eds.) Kalipeni E., Craddock, S., Oppong, J. R. and Ghosh, J. *HIV and AIDS in Africa: Beyond Epidemiology* Oxford: Blackwell Publishing, 2004, pp89-103.

<sup>42</sup> Kim J. C. and Watts C. 'Gaining a foothold: tackling poverty, gender inequality, and HIV in Africa.' *BMJ* 2005; 331; 769-772.

<sup>43</sup> Mhloyi, M. M. 'Racing against time.' In Reid, E (Ed.) *HIV & AIDS: The Global Interconnection*. West Hartford, CT: Kumarian Press for UNDP. Pp13-25.

<sup>44</sup> Akeroyd, A. V. Coercion, constraints and "cultural entrapments". ' In (Eds.) Kalipeni E., Craddock, S., Oppong, J. R. and Ghosh, J. *HIV and AIDS in Africa: Beyond Epidemiology* Oxford: Blackwell Publishing, 2004, 89-103.

<sup>45</sup> Lyons, M. 'Mobile populations and HIV/AIDS in East Africa.' In (Eds.) Kalipeni E., Craddock, S., Oppong, J. R. and Ghosh, J. *HIV and AIDS in Africa: Beyond Epidemiology* Oxford: Blackwell Publishing, 2004, pp175-190.

<sup>46</sup> Oppong, J. R. and Kalipeni, E. 'Perceptions and micperceptions of AIDS in Africa. In (Eds.) Kalipeni E., Craddock, S., Oppong, J. R. and Ghosh, J. *HIV and AIDS in Africa: Beyond Epidemiology* Oxford: Blackwell Publishing, 2004, pp47-57.

37. Migration and family separation also impacts negatively on male health, especially in relation to HIV and sexually transmitted infections. For example, high levels of HIV infection have been found in men working in South African mines. Such men, it is argued, use sex as a way of expressing their masculinity and coping with the stresses of a physically demanding job where accidents are common.<sup>47</sup> Soldiers and others in occupations involving high physical danger may view unprotected sex as a minor risk compared to the chances of being killed in action. Unemployment leading to the inability to support a family or to marry in the first place, may also impact negatively on male identity and self worth and contribute to a sense of hopelessness where risking HIV infection matters little to them. Yet, while the social conditions of family separation, unemployment and migration cause male vulnerability to HIV, data from across the sub-Saharan Africa show that the sexual partners of such men are even more vulnerable.

(c) **Legal Protection**

38. More interventions that target men and their sexual behaviour, such as through peer groups, are required. However, these initiatives will not bear immediate fruit. In the meantime it is important that the law in all African countries should protect women from sexual violence and coercion, within and beyond the family. Legislation has been enacted in some countries to afford women greater protection. These efforts need to be intensified, and support given to civil society organisations such as women's and human rights groups, and community based organisations should be encouraged to work with governments to work towards greater protection for women and girls.

(d) **Gender and TB Prevalence**

39. Globally males account for about 60% of deaths from TB. However, surveys show that both the prevalence of infection with the bacillus that causes TB as well as active TB disease is comparable between males and females until the age of 15 years.<sup>48</sup> After the age of 15 it is thought that different social mixing patterns, leading to greater or lesser exposure to infection, by men and women may account for the difference. Hence, men may mix socially in public places more than women, who are more confined to the domestic sphere.<sup>49</sup> In most African countries the burden of TB is higher amongst men, while in countries where there are high levels of HIV, the gender gap is smaller.<sup>50</sup>

**VI. Section 6: Changing Culture**

(a) **Culture and Tradition**

40. Culture is considered to be part of the precious heritage of a nation or ethnic group. As such, culture is seen as part of an unchanging tradition that stretches back into the past, and as a vital part of the identity of most Africans. Sacred objects and everyday tools that are characteristic of, or even define, a culture are collected and displayed in national museums. Museums exhibits, televised displays of traditional dances and ceremonies and rituals celebrate core cultural values. Yet, cultures change, adapt, develop and decline. Cultures have also always been subject to outside influences, exchanging, absorbing and adapting new elements.

