27. Seeking to optimise care for HIV positive women and extending the gendered rights' discourse —conceptualising the dilemmas, with illustrations from fieldwork in rural South Africa [1]

Gill Seidel

Introduction

It seems important in an encounter of this kind, where we have the rare opportunity as social scientists to take stock, not simply to report in a seamless fashion on recent work, as is customary in medically dominated conferences, but, instead, to emphasise the very different discursive frameworks and intellectual agendas that we as social scientists bring to the field of STDs and HIV/AIDS (Schoepf 1991) —and in which our potential contribution has been marginalised (Seidel 1994); and, against this backdrop, to identify and articulate certain dilemmas which hitherto have remained largely unreflected, partially silenced, or remained semi-digested experiences.

The competing discourses and their various effects have been discussed in more detail elsewhere (Seidel and Vidal 1997; Seidel 1993a, b; 1996c). The dilemmas are theoretical, discursive, political, methodological and ethical. These are not only abstract intellectual concerns: they have material and practical implications (Seidel and Vidal 1997); and impact on women in particular ways.

Many interventions and policy decisions have not been well informed. In the place of 'quick, ugly fixes' (Obbo 1994), what is needed is a reflection on the origin and status of what passes for knowledge, and on our 'ways of knowing' (Schrijvers 1992), and an analysis of the social relations of power, to include gender relations. Much of the emphasis of health promotion has been on the 'health consumer' as an individual. This neo-liberal discourse is deeply problematic in that it ignores the crucial importance of social actors and new social forces in bringing about change (Escobar 1992). It also ignores the different experiences of women and men, and hence of the historical and social construction of gender.

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This introduction seeks to provide a critical framework through which the research questions and ethical concerns underlying this South African-based work and dilemmas that arise from the possible applications of findings from a pilot study on confidentiality, care and gender (Seidel and Ntuli 1996; Seidel 1996a; Seidel 1996b) may be more clearly conceptualised and addressed.

The centrality of rights' discourse — but what happened to care for women?

It had been argued, notably by Mann, that an emphasis on *rights* offers an extremely powerful analysis of societal dimensions of vulnerability to HIV and a guide to action (Mann 1996); and one which could put some people at odds with government and other sources of power, including health bureaucracies. This is now a more widely shared view, and one that highlights the importance of NGOs and advocacy groups, including women's rights groups, in the building of civil society, and as agents of social change.

Prior to the AIDS epidemic, progressive health professionals in Southern Africa emphasised the essential political link between human and democratic rights and the physical and mental health of entire populations. These are crucial insights for us all, North and South.

Another important link, in terms of ethics and rights, is that between prevention and care. This was emphasised by TASO, Uganda, the first indigenous AIDS Support Organisation in Africa, as early as 1987 in lobbying the first Director of the AIDS Control Programme. Their voice was not heeded at that point because it was a minority voice. It had been decided by the North to prioritise prevention, and condom use, with no linkage to care provision, or in-depth research. The ethical link between prevention and care has been stressed more recently by clinicians and NGOs (de Cock *et al*. 1993). The non-prioritisation of care, and of research (Huber 1993) into the social contexts of transmission is extraordinary and disturbing.

The single emphasis on prevention may be interpreted as an effect of the North-South divide, that is, the distinction between resource-rich and resource-poor countries in which this resource gap and counselling women about condom use were seen as largely non-problematic (Worth 1989; Bledsoe 1990). It also served to obfuscate *the gender of care,* in part through the convenient inflation of a 'culturalist' myth about the endless capacities of the African extended family and their 'coping mechanisms', with little gender specificity or gender equity concerns; and, lastly, it also ignored the clinical manifestations of AIDS in women (Berer and Ray 1993; Denenberg 1990). These skewed perceptions and silencing constitute an ethical and conceptual scandal.

Epidemiological discourse has had other effects. In choosing to focus, as a first step, on a category of working women —'prostitutes', a Eurocentric and moralistic category (Pheterson 1990), as ' high risk groups'— and on pregnant women as sentinel groups, among the first

to be tested, a simplistic dichotomy has been set up between 'good' (married) and 'bad' (more independent) women, which has ignored women's real situations and needs (Hamblin and Reid 1995; Hadden *et al*. 1995). Through this discourse and its effects, women are being positioned as 'vectors', or as potential educators and carers for men and children, and of the community. This may be seen as an extension of their 'natural' role as mothers, part of 'naturalist ideology' (Guillaumin 1978). While motherhood is an important relationship, and, in most of sub-Saharan Africa, and especially among grassroots populations, it conveys important status (Preston-Whyte 1993), this construction is reductionist in that ignores women as social and political beings outside and irrespective of their biological function (that is, it ignores *social gender* as opposed to *biological gender*) (Mathieu 1985; 1991). The title of an important article that sets out to redefine the needs of women and sets out to undermine this discourse is entitled: '*Neither madonnas or whores*' (Carovano 1991).

What these epidemiological interventions also mean is that there is no specific care provision for women who are the most affected by the epidemic (Berer and Ray 1993; Seidel 1993b); and that in a heterosexist ideology, women are being further instrumentalised into providing unpaid care for men and children, and entire 'communities', irrespective of their own health and serostatus.

It is these fundamental divergences between medical and social sciences cultures and agendas, and the sidelining of *gender and development discourse* (Kabeer 1994) that account not only for very different conceptualisations of risk but also for very different research designs, ethical practices, and modes of evaluation.

The politicisation of medical culture in South Africa

In South Africa, a country in transition, the strength of AIDS activism is that it has been able to draw on and extend the official rights' culture. Liberal notions of human rights are being extended to include gender rights (Peters and Wolpe 1995; Mabandla 1995), and different sexualities, fracturing the limited liberal and enlightenment discourse (Capitan 1988; 1993). At the same time, there is an ethical concern that women alone should not be the prime 'targets' for IEC, as this would seem to justify their blaming for HIV spread (Strebel 1993; 1995). Other South African work has given particular emphasis to gender-based violence (Armstrong 1994) and the particular socio-economic conditions, especially of STD spread, in which homelessness (Evian 1995) —not a membership of an epidemiologically defined 'risk group'— constitutes an important 'risk environment' (Zwi and Cabral 1991). This constitutes a break with epidemiological discourse on AIDS.

With differing emphases, the official rights' culture and rights' discourse has stimulated a broader conceptualisation of risk, particularly in the townships. This understanding of the multi-level factors has extended to include a widespread concern with male

violence, and with women and child abuse. This could not be conceptualised within the medico-moral discourse. Advocacy groups have sprung up in many communities, linked to existing NGOs and women's groups, including in Kwazulu-Natal. The ubiquity of rights discourse, at least in the cities and townships —but not extending to rural areas— means that these abuses are not conceptualised exclusively within conventional structural terms of poverty and deprivation and joblessness, although this legacy will continue to resonate in every area of activity. Although these discourses derive from different productions of knowledge, what they have in common is a concern with power and its multiple sites, including gender relations, gender construction, and the political interests of gender (Jones and Jonasdottir 1988). A problem with conventional medical culture is that gender is not an analytical category.

It is this same focus on gender, within a broader rights' framework, to encompass women's rights, and involving special interest groups, that has helped to put sexuality, sexual health and gender-sensitive HIV intervention programmes on the agenda (AHRTAG 1994; Gordon 1995; Heise and Elias 1995).

Our main argument here is that the accessibility and legitimacy of rights' discourses, and the foregrounding of the gender in development paradigm, provide insights into and help to conceptualise vulnerabilities to STDs and HIV (Seidel and Vidal 1997). These discourses, together with more adequate conceptualisations of the many sites of power, assisted by social and political theory revisited by those who have been marginalised by them, help to illuminate the processes of stigmatisation and marginalisation. It is not only women's symptoms that have been ignored but women's specific needs for information, care and support.

Public health discourse as a false universal: conceptualising the pilot project concerned with gender and prioritising care for rural women

This pilot project in rural Kwazulu-Natal was conceived in early 1994, during a workshop in which a formative evaluation of a home-care programme was presented and discussed (Soldan *et al*. 1994). This programme was a first for South Africa, inspired by exchanges with Chikinkata, in rural Zambia; and located in a very under-resourced region that encompasses remote homesteads and difficult, mountainous terrain.

The principal recommendation of the evaluation, received as pragmatic and common sense and non-problematic, was that in pre- and post-test counselling sessions, patients should be encouraged to name a care-giver. There were persuasive public health reasons for this decision: it would facilitate the work of nurses who were not able to educate the 'family' because of medical confidentiality.

But what of the gender dimension? Public health discourse is not gender-specific: it fails to differentiate between men and women who

are HIV symptomatic, or who have AIDS. But in practice, the apparently gender-neutral proposal to name a 'care-giver' and 'educating the family' both mask the political realities of caring, and differential access to material and symbolic goods, including decision-making. It also failed to take into account the largely informal data, some of which was available at the same meeting from testimonies of women with AIDS, and from elsewhere (Temmerman *et al*. 1995), that some women who share their experiences are rejected and beaten, and made homeless (Seidel and Vidal 1997). In other words, this principal recommendation framed within public health discourse was problematic in that it took the man as the norm. It completely passed over women's experience.

A more detailed investigation was important; and this is the genesis of this pilot research undertaken in 1995. Although rural women have been explicitly prioritised for STD and HIV interventions in the South African Reconstruction and Development Programme (1994), very little work has been carried out concerned with and in cooperation with people with HIV/AIDS in rural contexts, in South Africa or elsewhere (Preston-Whyte 1995). This lack of data invites a series of reflections.

The main research questions that exercised us were these:
1. What are the discourses that construct gender, and their effects, in relation to care in our fieldwork area?
2. Through what agencies, in what conditions, and in what time-scale can more gender-sensitive agendas be introduced, questioning the dominant social construction of gender and gender ideologies, and thereby accessing or extending rights' discourse and knowledge in a participatory fashion, with the awareness that vertical programmes do not work?

The pilot project: narratives and the choice of gendered parameters

The policy-related project in KwaZulu-Natal was formulated as a pilot study of confidentiality, gender and care, working in a deeply rural area, in Hlabisa, in a region whose economy is shaped by labour migration. Findings have been briefly reported in correspondence to the *Lancet* (Seidel and Ntuli 1996; Seidel and Coleman 1998).

The objective was to elicit gendered experiences of disclosure from a sample of women and men, diagnosed as HIV+, after receiving pre- and post-test counselling. There is a policy operating in Hlabisa to assist towards disclosure (Seidel 1996d) —and of receiving and, no less importantly, of expectations of care, since many were still well.

This kind of information is emphatically not available from questionnaires or KAP type surveys favoured by the WHO. But it is not only a question of methods, but of conceptualisation and different productions of knowledge. Access to respondents was negotiated through nurse-counsellors in order to respect confidentiality. The local peer support group also facilitated access and acted as initial hosts. To elicit this highly sensitive information, and to be able to

discuss it with interviewees to seek further information in a form of dialogue, to which we hope to return, an innovatory methodology was designed (and pre-tested elsewhere in the region), influenced by dynamic storytelling work in South Africa (Watson 1994; Seidel 1994), using two mini-narratives, or 'vignettes', *Joseph and Thandi's story*, and *Zanile's story* respectively. After the telling of each story, questions were constructed around gendered parameters. We were specifically concerned with gendered attitudes to care (for example: in Joseph and Thandi's story, who would care for the wife in the village? for the girl child? boy child? And the reasons for naming/not naming a particular person as carer).

Discussion of the key answers, which involved explanations, not merely yes/no or closed responses, called for a reflection around the gender of care and of care-related decisions (e.g., Who decides if there is enough money to travel to the hospital?). Responses involved reactions, repercussions, explanations (often justifications), with the first set of narratives relating to a semi-fictitious but realistic situation —the category of 'faction'. Questions were also attached specifically to TB, STDs and HIV and in whom the main 'factional' character in each of the two narratives, respectively a man and a pregnant woman, would be likely to confide about their TB, STDs and HIV, and why.

Then, in a second order narrative, the interviewee was invited to respond to the same basic questions around disclosure and care not in respect of Zanile's or Joseph's or Thandi's likely decisions, options and priorities, but in terms of their own experience. In the second order narrative, they would reply in the first person, describe the reactions, care or rejection experiences and by what sex, in the present, recent past, and projected future. Finally, we set out to elicit some initial idea of their hopes and precise needs, including but not only narrowly 'informational' as in a predominantly medicalised view, in a 'rewriting'/'retelling' by them, of the 'best' scenario for their situation. The stories were told in accesssible Zulu and the questions translated and put by Neli Ntuli, research worker and nurse-counsellor based at Hlabisa Hospital, in joint interviews.

Findings

What emerged quite strongly from this albeit small purposive sample of eight women and seven men —the exemplary study of male sexualities in the mines (Moodie 1990), and a sensitive study of sexworkers in KwaZulu-Natal (Abdool-Karim *et al*. 1995), were also based on small numbers— and of particular interest to us here were three findings.

First, the isolation of women, who, if married, are far removed form their own biological families in a patrilocal arrangement; and the isolation of unmarried women who expected little support, other than for tuberculosis, even from their own mothers, pointing to a lack of solidarity between female generations.

The married woman in the narrative would be blamed for passing on HIV to her largely absent husband, a migrant worker, despite the number of his own sexual encounters in the town, certainly by her mother-in-law, who would be in control of the home, of household decisions and expenditures, the husband's absence, and that *'she would probably hate her'*.

Yet it was supposed that the same mother-in-law would be the carer for the despised daughter. It was difficult to draw out the implications as to the likely quality of care. Perhaps this was obvious. And some men respondents showed marked impatience when we sought to engage further discussion on gendered issues.

Secondly, the genderisation of care was expressed in fundamentally biological terms: a woman was seen as the 'natural' carer —by both women and men:

'*Because she has suffered: she has known pain through childbirth. She knows what suffering is'*

It follows that all men, married or single, can anticipate receiving care from a mother, girlfriend, or wife.

Only one respondent, a young, formally uneducated man, who had lived in a large township, suggested that a care-giver for a man or a woman could be a friend, and of either sex, but would be more likely to be a woman, indicating at least the potential acceptability from his broader perspective of a man as a carer.

Thirdly, the lack of reference to 'community', a ubiquitous reference in the townships where it is a vibrant source of shared experience and shared political activism (although open to manipulation by various interests, including by NGOs and researchers). While some insisted *'the government should help us'* in terms of free medicine and treatment (which goes against the 'fee for service' philosophy now common to neo-liberal health reforms (Walt 1995) in both the South and the North), one man, who was already very sick with pulmonary tuberculosis had internalised existing economic structures and spatial arrangements of hierarchy and exclusion. His 'ideal' scenario was one in which special huts, or small villages, would be built for people with AIDS, like the huts built by white farmers for their labourers (where conditions are among the worst in the country). Here they could share basic facilities and live among themselves, women would care for their families, and people there would not have to worry about hostility from outside. This is a poignant illustration of how care ideologies are embedded in existing social relations and social structures, in this case both racist (apartheid labour policies and arrangements with exploited black labour on white farms) and heterosexist (the unproblematic assumption that it is women's function to care for men). It was an arresting illustration of the seeming 'naturalnesses' of such discourses and arrangements.

We included a question about the usefulness or otherwise of an organised support group, which took a long and participative

paraphrase to explain in Zulu. Most thought that a group of people like them, an ASO, could help, but transport and money for transport was a major problem, and many lived in very remote homesteads, at some distance from a road. Others, particularly women, commented that it would be depressing as they would talk all the time about illness. But they thought it could be good for them if they could do other things and have some source of amusement. For most, electrification would be a great advantage.

The urban and rural divide and the dilemma of gender advocacy: transgressing boundaries

The findings clearly suggest that women need specific support and care provision. How can these pilot findings be used to inform AIDS work and gender advocacy in the region in which rights' activism in the towns has no equivalent in rural areas, and where very different discourses are in circulation.

Networking is crucial; and this may lead to different productions of sense, through working dialectically and 'sideways' (Schrijvers 1992). The findings have been welcomed by the institutional hosts, by the rurally-based regional co-chair of NACOSA (National AIDS Convention of South Africa), who liaises closely with the regional PWA group, and has been a key player in AIDS health promotion in the region; and by a woman doctor at Hlabisa who has played a crucial role in encouraging peer support groups and community education (McCoy and Coleman 1995; Seidel 1996b; Seidel and Coleman 1998). Coleman's work has included taking the initiative and much of the organisation around the production of an important Hlabisa video made with people with HIV/AIDS who speak directly to camera.

Our shared concern is with the interpretation and possible application of these findings in such a way as to make existing programmes more gender-sensitive, as a development of the existing peer education and peer support schemes in the region.

But what of regional rural discourses on gender relations? Although discussions on the high cost of *lobola* (bride-price to be paid by the groom) are commonplace throughout KwaZulu-Natal, including on Radio Zulu, questions of gender ideologies, of gender construction, of the gender of care, and gender rights are not. Most discussions come down to a defence, albeit in some cases a resigned defence of 'traditional' warrior culture, where warriors in the service of famous kings defended the 'Zulu nation', against the British invaders, are still celebrated, but now manipulated by and a hostage to divided IFP (Inhkata Freedom Party) ambitions in the region.

> 'You need to know our Zulu men and to understand our culture. Our men are hard. They are like that. You know about our warrior tradition? How can we change our culture?

> Some of us want to change lobola - it costs too much. People are greedy. But other say we should keep it —as our culture is all we have left. We have lost everything else'.

This is a summary of the somewhat ambivalent response when the researcher attempted to raise these issues informally with Zulu-speaking women in Hlabisa and the environs, irrespective of their educational background. However, more critical responses are provided from a small number of women discussants, community and health workers from the region, who identify as Zulus and as South Africans, and who have been more exposed to rights' culture, including gendered rights. Their informal comments provide a gloss:

> 'Yes, that is the culture here, that is true. People value their culture very highly. We are proud of it. But that is not the only influence'.

There is a dynamic sense here that the gender problems are both more universalistic and more particularistic. Mobilising this more dynamic discourse on gender, culture and identity, that is also produced and circulated within the region, through drama of the kind inspired by Boal's Theatre of the Oppressed (Boal 1995) may be the most appropriate way forward in this context to develop this critical process. Academic or 'outsider' knowledge, both negatively connoted, is more likely to be viewed with suspicion in a setting where distrust of 'outsiders' of any origin was fostered by apartheid's enforced separations, including ethnic divisions among black South Africans, and by other processes (Mare 1993); and suspicion of 'outsiders' remains very vigorous at all levels of society.

A comparable ambivalence in the construction of gender and regional identity, where this region, the stronghold of the ultra-nationalist and 'traditionalist' IFP, denotes 'Zulu-ness', has been acted out in AIDS education through school performances. Dramaide, hitherto a regional-based AIDS-related drama initiative in KwaZulu schools, seeks to encourage AIDS education through performance, and largely through dance. Some codes appear to be undermined, where schoolgirls perform dances conventionally performed by men. This may set the scene for a fracturing of dominant gender ideologies. Schoolgirl participants clearly enjoy this experience of greater freedom of movement, body displays (deemed appropriate for single but not for married women) and access to particular symbolic forms normally denied to them. However, without more sustained discussion and challenges, such performances may remain 'rituals of rebellion'; and harnessed to political ends by the still dominant traditionalist culture (Dalrymple and Preston-Whyte 1996). The dilemma is that much of the dominant symbolism and references to 'nationhood' (and songs about saving the 'nation' from AIDS) inevitably may be interpreted as referring to and as grounded in the 'Zulu nation'. This is a region with a clear IFP presence in the rural areas, mainly tribal trust land, where 'traditional' values remain very strong, and where any form of minority culture or challenge is profoundly silenced.

Possibilities of extending the research partnership

It has been suggested that a new kind of partnership bringing together researchers, community activists and special interest groups may be in a better position to undertake research on gender violence (Heise *et al*. 1994) and, by implication, gender relations in various forms. This community-based insight has further implications for work on gender construction and for the extension of gender rights.

Another key development within the region, and exemplary in many ways in terms of non-vertical community education, has been that of Positive Speakers involved in talks and 'telling their stories' in community venues. This initiative, influenced by the Phillys Lutaaya project in Uganda (Amooti 1996), and a similar project in New York, has been given an impetus by work in and around Hlabisa, and the Hlabisa-made video referred to above. There is also an indication of proposed future networking with a group for rape survivors and battered women, but the origin of this proposal is not clear.

How can this process and important networking —probably the best source of support for women where limited family support is available— be assisted and sustained? And through what agencies? And in what time-frames?

The one and only 'traditionally' married woman interviewed in our very small sample who did admit that her husband was beating her (and this behaviour apparently pre-dated confirmation of their common HIV positive status) 'justified' his abuse in terms of unemployment and frustration, which has led to drinking bouts. The absence of a gender explanation is problematic in a broader and feminist perspective of rights which is present in South African urban contexts, and very strong among ANC (African National Congress) women activists.

It seems that there may be a difficult choice between a slow road —that involves in listening to women, and in this way showing that they are respected, and a faster, activist lane which stresses connecting with other NGOs and ASOs. In fact, there is already a kind of dual lane in terms of links with the national and regional PWA (People living with AIDS) associations; and where more frequent contact with PWA associations from the rest of the region, and beyond, is a great moral booster and opens up new perspectives of all kinds.

Apart from problems of unrest in the region however, the faster lane raises some ethical as well as organisational and financial problems. It could involve detaching the same small group of people away from the tiny but clearly expanding peer support group (PC Jaffe June 1996). And would most women have the same mobility as men? It is also a question of ownership of the process and sustainability —where 'outsiders' are frequently analogised as cancer and AIDS. If this initiative is not coming from a member of the existing ASO, will it be considered acceptable and legitimate, and will it work? A lot may depend on the delicate balance between 'community' input and the

involvement and the perception of 'outsiders' that would lead to a 'balanced community development' (Schaffer 1995).

Another related ethical and political dilemma concerns the ways used to silence gender questions and which also hold back the conceptualisation of male violence, including rape (Armstrong 1994), preventing it from becoming an advocacy issue locally. Family members try to 'hush' it up and not take it further (PC social worker, Hlabisa Court, September 1995; PC Z. Nxumalo 1996). Women in such situations have recourse to a series of survival mechanisms that are interiorised. Is there not an ethical issue involved in seeking to suddenly problematise this violence in deeply rural settings where no advocacy groups exist? The concern is that this could mean removing or undermining these survival strategies while there may be nothing tangible to be put in their place. (Is this not in a sense what happened to forms of knowledge when missionaries banned puberty rites in the 1930s?) Such a move could increase women's vulnerability; and it is this dilemma that would caution in favour of any fast, overtaking lane approach to this ideological and political work in this profoundly rural area.

At the same time, when women advance not specifically gendered explanations for male violence, or see it as unavoidable, it is not necessarily a form of 'false consciousness' in a marxist sense: women may be aware of the very circumscribed and subordinate nature of their lives, but are unaware of what to do about it, or have few options. Metaphors women use about themselves and which can be elicited can be very revealing in this respect. However, the 'power' that entails the experiential recognition of these meanings cannot be given from above: it has to be self-generated in political work with others. Some participatory learning techniques share these perspectives (Koning and Martin 1996; Pretty *et al*. 1995) in a national context in which community participation is valued (Shisana and Versfeld 1993). Different country examples and from different continents, including from South Asia and Latin America, suggest that such process can be assisted by issues by grass-root NGOs promoting innovative and participatory strategies (Kabeer 1994) —and more obviously by the creation of job opportunities where women have a greater measure of economic independence.

A particular example of community activism, one predicated on rights, is available from Clermont, a largely ANC township, near Durban. Women's organisations are particularly vocal and active in the township. Rooms have been converted adjacent to a church to serve as an informal drop-in centre where a range of information is available, on HIV, and which, at the same time, is also a centre for rights' education conducted by community activists. Encounters and exchanges of this kind could provide a political and heuristic space, disrupting boundaries. However, in much of KwaZulu-Natal at this political juncture, even to consider such exchanges, and their practical feasibility, the history of the political struggles between the ANC and the IFP (Inkatha Freedom Party) and the politicisation of spatial relations must remain part of the equation.

Conclusion

To provide specific care and support for women, rather than women being instrumentalised to care for men, and positioned by 'naturalist ideology', calls for a profound change in political culture. Gender-sensitive programmes demand that an unequivocal gender lens applied to all facets of women's lives and decisions which affect them (Cancian 1992; Heise and Elias 1995). Such programmes also call for the scrutiny of such apparently sex-neutral concepts and phrases as 'community care', including their modes of costing and evaluation, where these are almost invariably gendered and involve gender interests. Public health discourse because of its assumed and false universality cannot take account of gender relations, and hence is profoundly flawed. While a gender and development discourse is present in urban South Africa (Preston-Whyte 1995), this cannot be assumed to be the case in rural areas, where there is limited HIV related research on women's support networks and care for women. Sociological research on sexual networking as carried out elsewhere in Africa does not in itself assist women.

Public health and medical discourse may also have affinities with naturalist ideology and hence seek to perpetuate 'traditional' gender roles. An informal evaluation has been offered by a highly placed health professional in the region of 'positive living' of an HIV positive woman who, after receiving support and counselling, is now prepared to care for her husband. This is very double-edged. It carries with it the idea of potential psychiatrisation of women who do not conform. And, in general, it is also an indication and warning of how the political agenda of sexual and reproductive rights, in many contexts moved more to the centre by the epidemic and by AIDS activism, may be being subverted, and re-conceptualised within older medico-moral and 'traditional' discourses, constituting an overlapping of meanings (or vertical 'inter-textuality') (Fairclough 1992).

In evaluation for 'empowerment' (Baylies and Bujra 1995; Plaat 1995; KIT and WHO 1995), and in all work concerned with women's subordination and its effects (Elson 1991), this conceptualisation and scrutiny are usefully informed and assisted by critical social theory, by post-structural analysis influenced by post-colonial polyvocality and discursive theory; and by the kind of feminist epistemology and practice that addresses both gender and racist issues, and which seeks to analyse gender not as 'essentialism', not as a biological given —but as power relations between the sexes.

For this work to be effective, it also calls for advocacy work and activism, since a government or state cannot act as a social agency. And find ways of challenging masculinist representations that assume 'traditional', univocal forms, 'common sense' and 'naturalist' ideology —and which may be used to mask and to naturalise both gender and racist oppression.

It has been demonstrated throughout the world that sustained behaviour change is dependent on peer and community support. In much of South Africa the perception of the individual rights and

especially of gendered rights still remains weak in rural regions. It is men's, not women's experience that is not taken as the basis for theorising and enforcement (Binion 1995). Some townships women's organisations, like Clermont, have remained strong, and they contribute to and at times challenge different representations of gender within the immediate community. Together with some ASOs, and assisted by a core of progressive professionals, black and white, they constitute the new social actors. The possible 're-connections' and political opportunities are there. But it takes full-time participation, trust, and anthropological, not managerial or medical time-frames, and a shared language medium —and, no less importantly, an extended 'dialogic space' (Schrijvers 1992; 1993), in which the researcher does not disappear, in order to elicit these challenges, and to 'hear' them.

In the context of post-apartheid South Africa in which community-builders are celebrated and honoured, women are being called upon and mobilised as a rich potential resource for reconstructing violence-torn communities enabled by rights' discourses. Some of the dilemmas for women in caring roles, and the possibilities for total burn-out and unacknowledged workloads are contained in an unsolicited comment from a Zulu-speaking member not from KwaZulu-Natal, but from a Soweto-based ASO. It followed on a threatened attack on herself and her home, but which only served to strengthen her resolve:

> 'I thought I belonged to my husband. Then when I began this work I understood that I belong to the whole community' (PC, Community ASO activist, Society for AIDS Families and Orphans, Soweto, May 1994).

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Gill SEIDEL, *Seeking to optimise care for HIV positive women and extending the gendered rights' discourse —conceptualising the dilemmas, with illustrations from fieldwork in rural South Africa*

Summary — Since the start of the epidemic, African women have been positioned by goverments, non-government and community-based organisations and mobilised to provide care for their families and 'communities'. Meanwhile, women's needs, particularly those in rural areas, their access to resources of all kinds, and the support networks available to women, have not been prioritised. This pilot study based in rural KwaZulu-Natal, South Africa, seeks to analyse the support networks available to HIV+ women within a gender-sensitive framework.

Keywords: HIV/AIDS • South Africa • women • gender • care • rights • discourse.

Gill SEIDEL, *Chercher à optimiser la prise en charge des femmes séropositives et étendre le discours de genre sur les droits - conceptualiser les dilemmes, avec des illustrations tirées d'une étude en milieu rural, en Afrique du Sud.*

Résumé — Depuis le début de l'épidémie, des positions spécifiques ont été assignées aux femmes africaines par les gouvernements, les organisations non gouvernementales et les organisations communautaires de base qui les ont mobilisées pour la prise en charge de leurs familles et de leurs communautés. Cependant, aucune priorité n'a été accordée aux besoins des femmes, particulièrement de celles vivant en zones rurales, à leur accès aux ressources et à la mise en place de toute forme de réseau d'appui disponible pour elles. Cette étude pilote, menée en milieu rural au KwaZulu-Natal (Afrique du Sud), essaie d'analyser les réseaux d'appui disponibles pour les femmes VIH+ dans une perspective sensible aux questions de genre.

Mots-clés : VIH/sida • Afrique du Sud • femmes • genre • prise en charge • droits • discours.

28. Socio-cultural relations in the Nigerian family: implications for AIDS in Africa [1]

Felicia A. Durojaiye Oyekanmi

Introduction

In the mid-1980s when the acquired immune deficiency syndrome (AIDS) was first heard of in this part of Africa, many Nigerians and even health professionals referred to it derisively as 'American Invention to Destroy Sex'. Little did we realise then that we were starting to deal with a disease which would spread like wild wood fire and defy all cures (Lamptey 1994). Perhaps the most important epidemiological finding about AIDS is that sexual transmission accounts for about three-fifths of HIV infections worldwide. Even though parental transmission (blood and injections) plays a key role in the spread of HIV in some countries, it is not a major factor in driving the pandemic.

The link between HIV infection and other STDs may partly explain why HIV in heterosexual population is more prevalent in Africa than in Europe and the United States of America, where STDs are more often treated and cured. We have also learnt that women are particularly vulnerable to AIDS and that prevention programs must address their special needs (Henry 1994). The major factors that put women at risk of HIV infection are social and economic, such as poverty, gender discrimination, lack of power in negotiating sex (Oyekanmi 1994) and lack of educational and economic opportunities. The prevalence of HIV infection in Africa is highest in the 25-35 years old age-group in males, and in the 15-25 years old age-group in females. This difference is due to the fact that on the average, sexual partnerships are formed between older men and younger women. In the urban areas the distorsion of population profile caused by male migration may give a 1: 1 ratio of male: female HIV infection rate, but as the epidemic spread into the larger rural population, the absolute size of the most severely affected young female population is larger than the size of the male population, which eventually results in a higher number of infections in women.

The infection of women also adds fuel to the emerging epidemic of pediatric AIDS (Decosas and Pedneault 1992). Babies born to the

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infected women would be affected either at birth or through breast feeding. Several public health policies have been suggested to narrow the male: female age-gap of sexual partnership formation, as well as policies to address the economic migration of the male and female work force; and policies to narrow the base of the general population pyramid. AIDS and STD specialists tend to ignore the fact that the future-at-risk generation has already been born. For example, in Nigeria about 45 percent of the population is of age 0-14 years. Even if the incidence rates of HIV infections stabilises, the absolute number of cases will still continue to grow, driven by demographic forces. This trend will continue and it may well outpace any possible health programme response unless it is reversed by a decrease in fertility. An effective population policy is thus one of three imperatives for addressing the social and demographic risk factors associated with AIDS in this country as in the rest of Africa. The other two public policy areas are an effective gender and education policy and a family-friendly industrial and economic development policy.

To enable individuals to sustain behaviour change, we need to address community and societal factors, policies and structural issues that influence and shape behaviour. The most important risk-taking behaviours that are primarily responsible for the rapid spread of HIV throughout the world include frequent change of sex partners, and sex with a partner who has mutiple partners. Thus as social scientists, we need to take a look at the socio-cultural factors and cultural expectations that shape behaviour. The family being the primary unit of any society assumes a prime position in this context.

Forms of family and marriage

Our cultural practices exert direct and indirect influences on our population dynamics. By population dynamics we mean those aspects of our lives which have consequencies for mortality (as well as morbidity), fertility and migration —all three of which constitute the main components of population change. These in turn have bearing on the issues concerning HIV/AIDS in any country.