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<sup>47</sup> Campbell, C. 'Migrancy, masculine identities, and AIDS: The psycho-social context of HIV transmission on the South African gold mines.' In (Eds.) Kalipeni E., Craddock, S., Oppong, J. R. and Ghosh, J. *HIV and AIDS in Africa: Beyond Epidemiology* Oxford: Blackwell Publishing, 2004, pp144-154.

<sup>48</sup> UNDP *Investing in Strategies to Reverse the Global Incidence of TB*. UN Millennium Project. Earthscan, UK and USA, 2005.

<sup>49</sup> Dolin, P. 'Tuberculosis epidemiology from a gender perspective.' In Diwan, V. K., Thorson, A., Winkvist, A. (Eds.) *Gender and Tuberculosis* Nordic School of Public Health/SIDS/WHO, 1998.

<sup>50</sup> UNDP *Investing in Strategies to Reverse the Global Incidence of TB*. UN Millennium Project. Earthscan, UK and USA, 2005.

(b) **Culture and Health Seeking Behaviour**

41. Within the health sector, culture is often viewed as a barrier to positive behaviour change or to treatment seeking. Hence, people's health-related understandings of issues, such as the link between mosquito-bites and malaria or the desire to have flesh-on-flesh sex, are sometimes labelled as 'cultural beliefs'. Behind this label lie implications of conservatism and ignorance. Adherence to culture is seen as resistance to change. Apart from the traditional sector, health services are largely or entirely developed from western models that were introduced by colonialists and missionaries. Health staff, through their training have adopted practices and internalised values that may run counter to the culture of the people they serve, and this may reduce the level of respectful treatment that they accord patients<sup>51</sup>. For example, a 40-day post-partum period of seclusion with the home is a part of many Muslim cultures. Rather than seeing the 40 day period as a potential barrier to accessing post-natal care, service provision should be designed to accommodate and work with a practice that that enables women to rest and bond with their new baby.<sup>52</sup> It is important that health workers respect the culture of the users of their services, especially in relation to ethnic minority groups. Meeting the needs of semi-nomadic pastoralists presents particular challenges to health service providers. Across Africa and indeed the world, such groups are often looked down upon by members of the majority culture who stem from agriculturalist roots.<sup>53</sup> Health interventions should start working with culture and not against it, so that marginalised groups feel less alienated and excluded. Such a shift in attitudes would increase demand for services and could play an important part in efforts to control malaria, TB and HIV/AIDS.

(c) **Culture and Religion**

42. Religion is closely linked to culture. A minority of people in Africa adhere to traditional culture-specific religions, while the majority identify themselves as Christians or Muslims. In many countries, alongside established denominations such as the Catholic, Methodist and Anglican churches and the newer evangelical movements led by groups such as the Southern Baptists of the USA, there is an explosion of entirely African Christian movements. All these churches, regardless of whether they have indigenous or overseas origins, have taken on aspects of African culture in their forms of worship, and sometimes in relation to doctrine. Christianity is very successful and influential in many parts of the continent. Islam has deeper roots than Christianity in many African countries, and has permeated local cultures across the north of the continent and many parts of West and East Africa. As the Quran and other teaching provide guidance on everything from diet to usury, and because the days and years are punctuated for all Muslims by prayer, the Ramadan fast and the major Eid festivals, an Islamic culture is robust in Africa. Christian and Muslim teachings and moral precepts have a direct bearing on health behaviour. Religious teachings are listened to by an enormous number of people and adhered to by many. Religious leaders are powerful opinion leaders. Yet, in many countries, there is only limited engagement between the health sector and religious leaders. There needs to be greater engagement between the health sector and religious leaders, with regard to issues such as abstinence and condom usage.

(d) **Modern and Popular Culture**

43. But culture is not only part of tradition and religion, and the preservation of ethnic and national identity. If this were the case, Africa would not be the vibrant, varied and stimulating continent that it is. Despite the ravages of poverty, conflict, AIDS, TB, malaria and other diseases, cultural expression is thriving in the areas of fashion, music, the visual arts, including street art, film and TV. With increased

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<sup>51</sup> Gilson, L., Palmer, N., Schneider, H. 'Trust and health worker performance: exploring a conceptual framework using South African evidence. *Social Science and Medicine* 61 (2005) 1418-1429.

<sup>52</sup> Coeytaux, F. 'Celebrating mother and child on the fortieth day: the Sfax Tunisia Postpartum Program.' *Quality/Calidad/Qualit* No. 1. New York: the Population Council, 1989.

<sup>53</sup> Heggenhougen, H K, Hackenthal, V. and Vivek, P. *The Behavioural and Social Aspects of Malaria and its Control (TDR/STR/VOL/030*. UNDP/ World Bank/ WHO/ TDR, 2003.

movements of people, urbanisation and new information technology providing unprecedented access to images and sounds from across the continent and beyond, new popular cultural forms are emerging that blend African and imported elements. While the wealthy and middle classes view satellite TV, in urban areas many poorer people can also consume these cultural forms. Many small local cafes have TVs and even some long-haul buses show videos video parlours provide access not only to football matches, but to other forms of entertainment, some of which is produced on the continent. West African tailors create fantastic designs; Nigerian film makers produce entertainment that enjoyed at home and in East Africa; Kenyan local artists have taken the decoration of 'matatu' mini-buses to new heights<sup>54</sup>; popular singers, such as the 'rai' artists of North Africa blend diverse musical elements to shape and reflect contemporary themes.

44. In order to overcome some of the obstacles to the control of malaria, TB and, in particular, AIDS, political leaders and health promoters should tap into popular youth culture, transmitting positive messages through youth media. For example, East African TV broadcast from Tanzania, combines pop-videos with condom promotion as 'cool'. As East African TV has done, lines between entertainment and health promotion should be blurred in the interests of reaching more young people. Existing good-will ambassadors for malaria, TB and HIV prevention should be joined by celebrities, such as African footballers or rappers and DJs, who have high credibility with youth. In particular, messages from celebrities from the entertainment world about the availability of AIDS treatment combined with the continued importance of HIV prevention, should lessen denial and ignorance, and contribute to a reduction in stigma for people living with AIDS. In Nigeria Femi Kuti has set an excellent example, by talking openly about AIDS and promoting HIV prevention. He should be joined by many more African stars.

(e) **Urban sub-Cultures**

45. With increasing numbers of young people born in cities, ethnicity is becoming less of a marker of cultural identity. Popular youth culture for many is an important part of their identity and a major influence on behaviour. Different elements of youth culture may promote or undermine health. For example, drug centred sub- cultures are a way of life for many young people. For example, in East Africa, khat use is increasing fashionable amongst young people. Of particular concern is the recent spread of heroin in a number of African countries. Within the continent, it has long been assumed that injecting drug use (IDU) is rare or non-existent. However, studies from Dar es Salaam in Tanzania report on an emerging youth sub-culture of heroin injectors<sup>55</sup>, and alarming practices of needle sharing and blood exchange by female sex workers, amongst close knit groups of young people who share a common street-language and raise money together for subsistence and to purchase drugs<sup>56</sup>. These women are part of a sub-culture of heroin users that spans East Africa. In an increasing number of African countries (including Kenya, Tanzania, South Africa, Nigeria, the Seychelles, Mauritius and Egypt) injection drug use has been reported<sup>57</sup>. Evidence about the spread of heroin use, and associated sharing of injecting equipment between users living in large towns, is mounting. Some data on the HIV rates of drug injectors also exist. In Nairobi and Mombassa (Kenya) 50-70% of heroin injectors were found to be HIV positive<sup>58, 59</sup>. Harm reduction approaches, including needle exchange programmes, reduce the sharing of injecting equipment and therefore HIV risk, and promote drug-abstinence and

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<sup>54</sup> Carrier, N. "Miraa is cool": The cultural importance of miraa (khat) for Tigania and Igembe youth in Kenya. *Journal of African Cultural Studies* 17(2), 2005, pp201-218.