What do we mean by culture? As defined by Edward Taylor, culture is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of the society (Olurode 1989). It means that culture is the totality of living. Some basic characteristics of culture include the following: culture is shared, it is learned and not genetically transformed. Cultural traits, mode of behaviour are learned through the process of socialisation in a society.

These cultural traits are usually learned within the family. In fact the family is the smallest unit of organisation within the society; much akin to the atom in science.

It has been generally noted that what constitutes the family varies from society to society. Various definitions include the nuclear family,

the extended family, and so on. Various traits are usually observed when the definition of a family is being undertaken. These include:
• family type: joint / extended
• marriage type: monogyny / polygyny / polyandry
• residence arrangement: unilocal / matrilocal / patrilocal
• life cycle or stage of the family
• inheritance system - property, widowhood
• marriage ceremony - customary / ordinance / religious.

Other traits which could influence the behaviour of members of the family include:
• value of child: child bearing practices / quality of child / preference for sex of child
• gender relations in the family: culture as regards relationship between couples, relationship to persons who are neither biological nor affilial kin / level of development / status of women / female autonomy / male dominance / education, etc.
• health care pratices and services
• family planning methods: knowledge, attitude and practice / use / availability and cost of family planning services / information, education and communication/population policy.

The structure or type of a family is usually defined in terms of the individuals comprising the family unit as well as the relationships / interactions among these members.

The family is a group of people recognised by their community as related to one another by ties of marriage. The members are bound together by relationships involved in living together. Usually the group is composed of a man and his wife or wives and their children. At its simplest form, the nuclear or conjugal family is a married couple and their children (Bloom and Ottong 1987) as shown in figures 1A and 1B.

Figure 1A: *A typical nuclear family, a husband, wife and four children. Nuclear family (monogamous)*

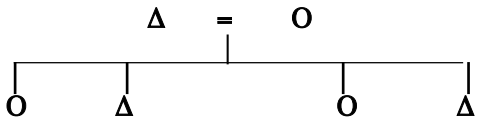
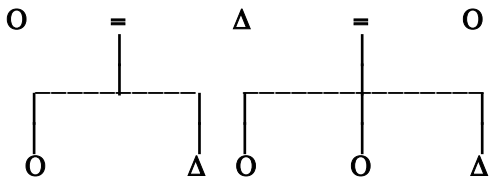


Figure 1B: *Husband, two wives and their children Nuclear family (polygamous)*



Key: Δ: Male; O: Female; = : Marriage

This is the simplest form of family. In real life there may be variations. In some families there may be adopted children. Sometimes the household may include relatives of the wife or the husband. The conjugal relationship between spouses is the major link in the nuclear family. The nuclear family is more predominant in the European and other Western cultures.

Much more common in Africa is the extended family. This is a family composed of two or more nuclear families, joined either through the line of parents and children, or by relationships between siblings. The extended family goes beyond the mother-father-children to include other relatives. It frequently spans three generations - grandparents, parents and grand children as shown in figures 2A and 2B.

Figure 2A*: Monogamous unions in extended family formation*

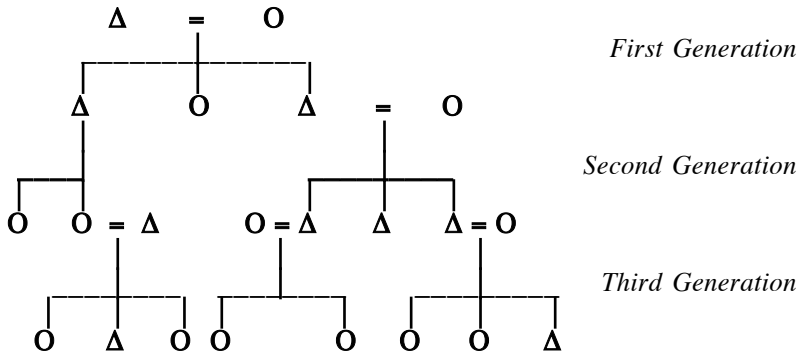
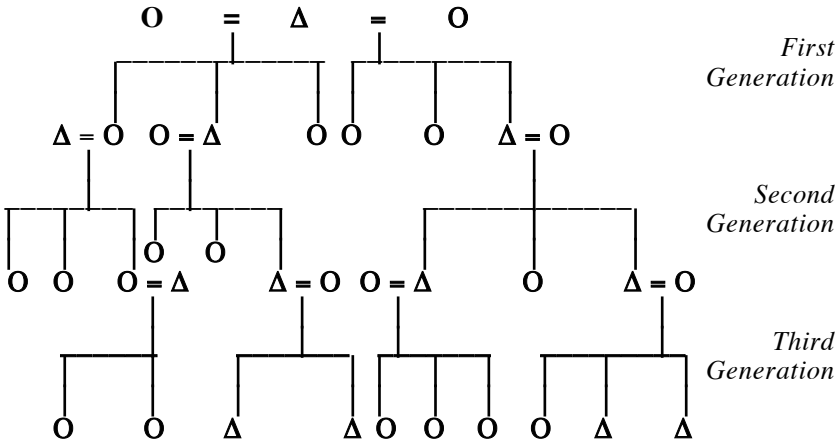


Figure 2B: *Polygamous unions in extended family formation*



Not all the members of the extended family live together in one household. In many instances, the extended family is split into smaller nuclear units, each with its own household within a compound. The summation of all the family units make up the community/society.

Sexual relations

Variations do occur in the actual sexual relations within families depending on the culture of the society concerned. For example among the Masai of Northern Kenya a woman is recognised as being married to a particular man within a lineage. However, other men within the lineage can come to her for sex at any time that her husband is away hunting or tending to cattle. This ensures that during the long stretches of time that these nomadic herdsmen are away from home, the wives are served sexually by the husband's kinsmen in a way that would maximise fertility performance. The man cohabiting with the woman at any time puts his spear into the ground in front of the woman's residential hut.

Furthermore upon return from the long sojourn away from home, the husband of the particular woman keeps away from the hut where the woman resides as long as there is another man's spear stuck in the ground in front of the hut. If the woman gets pregnant the offspring belongs to the clan/lineage so there is no question about the paternity of the child.

Another pattern has been cited among some groups in Uganda where the burial rites performed on the demise of a husband includes the purification/cleansing of his wife. Such cleansing consists of the junior brother of the deceased man sleeping with the widow and having sex with her on the night her husband is buried so as to exorcise the latter's ghost.

In Nigeria, among the Yagba of the middle belt area, there exists a custom whereby the height of a man showing his friendship to another man is for the former to give his wife to the latter to sleep with her as a mark of the closeness of their relationship. No connotation of adultery is attached to such sexual liaison because sleeping with such a wife is regarded as a way of strenghtening the men's friendship.

From the point of view of likely proliferation of sexually transmitted diseases we see that the above traditional practises in Kenya, Uganda and even the polygyny or emerging serial monogamy in Nigeria are very potentially dangerous. This is because if any single HIV positive person is within the ring of sexually networking people then the disease transmission is more or less 100 percent assured.

The succeeding sections would go on to elaborate in detail how other socio-cultural factors related to the family can affect or be affected by the HIV/AIDS pandemic.

Condom use

Although, endowed with great human and natural resource potentials, Nigeria, with a persisting high population growth rate, an infant mortality rate of about 84 percent live births, life expectancy at birth of about 54 years, a per capita income of less than US$300, poorly developed systems of education, medical and social services is still one of the world's poor and under developed countries.

The 1990 Nigeria Demographic and Health Survey shows that total fertility rate in Nigeria was 6.0. Similarly the 1991 Post Enumeration Survey after the national population census showed that the total fertility rate was 5.88 and that a woman would bear 6 children at the end of her reproductive career. While the crude birth rate was estimated at 45 births per 1000 population in the country in 1991.

The AIDS pandemic has brought into sharp focus the issue surrounding usage of condom in Nigeria; not only for reproductive health but to stem the transmission of HIV/AIDS.

In Nigeria the Information, Education and Communication (IEC) Committee of the National AIDS Control Programme has mounted a vigorous nation-wide mass-media campaign to inform and educate the Nigerian public on the dangers of AIDS, and the need to adopt 'safer sex' measures by regular use of condoms. As shown in table 1, the rate of condom use in Nigeria is still low (Obikeze *et al*. 1993) with 9.2 percent ever-use and 2.6 percent current use by male and female.

Table 1: *Ever-use condom data from NDHS (1990), DHS Ondo State (1986), and Condom Use Survey (1991)*

Source	*Year*	*Coverage*	*% Ever-Use Condom*	
			Females only	Both male and female
NDH Survey [a]	1990	Nigeria	2.5	-
DHS Ondo State	1986	Ondo State	4.4	-
Condom Use Survey	1991	Three States:		
		Anambra State	5.5	7.6
		Kaduna State	4.9	6.2
		Lagos State	13.6	15.1
		Overall (National)	8.5	9.2

Source: Obikeze *et al*. 1993, table 4.17

[a] = covered women of child bearing age.

But this figure is significantly higher than the 2.5 percent ever-use reported by the Nigeria Demographic and Health Survey (NDHS 1990). The challenge remains how to popularise the use of this reproductive health device in not only Nigeria but also in West Africa.

Although the financial cost (economic) of the condom is moderate and generally affordable, the social and psychological costs of obtaining and being associated with the condom are very high and prohibitive. Six major reasons for non use of condom are (1) misconceptions due to misinformation and ignorance, (2) inherent poor public image and old prejudices, (3) high breakage and failure rate of available condoms, (4) incompatibility with traditional sexual norms and practices, (5) high social and psychological costs associated with condom procurement and use, (6) disapproval by the major religions in the country. For example, as explained by Obikeze *et al.* (1993), the perceived availability of the condom comprises three distinct components, namely: product visibility, physical (de facto) presence, and affordability in terms of both economic and social costs. As one focus group discussant dramatically put it, persons involved in condom transaction tend to 'speak in tongues' using slang known to buyers and sellers. Low level of education was also shown to be strongly associated with negative user-acceptability of the condom.

Socio-cultural practices

The issue of power relations within the family has been much studied in different cultures. For most of the language / tribal groups in Nigeria, the husband is assumed to be the head of the household. He dictates what gets done in the family including when he has sex with his wife or wives. It is therefore inconceivable to think of a situation where the wife would refuse to grant sexual favours to her husband on demand. The woman can also not insist on the man using condom or any other protective device while having sex with her without incurring the wrath of the man. This powerlessness of the woman to negotiate conditions favouring her is even made worse if she is an illiterate, poor, and rural dweller.

The economic dominance of the male gender is such that the man's sexual relations within the family or his extra-marital affairs can endanger the health of his wife or wives without any sanction being imposed on the man (Odebiyi 1992). Odebiyi has also shown that even male undergraduate students at University of Ife though aware of the danger of AIDS, nevertheless did not favour the use of condoms. The pilot study done by Oyekanmi in Ilesa, Oshun State in 1991 (Oyekanmi 1994b) also showed this unwillingness of the men to use condom. Moreover the married women felt that even if their husbands contract any sexually transmitted disease God would not allow the wives to catch it from them. This extreme positivism has been developed in many cultures as a means of wishing away whatever bad phenomenom that we cannot control, women in particular seem to have developed this defence mechanism to a larger extent than the men.

The gender inequality in decision taking also bothers on the question of who takes decisions about health care in the family. In a large percentage of cases it is the woman who first notices if anybody is not feeling well. At home women are usually the first to be told

when someone does not feel well, and they help to decide what to do next. Most "patient" communications for and about family members flow through women; they report signs and changes, symptoms, responses to treatments and medications. It is little wonder that single or divorced men tend to have higher mortality rates than married males (Oyekanmi 1994a). However, in cases where expenses have to be incurred in order to procure a cure to any disease the woman has to defer to the husband's opinion. If the husband therefore does not adjudge the situation to be a serious problem no health care service would be sought in time to avert a disaster. In the particular case of sexually transmitted diseases including AIDS we are dealing with an issue concerned with sexuality and therefore ego factors of the male. In such cases, changes in behaviour, would be more difficult to effect. Moreover, fears for acceptance of guilt in a particular individual may cause people not to report symptoms in time. Over time experience has shown that changes come slowly, especially where issues concerned are intertwined with customs or religion and tread on vested interests (Corea 1985).

Some of our traditional practices that may have an effect on HIV transmission include circumcision of male and female newborn babies, tattoo and other tribal marks and shaving of hair with unsterilised blades. Among the Igbo a person's hair is completely shaved if he or she loses a parent irrespective of age. Moreover as part of burial rites for a deceased husband, the wife's hair is shaved.

Where these various traditional chores are done by traditional birth attendants e.g. cutting of the umbilical cord or circumcision of a newborn baby with unsterilised instruments, it is quite possible to pass on the HIV virus from one person to another. Since the incubation period for full-blown AIDS is about 10 years, one can quite imagine the number of people who can plausibly get infected in this manner.

In some cases the traditional herbalists associate AIDS with *'magun'* (Odebiyi 1992). In Yorubaland '*magun*' is a disease which is caught through having illegal sexual intercourse with any woman who has been laced with poison by her suspicious husband. The husband carefully avoids having sex with the woman after the poisoning and any man who first has sex with her subsequently is believed to catch '*magun*', the symptoms of which include jumping thrice or crowing like a cock thrice before the man falls down dead immediately. So far the antidote for '*magun*' is known only to so few herbalists that the affliction is said to have no cure. Thus men are advised to keep away from illegal sexual liaisons with women whose husbands are suspected to be wicked/jealous enough to administer such poison on their wives. Nevertheless it is noteworthy that even the few herbalists who claim to be able to cure '*magun*' have not cured any known AIDS patient.

The cultural practice of marrying girls at very tender ages —sometimes at 12 years or younger— to older men, for example among the Hausa-Fulani of Northern Nigeria and adherents of the Islamic religions, is also taught to be fraught with danger. Trevor (1975) estimated that between ages 13 and menopause the average Hausa/Fulani girl would contract three marriages. And even after menopause she is

likely to contract one additional marriage, if only for economic survival. This implies a high rate of sexual partnership and may even encourage promiscuity among the females, with the attendant danger of STD transmission. In some cases control of sexuality among members of a particular family may be difficult, especially where there is a wide age gap between husband and wife. In a study in Ado Ekiti, Ondo State, Orubuloye (1993) has found that adult sons sometimes sleep with the young wives of their elderly fathers. The other members of the family even know about these events but keep quiet out of the fear of incurring the anger of their father.

The national population policy in Nigeria recommends that each woman should have four children; while each man is advised to have a 'limited' number of wives and bear the number of children whom he can cater for responsibly (Oyekanmi and Aig-Imoukhuede 1989). So we see that even at the official governmental level there is tacit permission for sexual promiscuity among men and for high fertility in the country in general. Given the prevailing broad based population pyramid in Nigeria with about 45 percent of population being aged 0 to 14 years, as well as the prevailing high fertility levels whereby each woman has an average of 6.4 children in her life time, one cannot help but worry about the implications of the possibility of the AIDS virus being passed from mother to child. In effect pediatric AIDS —both its occurrence and spread— should begin to be of great concern to all the relevant disciplines and planners. In Rwanda, for example, 33 percent of women registering for antenatal clinics are being found to be HIV positive.

High-risk behaviour

While there are some professions which have been recognised as high-risk ones in connection with the transmission of the HIV virus, other imported cultural practices need to be looked at critically. The practices which are believed to be imported into Nigeria include homosexuality (Oyekanmi 1994b), lesbianism, wife swapping (Orubuloye 1993). The high risk occupations include long distance driving, prostitution or commercial sex work, itinerant trading especially those selling food and drink at motor parks, international traders who go from one country to another within the West African subregion and beyond in order to buy and sell goods and services (Anarfi 1992). Even members of the armed forces, police and prisons who get transferred frequently in the course of their duties and often separated from their families are also high risk.

For the most part men who patronise prostitutes do not want to use condoms because they complain that the device diminishes the sexual enjoyment and some who agree to use the device even refuse to pay up the whole charged price after the contact since they claim that they did not have 'full servicing' because of the condom.

Studies of condom use in Nigeria have also shown that age is a significant determining factor in the usage of condom, despite the

knowledge or awareness of it as a protective device against unwanted pregnancies or transmission of STD. Ogionwo and Ademuwagun (1990) in their study of south-western Nigeria showed that age 40 seems to be a significant dividing line; percentages of respondents ever use of condom were 67.3 percent for respondents under 40 years as compared with 32.7 percent for respondents over 40 years in urban areas; compared with 75.4 percent for respondents below 40 years and 24.6 percent for respondents over 40 years in rural areas. Obikeze *et al*. (1993) also found that the rate of condom use is higher among youths than old people in a national survey of Nigeria. It would appear that the older people are more set in their habits than younger ones and therefore, more likely to resist modern methods of birth control or health care innovation generally.