<sup>55</sup> McCurdy, S.A., Williams, M.L., Kilonzo, G.P., Ross, M.W., Leshabari, M.T. (2005). The emerging heroin epidemic in Dar es Salaam, Tanzania: Youth hangouts, 'maghetto' and injecting practices. *AIDS Care* 17 (Supplement 1): S65-76.

<sup>56</sup> McCurdy, S. et al. 'Flashblood' and HIV risk among IDUs in Dar es Salaam, Tanzania. *BMJ*. 2005, 330.

<sup>57</sup> Jones. S. and Needle R. CDC Review of the evidence for injecting drug use in Africa, 2005; UNODC assessments and reports

<sup>58</sup> Ndeti et al 'Study on the assessment of the linkages drug abuse, injecting drug abuse and HIV/AIDS in Kenya: A rapid situation assessment.' UNODC, 2004.

<sup>59</sup> Odek-Ogunde, Maurice, Lore, Bill, Owiti, F.R, Munywoki, S & Moor, J.A. (2001). World Health Organization Phase II Drug Injecting Study in Nairobi. Rapid Assessment and Response Report

safer sexual practices amongst groups of injecting drug users. Such harm reduction approaches should be included in HIV prevention efforts in Kenya, Tanzania and other countries where heroin has become an easily available street drug that is injected.<sup>60</sup> The emergence of sub-cultures of heroin injectors in many parts of Africa, serve as a reminder that, in order to tackle HIV effectively, new social and cultural trends must be recognised and responded to with appropriate and timely interventions.

## VII. MITIGATING THE SOCIAL AND ECONOMIC EFFECTS

### (a) Impact of Disease on Development and Security

46. While Africans continue to show great resilience in the face of high levels of illness and death from malaria, TB and HIV/AIDS, these diseases are impacting negatively upon development. Thus, it is estimated that malaria has slowed economic growth in African countries by 1.3% per year.<sup>61</sup> Malaria keeps children away from school and adults from their work, and lowers productivity.

47. It is estimated that per capita growth in half the countries in sub-Saharan Africa is falling by 0.5% -1.2% each year as a direct result of AIDS.<sup>62</sup> AIDS was declared a development crisis by the World Bank in 2000, and in 2003 the AU recognised AIDS as a 'cross cutting issue'.<sup>63</sup> AIDS overburdens health and social systems and hinder educational development. Agricultural and industrial production is also negatively affected as large numbers of the workforce fall ill. In many countries of sub-Saharan Africa, as families and communities are struggle to cope with HIV and AIDS, their local social support systems are strained, just as the educational and health services provided by their governments are under stress. Assistance can only be mobilised by careful planning that aims to mitigate the effects of AIDS within a long-term development strategy. More government support is required to ensure social stability, and to reduce social disruption and human suffering .

48. AIDS has undermined the education system in a number of countries. With teachers ill, dying or caring for sick family members, schools have closed in some areas<sup>64</sup>. Demand for schooling also falls as students leave school to care for people living with AIDS, to contribute to household incomes by working, and because they have been orphaned and there is nobody to pay school fees. Being out of school, increases vulnerability to HIV for children. Hence, the vicious cycle continues. The challenge is now to ensure that sufficient teachers are deployed and that vulnerable children are supported to remain in education.<sup>65</sup>

### (b) Orphans and Vulnerable Children

49. By 2004 it was estimated that 14 million children under the age of 15 had lost one or both parents to AIDS; 82% of these children live in sub-Saharan Africa. The death of parents creates many painful experiences for children. These include: economic hardship; lack of love and attention; withdrawal from school; psychological distress; loss of inheritance; increased abuse and risk of HIV infection; malnutrition and illness; stigma and discrimination.<sup>66</sup> Some orphans are HIV positive themselves and require comprehensive support. In addition, some children take on responsibility for younger siblings, with all the attendance pressures of being a household head and caring for others.

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<sup>60</sup> Odek-Ogunde, Maurice. 'Harm Reduction as an alternative strategy for prevention of drug abuse and HIV/AIDS in Kenya.' Third Annual Meeting of Global Research Network: HIV Prevention in Drug-Using Populations. Durban, South Africa, 2000. pp113-117.