The issue of sexual permissiveness, moral decadence and laxity has been an age long affair, which is, unfortunately, more pronounced in recent times. Premarital sexual intercourse was not only considered a taboo, the fear of not finding suitable husbands after being disvirgined prevented young ladies from yielding unnecessarily to sexual temptations in the olden days. Besides the fear of being exposed to the gods, adultery was also seriously avoided by women in order to prevent the ridicule and shame of being caught and to avoid sexually transmitted diseases, of which gonorrhea was the most widely known. The situation is no longer the same today due to urbanization, migration in search of jobs, influence of contact with other cultures, economic strangulation of most parents, especially since the structural adjustment programme (SAP) was introduced into this country in 1986 by the government at the advice of World Bank and IMF; the get rich quick syndrome among the youths and other socially destabilising factors. It has been observed that these days students in secondary schools and in tertiary institutions of learning are freelancing as commercial sex workers in some hotels and brothels.

Moreover prostitution is no longer the preserve of the female gender. Males are also selling sex for favour. Where these males happen to be bisexual —having sex with other males and also with female depending on the circumstances— the chances for proliferation of STDs and possibly AIDS are greatly increased.

The modern health care delivery systems in Nigeria is not able to cope with the demand. It is estimated that modern medical services cover about 40 percent of our populace, while the rest get catered for by medical auxiliaries, traditional birth attendants and even quacks. 'Wonder drugs' are sold freely in our various markets. Thus the issues of screening of blood before transfusion to patients needing operations, incisions and cuts with sterilised instruments —shortage of water supply even to medical establishments are not uncommon— treatment of infections including STDs are pertinent questions which should be raised here. As of now we do not have enough laboratory facilities to even confirm the prevalence of HIV positivity in this country. On some occasions the needed reagents are not available even in the designated screening centers. Generally, it seems as if succeeding government administrations have failed to devote enough

resources to health and social services in Nigeria. Furthermore the environmental sanitation, especially in the urban centers —over-crowding in homes, poor cleanliness in all surroundings, bad drainage, etc— can lead to the propagation of diseases like tuberculosis which have been associated with symptoms of AIDS/HIV infection.

In addition to the foregoing is the high cost of procuring medical prescriptions/drugs. These have been seen to lead to a lot of drug abuse and misuse. Antibiotics and other drugs which could be effective in treating bacterial infections are grossly misused with the result that they fail to cure patients when really needed. Moreover the use of hard drugs —marijuana, heroin, cocaine, etc.— is becoming alarming in our populace, especially among the unemployed youths and these have been known to influence character formation and behaviour patterns malevolently. Obviously a person who is already high on a mind-bending drug is most unlikely to adopt safe sexual or even other health enhancing practice. Thus efforts at educating people on AIDS prevention should also link up with drug-abuse campaigns. It is necessary to stress that as of now there is no known vaccine to prevent HIV infection. Neither is there a vaccine to cure those already infected with the HIV virus that causes AIDS.

Health implication of sexual behaviours

From the foregoing discussion it is necessary to note that AIDS for now has no known cure. What can Nigeria do therefore in order to ensure that the family as a basic unit of the society acts as a reinforcing factor to stem the tide of the AIDS pandemic in our country.

First, it is important to stress the importance of parents/child interactions. What do parents pass on to their children as information on sexuality? The earlier the facts of male-female relations are given to children in emotionally free atmosphere the better for the children. In most cases the children, especially the teenagers, tend to pick up half-truths and disinformation from their friends and peers at school and during social contacts. Hence parents need to closely monitor and also discuss with their adolescent children. Parents can also be encouraged to give consent to sex education being taught in schools.

In this line, parents should be discouraged from giving out their daughters for marriage at tender ages. The minimum age at first marriage is 18 years and 25 years for girls and boys respectively as recommended in our population policy. People should be advised to respect these. Presently even the so-called leaders in the country flout this advice without any sanction being imposed on them.

Childrearing practices such as fostering, child labour as hawkers, should be reexamined in order to stem cases of rape and incest in families. Also rape victims should be well treated to avoid risk of STD.

In case of marital break-ups after the first marriage, it is essential that family support be given to the individuals so affected. This is because experience has shown that women, especially the uneducated

and poor, tend to rush into subsequent marriages as an economic expediency, much to the danger of their mental and physical health.

Religious and cultural injunctions which have been used to reinforce high fertility as well as preference for male children in our societies need to be re-examined. Even the *Hadith* in the Islamic faith says that a man or woman that can raise three females to maturity, even where he/she cannot have a male child is assured of a place in paradise. Similarly the Bible although enjoying people to go into the world and multiply, also cautions people to raise only those children whom they can cater for appropriately. Hence the stress of having many children, particular fot a woman, should be discouraged if we are not to have excessive population as an obstruction to our economic and social development.

Related to this perhaps is the issue of old age security for people. Where AIDS kills off able-bodied adults and old grandparents or siblings are left to take care of children of AIDS victims, then, the society at large has to come to their rescue. One would recommend that social security scheme be set up by our government to take care of all destitutes. Anybody whose income from all sources fall below a certain minimum level prescribed should be entitled to draw upon certain funds. In this way the family members also do not have to bear the full burden of caring for children and dependents of AIDS victims. Moreover, since AIDS does not kill the victim immediately, funds are needed to maintain him/her while still alive. Women especially cannot abandon their husbands or children in case of such affliction and anything which can be done to lessen their problems would be welcome. Even for young families the prevailing economic circumstances are such that the permanent disability of one earner in a family can be almost disastrous for all. We are all finding it increasingly difficult to be our 'brother's keeper'. Furthermore there is need for a closer look at home-based care of AIDS victims.

For career women (professionals in the modern sector labour force, employees, traders, entrepreneurs in the informal sector), it is becoming glaring that mother substitutes, such as househelps, drivers, etc, are needed to work at home while the woman goes out to earn a living. As a result of this, problems are arising as to sexual relations between such workers and members of the family. Cases of rape or sexual molestation of housegirls by husbands of such career women (madam's husband or '*oga*') are surfacing in increasing numbers. In addition rape of madam's daughter by house boys or drivers have been heard of. Of course nobody hears of sexual contacts based on mutual consent. In any case, any of these instances leaves room for the propagation of sexually transmitted diseases including AIDS. Hence one would advise that career men and women should be extra careful about their household members and workers.

Conclusion

The policy implications of all the foregoing would indicate a multisectoral approach to the issue of AIDS in Nigeria. We have to involve the family, the school, the Ministry of Health and Social Services, the Ministry of Education for formal and informal awareness programmes, the National Drug Law Enforcement Agency, the Armed Forces, Police, Customs and the professionals like Sociologists, Psychologists, to study behavioural patterns and possibility of changes therein. We need to take a close look at what we can change in our culture to favour safe sexual habits. Look at gender power relations within the family so as to locate the focus of power and influence it. There is need for better population statistics in this country to enable us know how many people we are dealing with and plan for them adequately. To this end one would advise that there should no longer be any cancellation of any census in this country.[1]

Reproductive health and family planning services should be given more attention by the health providers. Proper screening of any blood to be transfused must be stressed. The involvement of non-governmental organisations, voluntary associations, and multinational bodies are needed here to complement the efforts of our government. Nigeria should endeavour to disseminate more information on its AIDS Programme through such avenues as the mass media, conferences, seminars, etc., both within the country and internationally. We can thereby solicit for more resources for our national AIDS Programme.

Finally, in addition to general information, education and communication (IEC) programmes to generate awareness of AIDS in our populace as is done in marking the World AIDS day, it is imperative that special programmes be designed for specific groups like commercial sex workers, long distance drivers, adolescents in and out of school, institutional populations who are not normally covered in social surveys, married men and women, traditional leaders, and community opinion leaders and so on. We should not assume that any individual is too small or too important to be approached. We should stress that AIDS has no boundary.

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[1] Note that the 1991 population census figures were finally accepted by the government authorities in 1997.

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Felicia A. Durojaiye OYEKANMI, *Socio-cultural relations in the Nigerian family: implications for AIDS in Africa*

Summary — In Africa, women are particularly vulnerable to AIDS and the major factors putting women at high risk of HIV infection are social and economic such as poverty, gender discrimination, lack of power in negotiating sex and lack of educational and economic opportunities. The infection of women further propells the emerging epidemic of pediatric AIDS. This paper attempts to look at the different forms of family and marriage in Nigeria and how these relate to population dynamics. The prevalence of patriarchy and widespread practice of polygyny are seen as some of the factors reinforcing the subordinate position of women in the Nigerian family. The socio-cultural practices in these families especially those relating to sexual relations, child care and health seeking practices are explored with a view to linking their relation to the possible transmission of HIV/AIDS. The influence of migration on the STD/HIV transmission is explored in view of the high rate of mobility of peoples across and within national boundaries of African countries; voluntarily for better economic opportunites and involuntarily due to famine, civil wars and political destabilisation. The paper concludes by recommending a multisectoral approach to the issue of AIDS in Nigeria in particular, and Africa in general. Programmes designed to reduce sexual transmission will therefore have the greatest impact.

Keywords: HIV/AIDS • family • patriarchy • sexual relations • reproductive health • gender inequality.

Felicia A. Durojaiye OYEKANMI, *Relations socioculturelles dans la famille nigeriane : implications pour le sida en Afrique*

Résumé — En Afrique, les femmes sont particulièrement vulnérables au sida et les facteurs les mettant en situation de haut risque d'infection sont sociaux et économiques comme la pauvreté, la discrimination sexuelle, le manque de capacité à négocier le sexe, le manque d'opportunités dans le domaine de l'éducation et de l'économie. En outre, l'infection des femmes a fait émerger l'épidémie de sida pédiatrique. Cette étude tente de considérer les différents types d'organisation familiale et matrimoniale au Nigeria et de voir comment celles-ci interfèrent dans les dynamiques démographiques. La prévalence d'un système patriarcal et une pratique étendue de la polygynie sont perçues comme des facteurs renforçant la position subordonnée de la femme dans la famille nigeriane. Les pratiques socioculturelles dans ces familles, surtout en matière de relations sexuelles, de soins aux enfants et de pratiques pour la quête de la santé sont explorées afin de voir leur relation à une possible transmission du VIH/sida. L'influence de la migration sur la transmission des MST/sida est aussi explorée en considérant le taux élevé de mobilité des populations à l'intérieur et hors des frontières nationales des pays africains — que cette mobilité soit volontaire, traduisant la recherche de meilleures opportunités économiques, ou qu'elle soit involontaire et due à la famine, aux guerres civiles et à l'instabilité politique. En conclusion est recommandée une approche multisectorielle du sida, au Nigeria en particulier et en Afrique en général. Les programmes destinés à réduire la transmission sexuelle pourront alors avoir un impact notable.

Mots-clés : VIH/sida • famille • patriarcat • relations sexuelles • santé de la reproduction • inégalité entre sexes.

29. Valeurs morales et messages de prévention : la " fidélité " contre le sida au Burkina Faso

Bernard Taverne [1]

« *l'infidélité (…) ça n'existe pas.*
On dit il a une maîtresse, point »

Calixthe Beyala, *Assèze l'Africaine*

Au Burkina Faso, comme dans un grand nombre de pays d'Afrique francophone la formule la plus communément employée dans les messages d'information contre le sida se présente sous la forme de l'alternative : "fidélité ou capote" (Anonyme 1995). Le second terme de l'alternative ne prête à aucune confusion puisqu'il désigne un objet matériel – le préservatif –, mais quelle signification est attribuée au terme " fidélité " par les personnes à qui sont destinés ces messages ? La fidélité s'applique ici au domaine de la sexualité. Ce message est une injonction à un comportement sexuel précis, semblant "aller de soi" puisqu'il n'est pas explicitement désigné. C'est précisément de la nature de ce comportement sexuel dont il sera ici question.

L'observation des conduites de vie de jeunes adultes Mossi vivant en milieu rural (province d'Oubritenga, au Burkina Faso) [2] est à l'origine des interrogations suivantes : quelles significations accordent-ils au terme fidélité ? Quelle place ce concept occupe-t-il pour eux parmi l'ensemble des normes et valeurs régissant les relations homme/femme dans le domaine de la sexualité ? Quelle influence peut-on attendre d'un tel message auprès de ces jeunes ?

On ne peut s'interroger sur la signification accordée à une valeur morale dans le domaine de la sexualité sans tenir compte du cadre social et culturel dans lequel s'inscrit la sexualité. Celle-ci est à la fois une affaire de jouissance individuelle et de reproduction biologique mais aussi de reproduction de rapports sociaux. À travers la sexualité « ce que les hommes s'efforcent de reproduire, ce n'est pas leur espèce (…) c'est le groupe social auquel ils appartiennent » (Godelier 1995 : 119). Dans toute les sociétés humaines, la reproduction biologi-

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[1] Remerciements à Doris Bonnet (ORSTOM), Alice Desclaux et Marc Egrot (Laboratoire d'Écologie Humaine et d'Anthropologie, Aix-Marseille III), Jules Kinda (Université de Ouagadougou) pour leurs critiques d'une version préliminaire de ce texte.

[2] Environ 60 groupes ethniques composent la population du Burkina Faso qui s'élevait à un peu plus de 9 millions d'habitants en 1991 ; les Mossi (48,6 % du total) constituaient le groupe majoritaire (INSD 1994 : 9, 18, 33).

que/sociale est inscrite dans le système de parenté, à travers les règles de la filiation et de l'alliance. C'est dans ce domaine que s'exprime de la manière la plus précise la codification de la sexualité et la nature des relations de genre entre les personnes. C'est donc par rapport à l'alliance matrimoniale que seront décrites la valeur et la place de la notion de fidélité, avant d'être envisagées dans le domaine des relations prématrimoniales et paramatrimoniales.

Fidélité et sexualité chez les Mossi, en milieu rural

L'union matrimoniale

• *Mariage légal, mariage coutumier*

Au Burkina Faso, en 1996, les pratiques matrimoniales sont régies par le *Code des personnes et de la famille* entré en application en 1990. Ce code n'accorde "aucun effet juridique (…) aux mariages coutumiers et religieux" (art. 233) et "interdit les mariages forcés, imposés par les familles" (art. 234) ; le mariage par consentement mutuel est la seule forme légale d'union matrimoniale. Cependant, en pratique ce code est presque totalement inconnu et inappliqué en milieu rural, où habitent 80 % de la population du pays. La grande majorité des mariages s'y réalisent encore selon les règles du droit coutumier plus ou moins modifiées en fonction des appartenances religieuses des familles ou des époux.

Selon le droit coutumier des Mossi, ethnie patrilinéaire gérontocratique, ce sont les doyens de lignage ou d'un segment de lignage (plus récemment les chefs de famille) qui décident des unions. Le mariage est avant tout une alliance entre deux lignages ; aussi « les relations matrimoniales relèvent de stratégies sociales et politiques à l'élaboration et à la réalisation desquelles jeunes gens et jeunes femmes ne participent pas » (Capron *et al.* 1975 : 16). Les stratégies matrimoniales apparaissent de prime abord totalement contrôlées par les hommes ; en fait, les femmes y participent aussi de manière très active, en ayant dans certaines circonstances l'initiative des alliances [1]. Il existe plusieurs modalités de désignation ou de choix du conjoint (don, lévirat, consentement mutuel/rapt, etc.) ; le mariage par don est la forme socialement la plus valorisée. Il existe plusieurs modalités de don – dont une qui relève d'une forme d'échange, tel le *pug-siuure*, décrit par Gruénais (1979). Les conséquences pour les conjoints en sont comparables : les jeunes filles sont promises en mariage dès leur enfance, "données" par leur chef de lignage ou leur père à un autre chef de lignage (ou à un chef de famille d'un autre lignage), à qui revient la décision du choix du mari. Le don d'une femme est le plus souvent décrit comme l'aboutissement, parfois seulement une étape de relations privilégiées entretenues entre deux lignages ; ces relations peuvent avoir impliqué des individus sur plusieurs générations.

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[1] Sur le rôle de la tante paternelle par rapport à sa nièce (*pugdba*) voir Bonnet (1988 : 51-56 ; Gruénais (1985).