<sup>61</sup> The Abuja Declaration, 2000

<sup>62</sup> GFATM: Fighting AIDS. 31/03/05 <http://www.theglobalfund.org>

<sup>63</sup> Maputo Declaration in HIV/AIDS, Tuberculosis, Malaria and other related infectious diseases. 2003

<sup>64</sup> Elbe, S. *Strategic Implications of HIV/AIDS*. The International Institute for strategic Studies, Adelphi Paper 357, Oxford: Oxford University Press. 2003

<sup>65</sup> UNESCO and other UN agencies, together with DFID, USAID and The World Bank. *HIV/AIDS and Education: A Strategic Approach* 2002.

<sup>66</sup> UNICEF. *A framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS*. 2004

50. Local communities, together with NGOs have taken much of the initiative in providing support for orphans. Families, and in particular female and children- headed households, require most support. The introduction of cash transfers to some such households in some countries is to be welcomed. However, governments and international donors need to develop comprehensive responses to the plight of orphans and vulnerable children in many countries. An important first step is the improved legislation that protects the rights of children.

51. In addition to the orphaned children, an even larger number of children are vulnerable to HIV because of poverty, hunger, armed conflict, harmful child labour practices and sexual abuse by adults. As AIDS continues to impact on communities and countries, undermining the social fabric, the vulnerability of children is set to increase. Much of the response so far, has been to see children as helpless victims and to hand out food and clothes. Children should be viewed as active members of their communities and partners in development and care. Poor urban children, including street children, have joined sub-cultures that may be centred on drug use, but also provide mutual support and comfort. These sub-cultures should not be ignored as peer pressures and norms will operate and may increase or decrease vulnerability to HIV.<sup>67</sup> While in most African cities more male children live on the streets, girls are at risk of sexual abuse through their work as domestic servants.

(c) **The Armed Forces and the Effects of War**

52. Civil unrest and war cause the movements of large numbers of people, both within and between countries. Refugees are internally displaced persons are particularly vulnerable to malaria, because the camps they occupy are often in environments prone to vector breeding. In addition, the poor conditions of most camps make it difficult to effectively screen and treat people for malaria. The movement of troops also contribute to the spread of malaria. Soldiers coming from malaria-free areas may be stationed in malarious areas and suffer from particularly high rates of malaria, due to their lack of immunity. After their tour of duty they may bring malaria back to their area of origin, thus, spreading the disease to their home area.<sup>68</sup>

53. In some African countries, members of the armed forces have rates of HIV infection between double and five times that of the general population<sup>69</sup>. However, it is not always the case that military populations have a higher prevalence of HIV than civilian populations. Rather, it is suggested that HIV levels in armies depend on many factors including the demographics of the army, the nature and stage of the epidemic in the country concerned, and the measures taken to control the disease by the military authorities.<sup>70</sup> There is evidence which suggests that HIV is not necessarily spread by soldiers: many countries that have suffered civil wars over 10 or more years' duration have lower rates of HIV than their neighbours. The possible explanation for this is that in conditions of war, health services are disrupted and less safe injections are given.<sup>71</sup> Although this argument may be contested by many, it is a sober reminder that health services must work towards ensuring 100% injection safety.

54. However, regardless of the effect of war on HIV transmission, countries should ensure that their troops have the knowledge and means (condoms) to prevent infection. Improved services for treating soldiers with AIDS should also be developed. Such measures will improve the health, and therefore the capabilities of the armed forces, as well as increasing morale. Hence, HIV prevention and AIDS treatment within the armed forces are in a nation's best interests.

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<sup>67</sup> Lockhart, C. 'Kunyenga, "real sex" and survival: assessing the risk of HIV infection among urban street boys in Tanzania.' *Medical anthropology Quarterly*. 16(3):294-311, 2002.

<sup>68</sup> Heggenhougen, H K, Hackenthal, V. and Vivek, P. *The Behavioural and Social Aspects of Malaria and its Control (TDR/STR/VOL/030*. UNDP/ World Bank/ WHO/ TDR, 2003.