— La fidélité selon les formes de mariage

Les articles législatifs régissant le mariage légal affirment "le principe de l'égalité des droits et des devoirs entre époux" (art. 235) et précisent qu'ils "se doivent mutuellement fidélité [1], secours et assistance" (art. 292) [2].

Pour la majorité de la population rurale du Burkina, en l'absence d'application du Code moderne, les droits et devoirs des époux sont entièrement déterminés par le droit coutumier et influencés par les règles des religions importées (islam et christianisme [3]). Les doctrines de ces religions accordent une place essentielle au principe de la fidélité sexuelle réciproque dans l'union conjugale. Mais en pratique, il apparaît que la contrainte de fidélité des hommes à l'égard de leurs épouses, que réclament les religions, ne parvient pas à s'imposer, notamment chez les jeunes adultes.

Le droit coutumier est fondamentalement inégalitaire dans sa répartition des droits et des devoirs selon les sexes. Il établit une très nette distinction sexuelle à propos de la fidélité conjugale : la femme a un devoir de fidélité par rapport à son conjoint, tandis que celui-ci a droit aux relations extraconjugales. En outre, la femme a le devoir de tolérer les relations extramatrimoniales de son époux.

Le devoir de fidélité des femmes est étroitement lié aux principes de patrilinéarité et de "fécondité lignagère" qui sont aux fondements de l'édifice social mossi (Bonnet 1988 : 23). L'enfant, qui est la propriété du lignage du mari, alors que son épouse y est considérée comme une étrangère, serait le receveur d'un principe vital transmis en ligne agnatique par les ancêtres *via* son père (Bonnet 1988 : 88). Dès lors, la fidélité féminine représente la condition essentielle au contrôle de la fécondité, au maintien des caractères du lignage et, au delà, à la reproduction sociale du groupe. La transgression du devoir de fidélité est considérée comme étant une remise en cause de l'autorité des ancêtres : elle pourrait avoir pour conséquence de mettre en péril la fécondité du lignage. « L'enfant adultérin est jugé comme un "bâtard" car il ne possède pas en lui les caractères du patrilignage transmis par l'homme » (Bonnet 1988 : 26). Lorsque survient une grossesse "adultérine", on demande le plus souvent à la mère "d'aller remettre l'enfant là où elle l'a trouvé" sitôt après la naissance, c'est-à-dire de le donner à la famille du père biologique.

L'énoncé sommaire des droits et devoirs des conjoints à propos de la fidélité selon le droit coutumier laisserait croire qu'il permet aux hommes ce qu'il interdit aux femmes. On ne peut s'en tenir à cette expression simplifiée, presque caricaturale. En effet, dans son application quotidienne cette discrimination sexuelle appliquée à la fidélité conjugale se révèle peu rigoureuse ; elle masque en fait

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[1] « Fidélité conjugale : obligation réciproque incombant à chaque époux de ne pas commettre l'adultère » (dictionnaire *Le Robert*, 1981, t. 3, p. 2).

[2] Formulation exactement identique à celle de l'article 212 du Code civil français.

[3] En 1992, le Burkina Faso comptait 20 % de chrétiens, 52 % de musulmans (INSD 1994 : 19).

l'espace de liberté sexuelle des femmes, qui s'étend tout au long de leur vie, avant, mais aussi après le mariage, et occulte les éléments qui déterminent l'usage de cette liberté par les femmes.

Cet espace de liberté est la condition du fonctionnement des réseaux sexuels pré- et paramatrimoniaux. Il ne peut être simplement attribué au "laxisme des institutions" (Lallemand 1977 : 150) puisqu'il en permet l'existence ; « il est évident que la liberté sexuelle des maris et des célibataires serait purement théorique si un nombre notable de filles ou de femmes ne parvenait à se soustraire à l'autorité du père ou de l'époux » (Pageard 1969 : 136).

— Relations extra-conjugales et séparation matrimoniale

La valeur accordée à la notion de fidélité conjugale peut être également appréciée à travers la manière dont sont perçues l'infidélité et ses conséquences sur l'union matrimoniale.

Dans le droit moderne, l'infidélité peut être la cause de la dissolution du mariage. Le divorce peut être "demandé par un époux lorsque la vie commune est devenue intolérable par suite d'adultère (…)" (art 376). Selon le droit coutumier, « jusqu'à une époque récente, l'adultère de la femme n'était pas un motif de répudiation chez les Mossi » (Pageard 1969 : 324). L'épouse est considérée moins coupable que son amant. « À l'égard de la femme coupable, le mari ne dispose que d'un droit de correction manuelle modérée. Il en use peu, de crainte que l'épouse maltraitée ne prenne définitivement la fuite. C'est plutôt l'amant qu'on cherche à atteindre et on recourt, s'il le faut aux forces spirituelles (…) la seule sanction vraiment efficace de l'adultère de la femme reste (…) la désapprobation de l'épouse infidèle (par sa famille). La femme supporte mal d'être condamnée par sa famille d'origine. Si cette condamnation vient à faire défaut, le mari ne dispose à peu près d'aucun recours » (Pageard 1969 : 136-137)[1].

Les relations prématrimoniales

Ces relations représentent la première occasion d'expression du libre choix personnel d'un partenaire sexuel. De l'adolescence au mariage, les jeunes des deux sexes « connaissent une intense période d'activité amoureuse, de quête de partenaire de l'autre sexe » (Lallemand 1977 : 123). Cette étape sentimentale, appelée *rolemdo*, est « institutionnellement reconnue par la société, elle doit théoriquement consister en une amitié amoureuse avec un partenaire de l'autre sexe en excluant tout rapport sexuel » (Bonnet 1988 : 37). Il s'agit d'une période d'expérimentation, de découverte des relations sentimentales et de nos jours, pour la plupart des jeunes, d'initiation à la sexualité. L'investissement affectif des jeunes est très fort vis-à-vis de

[1] Une situation similaire est décrite par Danièle Kintz chez les Peuls : « l'attitude peule par rapport à l'adultère est indulgente dans les faits si ce n'est dans le discours » (1987 : 127).

celle ou de celui qui est nommé *mam roelle* [mon ami(e), mon amant(e)], du moins lors des premières aventures.

Dans le domaine des relations prématrimoniales, le droit coutumier établit là encore une nette distinction sexuelle : il valorise la sexualité prématrimoniale des garçons et la virginité des filles au mariage [1]. Mais de nos jours une moindre valeur est accordée à ce dernier principe et les jeunes hommes affirment reconnaître le plein droit des jeunes femmes à une sexualité prématrimoniale. Aussi, actuellement la période du *rolemdo* correspond-elle le plus souvent à celle de l'entrée dans la sexualité [2].

En milieu rural, cette initiation sentimentale et sexuelle se déroule rarement de manière clandestine et secrète. Elle est l'objet d'un discret mais rigoureux contrôle social de la part des proches du garçon ainsi que de certains membres de la famille de la fille. Ce contrôle s'exerce en particulier dans le domaine du choix du partenaire. Bien que laissé à l'initiative de l'individu, ce choix doit respecter scrupuleusement les règles d'exogamie appliquées au mariage auxquelles s'ajoute l'impossibilité pour un garçon de prendre pour *roelle* une fille qui a déjà eu des relations sexuelles avec un des frères de ce garçon (biologiques et classificatoires intralignagers) ou un de ses amis [3]. Aussi, avant toute rencontre, les deux jeunes gens, parfois avec l'aide de leurs amis et sous la discrète vigilance des anciens, effectuent une mise à jour précise de leur parenté respective et de leur lien d'amitié afin d'avoir la certitude qu'aucun interdit ne vient empêcher leur relation.

Les rencontres doivent avoir lieu au domicile du garçon. La venue de la fille, en particulier s'il s'agit de sa première visite, doit être l'occasion d'une petite réception en son honneur. Avec l'aide de quelques-uns de ses amis intimes, le garçon se procure de la bière de mil, une volaille et du riz dont il confie la préparation à l'une des femmes de la cour (mère ou belle-sœur). L'hôte et ses compagnons vont ensemble animer la "causerie" avec musiques, chants et plaisanteries durant toute la soirée, avant que les amis se retirent un par un, prétextant l'heure tardive, pour laisser ensemble les deux jeunes. La jeune femme est reconduite le lendemain matin à son domicile, avant le lever du jour.

Dans ces conditions, tous les membres de l'habitation dans laquelle séjourne le garçon sont parfaitement informés de la visite de "l'étrangère" et chacun, y compris le chef de famille, peut savoir précisément qui elle est. De son côté, le départ de la fille de sa propre habitation est beaucoup plus discret, le plus souvent elle bénéficie de

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[1] L'exigence de la virginité féminine au mariage ne semble pas avoir eu partout et toujours la même importance (Pageard 1969 : 178-180).

[2] Sexualité où les risques de grossesse et de transmission des MST sont rarement maîtrisés.

[3] Un risque de mort pèse sur les deux hommes s'ils ont eu des relations sexuelles avec la même femme, même si cela s'est produit à leur insu et quel que soit le délai qui sépare ces actes. Cet interdit est communément retrouvé dans divers groupes ethniques en Afrique de l'ouest (Héritier 1996 : 273ss).

l'aide des femmes présentes (mère, sœurs et tantes), le père est laissé dans une totale ignorance des faits que son devoir lui imposerait de condamner. La clandestinité dans les relations amoureuses est réprouvée ; elle est considérée comme une preuve du non-respect des règles de choix du partenaire.

Le temps des relations prématrimoniales marque profondément jeunes gens et jeunes femmes. Ils en gardent le souvenir fort de leurs premières amours et souvent un attachement durable avec certains de leur *roelle* de l'époque. Ces relations ont la particularité de porter en elles-mêmes leur caractère éphémère. En effet, chacun des deux partenaires engagés dans la relation amoureuse sait que cette relation est par essence transitoire, puisqu'elle ne pourra pas ouvrir la voie à une union matrimoniale. Le plus souvent la jeune fille a déjà été promise en mariage et le jeune homme sait que le choix de son épouse ne lui appartient pas, mais relève d'une décision de son père. Cependant, cela n'empêche nullement les amoureux de se promettre "un amour jusqu'à la fin de la vie" (*viim teka*). Ces promesses correspondent au plus près à la définition occidentale de la fidélité dans la relation sentimentale qui associe au sentiment amoureux sa pérennité dans le temps (Erny 1995). Cette fidélité pourra les conduire à maintenir des liens au-delà du mariage de chacun d'eux : "certains *roelle* ne se fréquentent plus quand ils vieillissent, mais certains se voient tant qu'ils peuvent marcher", confie en souriant un "vieux" chef de famille.

Les relations paramatrimoniales

Les relations sexuelles pré- et paramatrimoniales entrent dans la catégorie du *yoobo*. Ce terme est souvent improprement traduit par "adultère", ou encore par "luxure, fornication" (Alexandre 1953 : 476 ; Zaongo 1985 : 132) [1]. Or, la connotation péjorative associée à ces traductions n'est pas systématiquement présente dans l'usage qui est fait de ce mot ; pas plus qu'il ne fait obligatoirement référence à la transgression condamnable du devoir de fidélité.

Le *yoobo* désigne un type de relation homme/femme en dehors du mariage obéissant à des règles bien définies par le droit coutumier ; relations non condamnées lorsqu'elles sont établies dans le strict respect de ce droit [2].

L'élément essentiel est là encore le respect de la règle d'exogamie. Il est formellement interdit à une femme d'avoir des relations sexuelles avec des hommes du lignage de son mari (père, frères classificatoires

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[1] Zaongo (communication personnelle 1996) reconnaît que la traduction de *yoobo* par adultère est inadéquate, bien qu'elle soit aujourd'hui communément admise ; le *yoobo* désignait auparavant une relation ludique, un jeu autorisé entre homme et femme.

[2] Une anecdote montre clairement l'impossible assimilation entre *yoobo* et adultère : lors d'un entretien avec un jeune homme sur la manière dont les anciens menaient leurs relations paramatrimoniales, celui-ci m'invita à venir demander à son père "comment il faisait le *yoobo* quand il était jeune" ; on imaginerait mal de demander à un homme de 70 ans "comment il pratiquait l'adultère dans sa jeunesse" sans que cela soit considéré irrespectueux.

ou utérins de son époux) [1] ; cette interdiction s'applique aussi à l'homme par rapport aux femmes du lignage de son épouse. Ces relations sont réprouvées et très sévèrement punies, elle ne relèvent pas du *yoobo* mais de l'inceste [2] ; les fautifs sont chassés du village et bannis de leur lignage car « ils entachent de souillure, donc de stérilité, toutes les femmes du lignage » (Bonnet 1988 : 23).

— Les hommes et le yoobo

Le droit coutumier permet aux hommes mariés des relations sexuelles hors mariage. Cependant ce droit n'est applicable qu'à la condition qu'une de ses épouses [3] soit sexuellement indisponible pour cause de grossesse, d'allaitement ou de menstruation. Aucun homme ne peut inviter chez lui une femme alors qu'une de ses épouses est sexuellement disponible ; la ou les épouses pourraient se plaindre aux autorités lignagères, et le mari prendrait le risque d'être blâmé par ses proches et considéré comme un "coureur de femmes".

Lorsqu'un mari ne peut avoir de relations sexuelles avec ses épouses, il est en droit d'inviter "une étrangère" à son domicile. La mise en œuvre de ce droit n'est pas séparable du devoir d'accueil qui incombe à l'épouse du mari ; cette dernière a en effet le devoir de "respecter" la femme de passage en la traitant avec tous les égards qu'on doit à un étranger (*sãana*).

Bien qu'il n'y soit pas obligé, il est bon que le mari prévienne son épouse de sa volonté d'inviter "une étrangère" afin de ne pas la surprendre. Dès lors l'épouse doit venir saluer cette femme, lui offrir de l'eau de boisson, lui proposer de l'eau pour la toilette, lui préparer un repas, puis venir faire un peu de conversation avec elle, avant de demander à se retirer pour la laisser seule avec son époux. Les autres habitants de la cour (frères, belles-sœurs, enfants) doivent également venir la saluer et échanger quelques paroles avec elle. *Le contexte de la polygamie oblige la ou les épouses du mari à considérer la femme invitée comme une épouse potentielle à venir.*

De son côté la femme invitée doit demander à saluer les "vieux" de l'habitation ; si elle a eu l'occasion de venir à plusieurs reprises, il n'est pas rare qu'elle propose d'aider l'épouse dans ses activités pour la préparation du repas ou la toilette d'un enfant. Il se crée une relation fondée sur le respect réciproque entre l'épouse et l'invitée, ce qu'exprime clairement un jeune chef de famille : "si ton amie vient, elle doit respecter ta femme, parce que c'est grâce à ta femme qu'elle va dormir avec toi, parce que si ta femme refuse, tu peux faire ce que tu veux, tu ne vas pas dormir". L'épouse manifeste la qualité de son entente avec son mari à travers le soin qu'elle apporte à l'accueil de la femme invitée. Celle-ci marque sa reconnaissance envers l'épouse ;

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[1] Sauf dans le cadre du lévirat, lors du décès de son mari ; il est alors proposé à la femme d'épouser un frère du défunt.

[2] Inceste du deuxième type, selon la distinction proposée par Héritier (1994).

[3] Par la suite, il ne sera plus fait mention qu'au singulier des épouses d'un homme polygame.

feinte ou réelle il arrive qu'une relation étroite s'instaure entre ces deux femmes : "des fois lorsqu'elle vient, je ne peux pas causer avec elle, c'est elle et mon épouse qui parlent ensemble" reconnaît un jeune mari. Il arrive qu'en signe de gratitude, l'invitée offre quelques cadeaux à l'épouse, à l'occasion par exemple de la naissance d'un enfant.

Bien entendu, toutes les rencontres paramatrimoniales ne suivent pas exactement cette description. Certains maris préfèrent passer la nuit avec leurs amantes dans une case prêtée par un ami sûr, à distance de leur village ; ils savent que leurs épouses n'accepteraient pas leur conduite, ou bien que la distance généalogique avec leurs amantes pourrait prêter à contestation.

— *Les femmes et le* yoobo

Les femmes peuvent rencontrer leurs amants uniquement à l'occasion des visites qu'elles effectuent à leur propre famille. Le droit coutumier leur reconnaît un droit de visite dans leur famille ; ce droit est imprescriptible en cas de naissance, maladie, décès, ou cérémonies funéraires. Le non-respect de ce droit peut entraîner la dissolution du mariage à la demande des autorités du lignage de la femme. En dehors de ces événements, la femme peut toujours obtenir de son mari une autorisation pour aller voir "ses parents", celui-ci ne peut pas s'y opposer systématiquement sans que cela lui soit un jour reproché par ses beaux-parents. Dès lors, « il est admis qu'une fois nantie de sa permission de visite à sa famille, la femme suive l'itinéraire qui lui plaît, sans escorte » (Lallemand 1977 : 150).

Arrivée dans sa famille, la femme retrouve la liberté d'aller rendre visite à qui bon lui semble, soit qu'elle se rende elle-même au domicile de son amant, soit que celui-ci lui ait donné un rendez-vous pour l'amener jusque chez lui. Selon la distance qui sépare l'habitation de l'amant de celle de la famille de la femme, celle-ci pourra venir toutes les nuits ou alors séjourner deux ou trois jours avec son amant, rarement plus.

Les hommes mariés ne sont pas dupes puisqu'ils profitent aussi de cette situation : "lorsqu'une hache s'en va en brousse, c'est pour couper du bois" affirment certains avec détachement, admettant ainsi qu'une épouse qui part chez ses parents a toute liberté d'aller retrouver un ancien ou un nouveau *roelle*.

Cependant, il est un élément qui, sans être directement lié au droit coutumier, entrave grandement les possibilités de relations paramatrimoniales pour les femmes. Il s'agit de l'interdit sexuel qui accompagne la durée de l'allaitement [1]. Toute relation sexuelle pendant cette période est censée "gâter" le lait de la mère allaitante et entraîner une

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[1] Dans son étude sur le cycle de reproduction des femmes Mossi, Doris Bonnet rapporte une durée moyenne d'allaitement de 29,6 mois après la naissance et d'interdit sexuel de 22,6 mois (1988 : 39) et précise que « la femme mossi vit dès sa puberté un cycle de reproduction non interrompu » jusqu'à la ménopause.

maladie qui peut être mortelle pour l'enfant [1]. Les femmes sont très attentives à éviter tous comportements pouvant avoir des conséquences néfastes sur leur enfant. Selon la maladie de l'enfant, la mère pourra être accusée d'en être la cause (Desclaux 1996a) ; il s'agit bien d'une autre forme de contrôle social sur la sexualité des femmes.

Quelques valeurs essentielles dans les relations homme/femme en milieu rural mossi

Il n'existe pas en *mooré* (langue des Mossi) un terme traduisant littéralement les mots "fidèle" ou "fidélité". Le plus souvent le concept est traduit par *pu-peelem* : ventre-blancheur . Au sens propre *pu* (*puga*) signifie le ventre, au sens figuré il désigne la conscience morale de l'individu (Poulet *sd* : 52) ; le terme *pu-peelem* signifie franchise, droiture, loyauté, sincérité et honnêteté dans les actes (Alexandre 1953 : 310).

L'absence d'un terme spécifique ne signifie évidemment pas que les significations habituellement accordées au mot fidélité (attachement, constance, etc.) n'existent pas dans l'*ethos* Mossi, bien au contraire. Une très grande valeur est accordée au dévouement, à la loyauté et à l'allégeance dans les différentes relations sociales, à travers le respect des principes d'autorité que représentent les ancêtres ou le chef (*naaba*) ; de même l'attachement, la constance et la persévérance dans les relations d'amitié sont considérés essentiels, comme en témoigne la longue durée des relations entre lignages qui aboutiront un jour à un don de femme.

La traduction du terme fidélité à propos de l'union conjugale s'avère difficile ; l'expression la plus proche serait *kis sida* [2], dont la traduction littérale est "donner la vérité", franchise. Or, si la franchise/fidélité est un devoir réciproque entre les époux, elle concerne bien sûr le domaine sexuel mais n'y est pas limitée, elle s'applique à l'ensemble de la relation conjugale.

La franchise/fidélité est une qualité nécessaire à l'entente conjugale, mais elle est secondaire au regard de la notion de respect du conjoint (*waoogre*) qui est la valeur cardinale de l'union matrimoniale chez les Mossi. La référence au respect mutuel apparaît à la moindre des conversations concernant la vie conjugale, quels que soient les interlocuteurs. Respecter son conjoint, c'est le considérer et le traiter avec tous les égards qui lui sont dus de par son statut social (chef de famille ou épouse/mère) afin de ne jamais le mettre dans une situation où son statut puisse être contesté par le reste du groupe. Cette valeur détermine l'attitude des conjoints entre eux face aux jugements que la société porte sur eux. Les sentiments personnels apparaissent

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[1] La cessation des rapports sexuels pendant la lactation est légitimée par un ensemble de représentations, définissant un antagonisme entre le sperme et le lait, qui se retrouvent parmi diverses sociétés en Afrique de l'ouest (Bonnet 1988 ; Cros 1990 ; Héritier 1996).

[2] *Pag tog nkisa sida ne a sida* : littéralement, la femme doit donner la vérité à/avec son mari ; en l'absence d'indication tonale, *sida* est l'objet d'une homonymie, le terme signifie vérité et mari.

secondaires par rapport à la préoccupation du maintien de l'étiquette sociale comme en témoignent les propos d'une épouse se plaignant du fait que son mari entretenait des relations avec une femme de parenté trop proche de son lignage : "s'il continue, il ne sera plus considéré comme un homme respectable et moi aussi en tant que femme, je n'aurai plus de respect , parce que si les gens ne le respectent pas, il ne me respecteront pas non plus, moi je ne serai rien, il faut que les gens le respectent, afin qu'ils me respectent aussi".

Parmi les sentiments individuels, une place particulière est accordée à la jalousie (*sukiiri*). En milieu rural mossi, l'expression de ce sentiment universel est fortement réprouvée, en particulier dans le domaine des relations entre hommes et femmes [1]. La jalousie est exprimée dans l'intimité des relations entre les conjoints ; elle éclate parfois au grand jour à l'occasion de tensions et de disputes dans l'unité domestique [2]. Mais l'émergence de ce sentiment est vigoureusement combattue ; il représente une menace pour l'équilibre familial. La jalousie est le berceau des mésententes et des disputes entre les femmes dans l'union polygame ; elle peut aboutir, pour peu que surviennent quelques décès d'enfants, à des accusations de sorcellerie et à des exclusions et bannissements de femmes. Ainsi, à une épouse se plaignant parce que son mari fait venir d'autres femmes, ses compagnes ou ses sœurs reprocheront de "commencer la jalousie pour que son mari ne gagne pas une autre femme, (…) ton caractère n'est pas bon, tu n'accepteras pas de co-épouse, la fille qui est venue n'a pas coupé le sexe de ton mari pour partir avec, pourquoi fais-tu des histoires ? Nous avons toutes vu ça avec nos maris" [3].

Les hommes en proie à ce sentiment à l'égard de leurs épouses ont parfois recours à un procédé magique : le *pug-bêdgo* (littéralement "femme-piège"). À son insu, la femme est l'objet de pratiques magiques sans conséquence pour elle, mais qui ont pour effet de rendre transitoirement impuissant son amant, au pire de lui donner une maladie sexuelle mortelle pour laquelle il n'existerait aucun remède. Une surenchère de procédés magiques se met parfois en place, et des hommes vont chercher à acquérir des moyens pour savoir si une femme convoitée a été "piégée" ou pour ne pas être atteint par le piège.

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[1] Il en serait de même chez les Peuls pour lesquels « la jalousie doit être tenue secrète, la manifester publiquement est un manquement aux règles de vie » (Kintz 1987 : 127).

[2] Le plus souvent, les épouses des ménages polygames la subissent secrètement, avec douleurs et résignation, comme le rapportent les témoignages enregistrés par Eliane de Latour au Niger (1992).

[3] En milieu urbain, l'influence du modèle matrimonial occidental, la moindre contrainte sociale sur les personnes, l'accroissement du pouvoir de décision des femmes, permettent l'émergence d'une contestation féministe qui remet en cause la subordination des femmes. L'infidélité masculine est l'objet de violentes récriminations de la part des femmes (Bardem 1994 : 98).

Fidélité et prévention du sida

Fidélité sexuelle et fidélité sociale

Ce long détour ethnographique n'est pourtant qu'une présentation minimale et incomplète qui permet seulement d'éclairer les aspects principaux de la signification de la notion de fidélité. Ces observations révèlent que pour les jeunes adultes mossi du milieu rural, le concept de fidélité n'entretient que des rapports lointains, voire inexistants avec le monopartenariat. Pour les jeunes hommes, la fidélité sexuelle n'a pas de sens. Qu'ils soient ou non déjà mariés, leur attitude sexuelle se réfère à la polygamie. Le multipartenariat est la condition indispensable pour trouver une épouse supplémentaire. La seule fidélité qu'un homme se doit de respecter est celle de ses différents engagements sociaux.

Pour les femmes, la fidélité sexuelle est imposée ; elle est décrite comme une obligation qui ne peut être transgressée. Cependant, dans le même temps, tout un ensemble de mécanismes d'évitement permet de s'en affranchir sans conséquence notable.

Si l'on s'en tient à une expression formelle du droit coutumier, l'infidélité sexuelle masculine n'existant pas, ne pourraient être infidèles que les femmes. Pour autant, les jeunes n'ignorent pas totalement le sens de l'appel à la fidélité. Mais pour lui restituer une signification, ils l'interprètent à travers ce qu'ils connaissent des valeurs morales qu'ils attribuent à l'Occident. Une représentation idéalisée de la fidélité "chez les Blancs" est largement répandue : "les Blancs n'ont qu'une seule femme avec laquelle ils vont partout, le mariage des Blancs est mieux, il n'y a pas de jalousie" affirme la quatrième épouse d'un homme polygame (de Latour 1992, extrait d'un entretien, 1h20 du début du film) ; les hommes en font une source de plaisanteries : "n'avoir qu'une seule femme toute sa vie ? Les Blancs sont comme les tourterelles !". Le monopartenariat est pensé par les femmes, envers leur mari, comme un idéal auquel elles n'auront jamais accès, et pour les hommes comme une étrangeté, qu'ils renvoient volontiers à un ordre "naturel", en affirmant que l'homme "ne peut pas aller toujours avec une seule femme".

Pour les Mossi, la signification accordée au terme fidélité recouvre un domaine beaucoup plus large que celui de la sexualité et s'applique à l'ensemble du comportement social. Aussi, dire d'une personne qu'elle n'est pas fidèle, c'est mettre en cause son comportement social bien au-delà de ses attitudes sexuelles. C'est une accusation grave qui désigne un comportement honni, un individu qui n'est pas digne d'être respecté. Dans ces conditions, il n'est pas étonnant que les jeunes hommes multipartenaires ne puissent se penser non fidèles. Cette impossibilité à appliquer à leur propre comportement un terme qu'ils jugent péjoratif leur permet de produire un discours bien construit sur l'infidélité. "L'infidélité, c'est le vagabondage sexuel" [1],

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[1] La popularité récente de cette expression résulte directement des campagnes d'information contre le sida.

ces deux termes étant étroitement associés et unanimement condamnés. Voulant prouver qu'ils ne sont pas moins informés que les citadins, ils affirment sans hésitation que "c'est le vagabondage sexuel qui amène le sida" ; cette conduite est toujours évoquée avec dégoût, souvent sous la forme d'une accusation envers une personne jugée immorale. Mais jamais un seul de mes interlocuteurs ne s'est reconnu "vagabond sexuel", alors qu'ils sont tous engagés dans un multipartenariat actif, cette expression concerne toujours un Autre.

La fidélité sexuelle évoquée par le message d'information contre le sida est submergée par l'interprétation sociale qui est en faite, et le conseil sanitaire a perdu l'essentiel de sa signification.

Fidélité et valeur morale contre le sida

Les questions que suscite le recours général et banalisé à la notion de fidélité dans les messages de prévention contre le sida sont nombreuses ; elles ne concernent pas seulement le Burkina Faso, mais s'appliquent à tous les contextes sociaux.

— La première difficulté que soulève l'emploi du terme fidélité est de nature linguistique et révèle les pièges de la traduction. Certaines langues, comme le *mooré*, n'ont pas d'équivalent lexical exact du mot de fidélité. Les traductions qui paraissent les plus évidentes doivent être minutieusement réévaluées, comme dans le cas du terme du terme "adultère" qui est traduit de façon insatisfaisante par *yoobo* en *mooré*.

— Au-delà de la traduction, on peut s'interroger sur la place que cette valeur morale occupe dans l'*ethos* de la société, en particulier dans sa signification par rapport à la sexualité. La fidélité n'est pas considérée dans toutes les sociétés de manière équivalente. Divers comportements sexuels peuvent exister en référence à la notion de fidélité ; ils peuvent n'avoir aucun rapport avec la limitation du nombre de partenaires sexuels. « Le problème ne consiste pas tant dans la compréhension d'un message que dans l'acceptabilité sociale des mesures préventives préconisées » (Jaffré 1991 : 410).

— La formule "fidélité ou capote" présente le double inconvénient d'obliger à penser l'objet préservatif par rapport à une valeur morale et ensuite dans un rapport d'opposition et non de complémentarité avec cette valeur. En effet, cette formule se présente sous la forme d'une alternative [1]. Ce procédé rhétorique est fondé sur le caractère opposé des deux termes mis en présence. L'alternative "fidélité ou capote" (un choix excluant l'autre) est équivalente, dans le cadre d'une décomposition logique, à la proposition : "fidélité et pas de capote" ou "pas de fidélité et capote" ; le dernier terme associe sans ambiguïté l'usage du préservatif à l'infidélité, à l'adultère.

Fidélité et infidélité sont deux notions étroitement scellées qui ne sont jamais pensées séparément (Chehhar 1995 : 69) ; elles renvoient obligatoirement à la dichotomie élémentaire entre le Bien et le Mal.

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[1] Plus précisément, il s'agit de la conclusion, présentée sous la forme d'une alternative, d'un syllogisme dont les prémisses sous-entendues sont : "si une personne n'est pas fidèle, elle est multipartenaire".

Dans cette opposition, la maladie apparaît une fois de plus comme la conséquence d'une transgression.

Ce message associe l'usage du préservatif à des relations sexuelles socialement réprouvées et situe l'usage du préservatif au sein du dilemme suivant : une relation sexuelle socialement acceptée ne nécessite pas l'usage du préservatif, et proposer le préservatif inscrit la relation dans le domaine d'une sexualité condamnée.

— Au Burkina Faso (Bardem *et al.* 1995 : 19 ; Desclaux 1996b), comme dans d'autres pays d'Afrique de l'ouest (Le Palec 1994 : 144-145 ; 1994 : 4 ; Orubuloye *et al.* 1994 : 69) ou d'Afrique centrale (Schoepf 1991 : 156), celui ou celle qui propose le préservatif trahit son infidélité ou sa défiance à l'égard de son partenaire. La suspicion d'infidélité qui accompagne la proposition du préservatif et le rapprochement qui en est fait avec la prostitution, associé à la subordination générale des femmes devant les hommes, interdisent presque totalement à ces dernières l'initiative d'en proposer l'usage (de Bruyn 1992 : 255). Parce que la notion de fidélité sexuelle est indissociable de celle de la confiance, de l'amour et/ou du respect des engagements sociaux entre les partenaires, la référence à la fidélité contribue à entraver la négociation de l'usage du préservatif dans les couples.

— L'usage très répandu depuis plus d'une dizaine d'année du slogan "fidélité ou capote" tient en partie à sa simplicité mais aussi indiscutablement à son caractère moralisateur. Les religieux de toutes confessions n'ont pas hésité à le reprendre à leur compte. La référence au préservatif ne leur convenant pas, ils ont entrepris de mettre systématiquement en doute son efficacité, ce qui permet ensuite d'affirmer que " combattre le préservatif c'est lutter contre le sida " ou que « le risque d'attraper le sida que courent les utilisateurs du préservatif dans nos pays ne doit pas être appelé risque, mais certitude » (J.-M. Compaoré, Archevêque de Ouagadougou, in *Regard 175*, 1996 : 29). Finalement, le message est devenu "fidélité ou sida".

En fin de compte, ce détournement de la signification initiale du message n'est pas surprenant. La fidélité est une valeur morale, et, à ce titre, la présenter comme un moyen de prévention du sida place le message dans le domaine des discours idéologiques. C'est bien parce qu'il est fondamentalement idéologique et qu'il intervient dans un domaine de lutte d'influence constante, qui n'a de rapport avec le sida que parce qu'il met en cause la sexualité, que les diverses Églises n'ont pas attendu pour se le réapproprier.