<sup>69</sup> Elbe, S. *Strategic Implications of HIV/AIDS*. The International Institute for strategic Studies, Adelphi Paper 357, Oxford: Oxford University Press. 2003

<sup>70</sup> Whiteside, A., de Waal, A., Gebre-Tensae, T. 'AIDS, security and the military in Africa: a sober appraisal.' *African Affairs* advance access, published online 18 January, 2006.

<sup>71</sup> Gisselquist, D. 'Impact of long-term civil disorders and wars on the trajectory of HIV epidemics in sub-Saharan Africa. *Sahara: Journal of Social Aspects of HIV/AIDS* 1(2), 2004:114-127.

**VIII. SECTION 8: NEW SOCIAL AND CULTURAL APPROACHES TO OVERCOMING BARRIERS TO REACHING TARGETS.**

(a) **Introduction**

55. This final section summarises the possible new approaches to tackling malaria, TB and HIV/AIDS that have been discussed in the main body of the paper. These are not recommendations in the sense of clearly defined actions for particular programmes. Rather, these recommendations are intended to provoke thought and reaction and to stimulate new ideas about how society and culture affect the health of Africans. They highlight the need to recognise cultural and social change and to respond differently to it. They are aimed at the enhancement of high-level leadership, and hopefully, present challenges to entrenched views of the world and ways of doing things. They are not ranked, but are presented in the order in which they occurred in the main text.

(b) **The Broad Recommendations**

- 1) Civil society and government partnerships should be fostered in order to enhance accountability and transparency of health expenditure, both at national and district levels. Particular attention should be paid to monitoring the distribution of ARVs and eliminating informal charges and irregularities in the application of inclusion criteria. The NEPAD Peer Review System should address the issue of ARV role-out as a matter of urgency.
- 2) Male leaders are respectfully urged to act as role models and to set an example, by examining their own sexual behaviour, the culture (both traditional and modern) of which it is a product, and rectifying any conduct that exploits or harms women. At the programme-level, HIV prevention should put more emphasis on working with men, in order to protect both their health and the young women who are most vulnerable to infection. Men should not be blamed for their conduct, but encouraged to explore their ideas of masculinity and their relationships to women.
- 3) One important, but often underestimated, barrier to health care access is the attitude of health workers towards either all service-users or towards particular ethnic groups or the poor. Training programmes and refresher courses for health workers should have an added component about the importance of inclusion, especially for the poor, and respect for other cultures and religions in their work.
- 4) In order to harness the power of religious groups to the cause of tackling the three diseases, high level and serious engagement with religious leaders is required. This should be on the level of serious theological debate within Christianity and Islam, and address the interface of morality and doctrine with health promotion. Once national-level leaders, such as Archbishops, independent church leaders, Chief Qadhis and Imams have been engaged in debate and deliberation, the results should be disseminated to the regional level, and debates continued.
- 5) A shift in thinking away from viewing 'culture' as a conservative and tradition-bound barrier to health seeking behaviour, and towards embracing popular culture as a medium for reaching and communicating with youth is called for. This move could be important, not only in terms of HIV and AIDS control, but also for tackling TB and malaria. After all, most parents of young children are young themselves, and perhaps can best be reached through the medium of popular culture.
- 6) Recruiting youthful African celebrities from the entertainment and sports world to raise awareness about the prevention and treatment of the three diseases. This will contribute to the reduction of stigma concerning TB and AIDS. In particular, celebrities who are willing to publicly declare their HIV positive status will change the culture of silence that persists around the AIDS epidemic. Political leaders should also re-pledge themselves to stimulating interest in the three diseases through speeches and other public platforms.
- 7) Injecting drug users are an emerging group causing concern in a number of towns and cities across the continent. Experience from other parts of the world and data from Kenya indicate that African IDU have, or are likely to have, very high HIV rates. Harm reduction measures for

IDU should be part of HIV prevention in affected countries. Kenya has taken a lead in including IDU needs in strategic plans. The timely implantation of plans is now required.