— Jusqu'à présent, au Burkina Faso les messages d'information contre le sida se réfèrent à trois thèmes principaux : 1) prostituées/ fidélité/vagabondage sexuel ; 2) migrants ; 3) pratiques traditionnelles (excision, scarification, lévirat). La mise en garde contre les prostituées, la condamnation du multipartenariat et l'appel à la fidélité font directement référence à des valeurs morales. Les messages d'information font plus souvent appel à la rigueur morale des personnes qu'aux informations techniques. Morale et technique apparaissent en concurrence. Les aspects pratiques de la prévention sont abordés comme la solution à la défaillance morale que représentent le "vagabondage

sexuel" ou la fréquentation de prostituées. La fidélité est présentée comme étant la prévention idéale.

Les explications concernant une gestion raisonnée du risque de contamination à travers l'association sérologie / préservatif sont inexistantes ; de même qu'il n'existe toujours pas en 1996 un seul centre de dépistage dans la capitale qu'est Ouagadougou.

— Enfin, ramener la transmission du virus à une question de moralité individuelle revient à occulter la complexité de l'exposition au risque de contamination, en particulier le rôle de la pauvreté et des inégalités sociales comme facteurs de la transmission (Farmer 1996 : 96).

Conclusion

Faire appel à la notion de fidélité, comme à n'importe quelle autre valeur morale (la sincérité, l'honnêteté, etc.), dans les messages d'information contre le sida, conduit à des messages ambigus. À une valeur morale précise ne correspond pas un ensemble de comportements universellement identiques. La morale se fonde sur les impératifs du Bien et du Mal, ils sont éminemment variables selon les sociétés. De plus, les messages qui inscrivent la prévention de la transmission du virus dans le domaine de la moralité enferment les victimes du sida dans le carcan de l'accusation ; ils cautionnent l'idée que la maladie est une sanction due au non-respect des règles morales élémentaires.

L'usage généralisé de la notion de fidélité révèle une étonnante uniformité dans la conception des messages diffusés, comme si un seul et même message était valide à l'échelle du continent, indépendamment des populations à qui il est destiné. L'expérience des 20 ou 30 dernières années "d'éducation pour la santé" semble complètement oubliée. Parce que la communication sanitaire sur le sida concerne au premier plan le domaine de la sexualité et que chaque société et chaque groupe social érige ses propres normes et valeurs à ce sujet, il faut, par principe, considérer avec méfiance tout transfert d'outils d'information conçus dans un contexte social vers une autre société. La principale difficulté dans la mise au point de messages d'information sur le sida réside précisément dans l'ajustement de leur contenu et de leur forme aux différents enjeux concernant les pratiques sexuelles dans la population concernée. Aussi, dans l'élaboration des messages et des stratégies d'information « le local, le spécifique, passent cette fois en première ligne », il faut s'attacher au particulier et considérer que la recherche faite « "ailleurs" a tout au plus valeur d'hypothèse, mais elle ne peut pas être directement utilisée "ici" » (Benoist 1996 : 7).

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Bernard TAVERNE, *Valeurs morales et messages de prévention : la " fidélité " contre le sida au Burkina Faso*

Résumé — La fidélité est l'un des concepts les plus utilisés dans les messages de prévention contre le sida. Elle est présentée comme étant la prévention idéale à travers l'alternative "fidélité ou capote". La description des normes et valeurs régissant la sexualité chez de jeunes adultes Mossi vivant en milieu rural au Burkina Faso révèle que si tous reconnaissent un rôle essentiel à cette valeur morale dans le cadre des relations sociales, elle ne concerne que de manière très secondaire le domaine de la sexualité. Dans cette société polygame la notion de fidélité sexuelle pour les hommes n'a pas de sens, et bien qu'elle soit décrite comme obligatoire pour les femmes, un ensemble de mécanismes sociaux précis leur permet de s'en affranchir sans conséquence notable. Faire appel à la notion de fidélité, comme à n'importe qu'elle autre valeur morale dans les messages d'information contre le sida, conduit à des messages ambigus. Le discours préventif cède la place à des injonctions moralisatrices. Ces messages inscrivent la prévention de la transmission du virus dans le domaine de la moralité, ils cautionnent l'idée que le malade est coupable, et que le sida est la juste sanction de l'inconduite sociale.

Mots-clés : fidélité • préservatif • Burkina Faso • Mossi • IEC • éducation sanitaire • sexualité.

Bernard TAVERNE, *Moral values and prevention messages: 'fidelity'' against AIDS in Burkina Faso*

Summary — Fidelity is one of the most widely used concepts in AIDS prevention messages. It is presented as the ideal prevention strategy when cited in the either-or choice of 'fidelity or condoms'. The description of the norms and values governing the sexuality of young Mossi adults living in rural Burkina Faso reveals that, although everyone acknowledges the key role played by this moral value in the context of social relations, it is but a distant secondary consideration in the realm of sexuality. In this polygamous society, the notion of sexual fidelity has no real meaning for men. Although fidelity is set forth as obligatory for women, a number of specific social mechanisms allow them to disregard it without suffering any serious consequences. Appealing to the notion of fidelity or to any other moral value in AIDS-related messages results in ambiguity. The dialogue on prevention gives way to moralising injunctions. Such messages place the transmission of the virus in the realm of morality and lend support to the idea that the person who is ill is guilty and that AIDS is the just punishment for social misbehavior.

Keywords: fidelity • condom • Burkina Faso • Mossi • IEC • health education • sexuality.

30. The attitude of nurses to HIV/AIDS patients in a Nigerian University Teaching Hospital

Gladys Effa-Heap

Introduction

> "The revelation that perhaps up to four million Nigerians might have contracted (the) AIDS virus should spur the country into some form of coordinated action. Despite the havoc which HIV/AIDS has caused throughout the world, particularly Africa, Nigerians have, regrettably, continued to carry on as if nothing is happening. Many people still maintain multiple sex partners and engage in casual and unprotected sex. Our AIDS control strategy remains, at best, unstructured, without direction. If the report that some people have received blood infected with the virus is true, then there is danger on the horizon. It only goes to show that AIDS screening is not properly carried out in the country. Sadly, the problem has been compounded by the fact that the disease is still being treated with a less than honest approach by many Nigerians" (*Daily Times* 1997).

This editorial by the leading government-owned newspaper conveys the lack of a proper reponse to one of the main threats to public health in Nigeria. The data is in line with earlier figures which calculated that 1,050,000 Nigerians were HIV positive by the end of 1994 and an extrapolation of over two million using the double-blind method (Orubuloye 1995; Sowunmi and Ikhemuemhe 1996). Three-quarters of commercial sex workers are HIV positive, so are 5 percent of blood donors and 4 percent of pregnant women (Sowunmi and Ikhemuemhe 1996). By implication, this means that babies from HIV/AIDS infected women are potential victims. The social width of the disease knows no bounds: the media reported the infection of schoolgirls in Akwa Ibom State and the AIDS-death of a community leader in Plateau State in the month of January 1997 alone (*Post Express* 1997; *Punch* 1997). The probability is that more Nigerians infected by HIV/AIDS is even higher than these startling figures suggest.

Compared to other African countries, Nigeria has been inordinately slow to wake up to the reality of HIV/AIDS. It has been even slower to embark on caring for HIV/AIDS patients. University College Hospital (UCH), Ibadan, is a Federal Teaching Hospital with a leading reputation for health care in the country. UCH operates an AIDS Screening Centre, the only one in Ibadan, a city of over 3 million inhabitants. In 1993, "the Oyo State Minister of Health declared wanted 43 blood donors whose blood showed traits of HIV" (AIDS

Information Exchange Resource Centre 1993). Wanted for receiving the appropriate care, or wanted like criminals? In whatever case, the infrastructure is simply not in place, being not a priority among hospital managers and government ministries.

For Nigerians with HIV/AIDS, health care is a misnomer. There is only health care neglect. On hearing a HIV/AIDS diagnosis of a patient, hospital authorities abandon all notions of caring. A notice of 23 March 1995 issued by the Chairman of the Medical Advisory Committee of UCH stated that:

"(1) established cases of clinical HIV/AIDS should not be admitted.
(2) using their own discretion, doctors could admit in rare cases HIV/AIDS patients for IV and blood transfusion, after which the patient must be discharged.
(3) known HIV/AIDS cases should be referred to the medical social services department for advice".

Many carriers of the causative virus are known to lead active lives. Allowing these people to remain in society without caution exposes the populace to avoidable danger. In the present setting, nothing bars HIV/AIDS carriers from donating blood or doing many other things which can impair the lives of other citizens. When asked in a recent magazine interview about the Federal Government's policy towards HIV/AIDS under the title 'Playing the ostrich', Dr Lolade Olusola Ojo of the National AIDS and STD Control Programme in Nigeria responded:

> "We have a policy that is still undergoing the normal scrutiny of the government. This delay on the policy is because when AIDS was first discovered the government did not believe we had AIDS in the country".

The Nigerian Federal Ministry of Health has been very slow in waking up to the realities of HIV/AIDS and making combative plans to control its spread. Nothing has been done about equipping hospitals for proper management of HIV/AIDS cases. Another aspect of Dr Olusola's revelations concerned the screening of blood:

> "There are 818 blood screening centres in Nigeria. A law is coming up to compel screening of all donated blood before transfusion. This is because for now, most of the medical laboratories write 'screened blood' on blood bags that are not screened. Sixteen percent of these so-called 'screened blood' [bags] are found to be contaminated".

Consultant haematologist Sumailman Akanmu also found a similar percentage of blood bags labelled screened and HIV negative, especially from private laboratories had, in fact been tainted with the HIV positive virus (Sowunmi and Ikhemuemhe 1996).

It is in this negative sort of working environment that nurses' attitudes to HIV/AIDS patients is examined with particular reference to UCH, Ibadan (Effa-Heap 1997). Specific sub-problems to investigate include the level of knowledge of nurses on HIV/AIDS; their sources of information on HIV/AIDS; their attitude towards caring for HIV/AIDS patients; the relationships between the nurses' age, exposure to infected patients, years of nursing experience, and the nurses'

attitude towards HIV/AIDS patients; and whether UCH is well equipped for the management of HIV/AIDS cases.

Literature Review

Sexually Transmitted Diseases (STDs) have been around for a long time and, in West Africa, STDs are next to malaria in spread. But man has tackled STDs because the causes, course, treatment and preventive measures are known. With the entrance of AIDS, all other STDs have been relegated to the background. AIDS is a devastating disease which progresses at an alarming rate. Death usually occurs within twelve months of diagnosis. AIDS dementia complex (ADC) is the most common central nervous system complication in people infected with HIV. Typically, HIV attacks white matter, the frontal, occipital, parietal lobe and the basal ganglia (Lasher 1989). At the end stage, infected persons become 'vegetative', with only rudimentary intellectual and social functionings. The treatment of HIV/AIDS patients is only palliative, composing mainly the management of opportunistic infections that take advantage of the body's impaired immune system.

In Nigeria, HIV/AIDS has been treated as a moral rather than a medical issue. The way in which the disease has been described and classified reflects the same social and cultural prejudices that made the disease shameful in the first place (Barnett and Blaikie 1992). Known cases of HIV/AIDS are stigmatised by the society in which they live. Features common to stigma include identifying the person concerned in terms of the stigmatizing attributes which in turn override other characteristics and social roles. It spreads to the whole person and 'spoils' the person's identity, devalues the person and leads to discrimination and outright rejection, all of which result in reduced opportunities (Goffman 1963).

Attitude derives from the Latin 'aptitudo', meaning 'fitness'; that is fitness to engage in the execution of the task (Reber 1988). The modern usage of the term is a predisposition to act in a certain way towards some aspect of one's environment, including other people. Attitude can be positive or negative and can affect the behaviour of an individual. They serve a primary function of bringing together the diverse experiences to which an individual is exposed and forming them into a cohesive, organised whole. It is through the attitude and belief systems of an individual that environmental perception acquires meaning. The danger is that attitudes may become so rigidly adhered to that instead of assisting an individual in understanding his environment and the events taking place within it, they become the perception. The process of changing attitudes requires that the individual objectively examine the critical elements of the attitude and identify those components that are valid and those that are prejudgements (Gross 1987).

Social psychologists describe attitude as a complex tendency of persons to behave in positive or negative ways or to respond in a

favourable or unfavourable manner to social objects in his or her environment. They all agree that attitudes are learnt, but differ on how. Attitudes are enduring systems but there are times when it is necessary to effect change. On the other hand, the functionalists believe that attitudes serve a particular motivational function, that is, serve ego needs and are therefore protective of self. They also form support for one's values and therefore are intrinsically rewarding. The view makes it difficult to change attitude since it would need to change what is motivating the individual, which is further compounded by the fact that what is underlying the motivation is usually unknown even to the individual. The cognitive theorists feel that the individual is always striving for consistency; therefore the way to institute change is through the components of attitude. They argue that there are three structural components of attitude and these are the affective components which refer to positive or negative emotions about something; the behavioural component involves intentions to act in certain ways, to engage in behaviours that are somehow relevant to one's attitude and lastly the cognitive component, which refers to the thinking and interpreting that goes into forming or using an attitude (Baron and Byrne 1991).

Attitude is gained through experience and contact with the world around us (Davis and Houghton 1995). As individuals develop, they acquire a set of beliefs and attitudes that in part influence how they interact. They may be altered by new experiences and information. Essentially, attitudes are formed through a learning process, which can occur in a number of ways: classical conditioning, operant conditioning, observational learning and imitation.

The nursing of HIV/AIDS patients requires special skills. They include the identification and management of specific clinical problems, counselling techniques, the administration of patient care and the ability to communicate effectively with individuals, families and community groups. Staff caring for HIV/AIDS patients need to acquire new attitudes, knowledge and skill as they become immersed in the multi-disciplinary problems of AIDS care and prevention. They should be ready to learn from personal experience and from their colleagues. When talking about attitudes, feelings and values, it is essential to remain objective, to empathise without becoming emotionally involved, to listen with respect and to challenge received wisdom where necessary.

Nigerian nurses are human beings living within the society. They do not exist in some rarefied atmosphere. Outside work they still interact with acquaintances, friends, family members and colleagues. They are therefore exposed to the same influences as the general public. If AIDS has been stigmatised, and its victims apportioned blame for being infected by our society, one should expect not only lay social groups but health professionals to respond differently to sick people for whom they hold responsible for the illness and those seen as blameless (Miles 1991). Ghodse's (1978) study of the attitude of British casualty staff towards caring for drug overdose patients showed that patients deemed to be responsible for their 'condition' received

less sympathy and medical effort than was the case with those whom staff deemed to be blameless for their condition. An important part of the sick's role is society's acceptance that sick people are not responsible for their condition, did not bring it about and could not have avoided it. If professionals or lay social groups input responsibility to sick persons for their sickness much less sympathy and assistance is accorded them; rather, they meet with social disapproval. Here again, HIV/AIDS infection, especially in adults, is illustrative of the sorts of condition for which the social group charges responsibility to the sufferer. The view widely held is that HIV/AIDS is the disease of 'the impure', affecting some culturally defined outgroups (Miles 1991).

Other factors shown by the literature which could bear influence on nurses' attitude includes the highly bureaucratic system in Nigeria's health care institutions, which ignores and fails to utilize the informal organisation. This demand to conform to bureaucratic regulation leads to ritualism, defensiveness and difficulties. But nurses do not believe that nursing care operates in a vacuum. They are apt to hold some strong opinions and be highly vocal. They view neither the supervisor nor the director of nurses as infallible. All this is not to say that today's nurses are unfeeling, lack dedication or are any less concerned with patient care than were their predecessors, nor have they lost respect for physicians and their awesome responsibilities. On the contrary, they want, and demand, participation and respect. In the rapidly changing health care patterns of today, however, the nurse finds herself in a precarious, threatened and frustrating position.

Fear is another factor which can blur judgement and compromise the quality of nursing care. It is brought about by feelings of impending danger and could manifest itself in the form of anxiety (Baird and Bearslee 1990). Some nurse experience nightmares and increased anxiety levels while nursing HIV/AIDS patients, while others have been known to request for transfer or even leave the profession. Armstrong-Esther and Hewitt (1990) found the level of fear among nurses was surprisingly high, and the desire to identify and isolate HIV/AIDS patients in clinical and social settings disturbingly high. In a related work by Akinsanya and Rouse (1992), 33 percent of hospital staff thought that nurses and doctors caring for HIV/AIDS patients would run the risk of infection. In their sample of hospital and community nurses, Melby *et al.* (1992) found the former group more fearful of nursing HIV/AIDS patients and thus more liable to refuse to care despite the availability of appropriate equipment.

The United States Centers for Diseases Control (1987) reported twelve health care workers to be HIV positive after work-related exposure to infected blood. Also, in a disturbing report in the *Nursing Times,* a nurse infected with HIV was indirectly forced to resign by constantly being given sick leave when he felt he was fit enough to work. When allowed to work, he was effectively reduced to washing bedpans and changing bedsheets. The hospital authority made sure the news about his diagnosis spread around the hospital, even circulating at a student party he attended (Carlisle 1993). Should

HIV/AIDS health workers be forced to keep a deadly secret for fear of their appointment being terminated? In this respect HIV/AIDS is dissimilar to many other serious diseases and its occurrence in the workplace raises questions which go beyond those posed by other illnesses.

Nurses may be knowledgeable about HIV/AIDS, but they still exhibit inappropriate behaviour and reluctance to undertake essential nursing duties. Nigerian nurses are yet to be trained on how to handle HIV/AIDS patients. Unlike in other nursing fields, there are no HIV/AIDS specialist nurses. The practicing nurses are not willing to take the risk, more so when the basic materials they need are not provided by the hospitals despite the grim reality that HIV/AIDS patients are growing at a perplexing rate (Sowunmi and Ikhemuembe 1996). Nurses should have the right to protection during the course of their professional duties, together with the right to a working environment minimizing work-related infection. Facilities, equipment and supplies must be made available (Abiteboul *et al.* 1992). Nurses should have the right to express their concerns and fears regarding AIDS (Melby *et al.* 1992). There is also the need to have the legal right to complain about potentially unsafe working conditions (Kazanowski 1992).

Nursing is a dynamic process of action, coordination and interaction between the nurse and patients such that the basic needs of daily living and the ability to cope with health and illness at a particular point in life is enhanced (Laoye 1988). Nurses' friendliness, demonstrable empathy and understanding of the patient as a unique individual have been found to be conducive in the therapeutic relationship. Positive encouragement and reassurance is of great value to the patient since many HIV/AIDS patients see their diagnosis as a death sentence (Beedham and Wilson-Barnett 1995). It gives them some kind of hope, which is a factor in maintaining and regaining health and accepting illness limitations and even death. Hope is present in all stages of life including dying (Stephenson 1991). Nurses should therefore accept HIV/AIDS patients for what they are and not attribute characteristics to them based on their illness or its source because the majority of HIV/AIDS patients are usually abandoned by family and friends, with the patient often left to rely on the nurse for care and support.

Methodology

The theoretical framework used in this study is based on the theory of interpersonal relationships by Peplau and Festinger's theories of cognitive dissonance. Peplau (1988) described nursing as a therapeutic interpersonal relationship which facilitates the growth and development of both patient and nurse. The nurse-patient relationship is the essential tool with which to heal, as vital as applying mechanical techniques or other procedure. Nurse-patient interactions are geared towards "helping a patient gain intellectual and interpersonal

competences beyond that which they have at the point they became ill and to nurture the evolving competencies" (Peplau 1988). Long-term involvement with HIV/AIDS patients affords the nurse an opportunity to elaborate this therapeutic relationship in a unique way and to recognise that it is a partnership in which both learn and grow.

Festinger (1957), on the other hand, assumed that attitude exists in an organised psychological structure and that in maintaining this structure individuals avoid dissonance and seek consonance among attitudes relevant to each other. A dissonant relationship exists between two attitudes or cognitive elements which one implies the opposite of the other. Festinger said that one way for attitude change to occur is through cognitive dissonance. This means that the individual has feelings of discomfort because he or she has two opposing views about the same thing. This is "generated by conflicts among a person's beliefs or by inconsistencies between a person's action (behaviour) and attitude" (Baron and Bryne 1991). The individual can reduce or resolve this tension to match the behaviour or discount the importance of the dissonance. The latter is usually done by rationalising either the belief, the behaviour or the feeling.

A study was carried out at the University College Hospital, Ibadan, Nigeria. 200 male and female nurses were selected, within all the nursing ranks, and between the ages of 20 to 60 years. 200 questionnaires were distributed, which consisted of two parts: the first sought demographic data, while the second sought the nurses' attitude towards caring for HIV/AIDS patients. 193 were completed (96.5 percent response rate). Each nurse administered a copy of the questionnaire was asked to fill it in private. To ensure their anonymity, respondents were instructed not to write their names, wards and addresses. Analysis of the data was done using percentages, means, analysis of variance and standard deviation.

Findings

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities which contribute to health, to recovery, or to peaceful death, that would be performed by the patient if the patient had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible.

This study therefore finds out what the attitude of nurses in a leading Nigerian hospital will be towards caring for an increasing tide of HIV/AIDS patients, even though these patients are normally thrown out of hospital on diagnosis. 193 responses of nurses were analysed, comprising of 150 females and 43 males. 68 fell within the age range 20-30, 92 within the 31-40 age range and 33 within 41-50. 67 nurses were single, 123 were married and 3 widowed or divorced. As regards years of nursing experience, 58 nurses had up to 5 years, 57 had 6 to 10 years worth and 78 had been health professionals for over 11 years.

All of the nurses had heard of HIV/AIDS. Information on this topic comes to nurses mostly in the form of medical journals and personnel (47.7 and 70.5 percent respectively [more than one answer allowed]), as well as through the media (53.9 percent) and conferences (25.4 percent). The nurses were also found to be highly knowledgeable about HIV/AIDS-related issues, picking out sexual intercourse, shared needles and transfusion from casual contact, toilet seats and towels as modes of spread. As regards the correct measures when dealing with HIV/AIDS patients, nurses cited gloves (92.2 percent), washing hands (83.9 percent), isolation (78.8 percent), decontamination (73.1 percent), barrier nursing (71.5 percent) and masks (35.2 percent). This is in contrast with a number of admittedly earlier investigations on AIDS-related knowledge, such as that found among Canadian nurses who were ill-informed and had over-cautious attitudes to AIDS patients (Armstrong-Esther and Hewitt 1990). Bond *et al*. (1990) then associated this lack of knowledge to the anxiety, uncertainty and fear experienced by nurses on the topic generally.

One interesting aspect of this study is that even with the high level of knowledge, virtually everyone sampled still believed nurses should be given more information on AIDS. To support this finding, Bond *et al*. (1990) also found that 70 percent of their nurses sampled felt that nurses should receive specialist training in order to safely carry out the nursing care of HIV/AIDS patients. Steele and Melby (1995) state that most nurses, regardless of where they work, gain knowledge of AIDS by reading nursing journals, watching television, listening to radio and reading newspapers and magazines. More than 60 percent of their sample also indicated that they felt insufficiently trained to care for HIV/AIDS patients. This creates an element of mistrust and fear prevails amongst nurse.

In relation to exposure to infected cases, 61.1 percent of nurses sampled claimed that they had been exposed to HIV/AIDS cases in the hospital, 8.8 percent in the clinic and 1 percent in the community at large. The majority (73.1 percent) of those exposed in the hospital claimed that it was without their knowledge. This they blame on University College Hospital's doctors and administrators who somehow felt entitled to the right to admit HIV/AIDS patients without informing the nurses who provide the care. This practice was stopped in 1995 after the nurses threatened to go on strike if the practice was not discontinued. In this respect, one then wonders why UCH was made an AIDS Screening Centre with the aim of identifying and checking the spread of the disease when in actual fact it is negligent in spreading the disease to its staff who are occupationally in contact with these and other patients.

A further finding of the study showed that 70.5 percent of nurses sampled believed that University College Hospital was not equipped to manage HIV/AIDS cases in terms of materials (even water shortages), resources and skills. This is similar to Plant and Foster's (1993) study in which the overall pattern of response indicated that the highest level of concern was related to the perceived lack of in-service training, the availability of resources to treat infected patients, the issue of keeping

up with current trends and developments, and the lack of experience in dealing with HIV/AIDS patients.

On the issue of providing care, over half (52.3 percent) of nurses claimed that they have actually nursed HIV/AIDS patients. Of these, 26.4 percent said their reaction was one of fear, followed by anxiety (52.4 percent) and skepticism (6.7 percent), while 7 percent managed to stay neutral and 6.7 percent remained calm. Reasons for this skewed response reaction include lack of proper equipment (60.1 percent), fear (15.5 percent), ethical considerations (13 percent), and the fact that they were trying to care for patients with an incurable disease (11.4 percent). Only tuberculosis epidemics in the past has ever resulted in such an equivalent public hysteria as HIV/AIDS has today (Breault and Polifroni 1992). As regards Nigerian nurses' attitude to HIV/AIDS, the sample divided into 62.7 percent neutral, 20.7 percent positive and 16.6 percent negative. This finding is in marked contrast to most other studies that have tended to show health care workers in a rather poor light, discriminating in their treatment of HIV/AIDS patients.

The study also found that a majority (54.9 percent) of nurses would willingly care for HIV/AIDS patients if their work could be carried out in a well-equipped hospital setting. An overwhelming majority, 82.4 percent, agreed that such patients should not be left to die alone just because there is no cure. Over two-thirds (68.4 percent) of nurses in this study felt that HIV/AIDS patients should not be apportioned blame for being infected and a similar total, 64.8 percent, showed willingness to make cash donations to AIDS funds. These findings contradict the findings of Wellings and Wadsworth (1990) who reported that 53 percent of their sample agreed with the statement that "AIDS sufferers have only themselves to blame". Kelly *et al.* (1987) used a simulation measurement technique to conduct an experimental study of the relationship between patients' medical diagnosis, sexual orientation and nurses' attitude towards patients. They found that an HIV/AIDS medical diagnosis and a homosexual orientation in a patient elicited negative judgemental attitudes. In the nurses' majority view, they considered HIV/AIDS patients to be responsible for their illness and so deserving of their dire health condition.

Finally, using the analysis of variance test, no significant relationship was found between the age of the nurse and the attitude portrayed. The data on the relationship between the knowledge of HIV/AIDS and the nurses' attitude to HIV/AIDS was not significant. No significant difference was also found in the attitude of the nurses exposed to HIV/AIDS and the nurses not exposed.

AIDS is spreading rapidly in Nigeria. Yet nurses are providing care for HIV/AIDS patients with inadequate protection in terms of education and physical hospital equipment. The health workers are scared of this condition; they can only feel comfortable when they are assured of their own protection. Nurses are not scared of caring for HIV/AIDS patients, but for their own safety and the implications of being infected. Such fears can only be countered with an adequately resourced nursing staff, with adequate support staff to help clean the

wards, fully equipped with gloves and anti-bacterial handwash, free access to running water, laundries, autoclaves, incinerators and other safe methods of cleaning or disposing of infected material. In relation to the attitudes displayed by Nigerian nurses, they differ little from contemporaries in others parts of the world. What has to be appreciated, however, is that the nursing of HIV/AIDS patients is a developing field of standards and procedures; this continuum of universal improvement means that some groups of nurses are further down the line towards appropriate measures in terms of practice, equipment and attitude than others. In this regard, Nigerian nurses, while lagging behind in material considerations, do possess qualities which lend themselves to caring for HIV/AIDS patients.

Recommendations

1. A law should be enacted and properly enforced for the proper screening of donated blood before transfusion.
2. Hospital management must reconsider the implications of dismissing or forcing HIV/AIDS health workers to resign from their jobs, especially when infection is work-related.
3. The recognition and full utilization of professional nursing skills by administrative and governmental bodies is required. Nurses should participate in planning and policy-making at all levels in the health service by establishing interdisciplinary teams to coordinate the educational and supportive responsibilities for providing high-quality care to HIV/AIDS patients. These teams will formulate, plan and implement inservice training for all ranks of nurses, as suggested MacNeil (1992).
4. All nurses caring for HIV/AIDS patients should be given incentives to motivate them. A large number of nurses in Nigeria are leaving nursing for jobs with higher salaries, less stress and more respect in other fields.
5. Both public and private agencies should be encouraged to establish support groups for HIV/AIDS patients. Evidence suggests that social support can act as a buffer against stress, cushioning its impact. It also has a direct, positive effect on psychological well-being (House *et al.* 1982).
6. Since the fear of HIV/AIDS is associated with occupational hazards, it is important for health staff to make use of universally accepted precautionary measures (Centers for Disease Control 1987). Care of HIV/AIDS patients can be properly provided in hospitals. The practice of hospitals forcibly discharging HIV/AIDS patients is an affront to basic human rights and must cease. The Federal Government of Nigeria must provide the resources to treat all HIV/AIDS cases.

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Gladys EFFA-HEAP, *The attitude of nurses to HIV/AIDS patients in a Nigerian University Teaching Hospital*

Summary — There may be up to four million Nigerians with HIV/AIDS, but Nigeria has been slow to embark on caring for HIV/AIDS patients. The Nigerian Government has not sufficiently resourced this area of the Federal Health Service; this has implications for nurses caring for HIV/AIDS cases. Using the specific example of University College Hospital (UCH), Ibadan, the leading Teaching Hospital in the country, the paper examines the attitude of nurse caring for HIV/AIDS patients. 193 nurses were sampled with a questionnaire, and their answers analysed using percentages, means and analysis of variance. Results showed that the nurses were knowledgeable about HIV/AIDS. Nurses' attitude to HIV/AIDS patients divided into 62.7 percent neutral, 20.7 percent positive and 16.6 percent negative. Over 70 percent of nurses believed UCH was not equipped to manage HIV/AIDS patients. No significant relationships were found between attitude and either the nurses' age, the nurses' knowledge of HIV/AIDS, or the level of exposure to HIV/AIDS patients. With realistic remedies to produce more dignified treatment urgently required, recommendations for future government policies and health care practices are suggested.

Keywords: nurses • attitude • care • HIV/AIDS • patients • Nigeria.

Gladys EFFA-HEAP, *L'attitude des infirmières envers les patients malades du sida dans un Hôpital Universitaire du Nigeria*

Résumé — Il se peut qu'il y ait quelque quatre millions de Nigerians porteurs du VIH/sida, mais le pays a été lent à s'engager dans la prise en charge des patients du VIH/sida. Le gouvernement nigerian n'a pas alloué de ressources suffisantes à ce champ d'intervention du Service Fédéral de la Santé. Cette situation a des implications pour les infirmières apportant les soins aux malades du sida. A partir de l'exemple spécifique du Centre Hospitalier Universitaire d'Ibadan, le principal Hôpital de Formation du pays, cette étude examine l'attitude des infirmières soignant les patients malades du VIH/sida. Un échantillon de 193 agents de santé a été retenu pour une enquête par questionnaire ; les réponses ont été analysées, en termes statistiques (pourcentages, variance). Les résultats ont montré que les infirmières étaient informées sur le VIH/sida. Leur attitude envers les malades du sida était divisée : 62,7% étaient neutres, 20,7% positives et 16,6% négatives. Plus de 70% parmi elles pensaient que le Centre Hospitalier Universitaire n'était pas équipé pour prendre en charge les malades du sida. Il n'y a pas eu de relations significatives entre leur attitude, leur âge, leur connaissance sur le VIH/sida ou le niveau d'exposition aux malades du VIH/sida. Avec des propositions réalistes pour promouvoir un traitement plus digne, qui est urgemment requis, des recommandations sont faites pour mettre en œuvre les politiques sanitaires futures et améliorer les pratiques de soins.

Mots-clés : infirmières • attitude • prise en charge • VIH/sida • malades • Nigeria.

31. Des infirmières face au sida.

Impact de l'épidémie sur les rôles professionnels dans un service de pédiatrie du Burkina Faso [1]

Alice Desclaux

Les études des sciences sociales menées auprès des professionnels de santé en Afrique de l'ouest se sont intéressées essentiellement aux attitudes des médecins vis-à-vis de nouvelles procédures liées au VIH, telles que le conseil et l'annonce (Collignon *et al.* 1994). Par contre, les paramédicaux [2], n'ont été concernés dans la plupart des pays que par des enquêtes CACP, (Connaissances, Attitudes, Croyances, Pratiques) portant sur leur niveau de connaissances biomédicales, leurs attitudes face aux malades, et leur perception du risque de transmission au cours des soins (Sicard *et al.* 1990 ; Rouamba 1991 ; Bouvet *et al.* 1992). Ces travaux reposent souvent sur des présupposés rationalistes qui associent l'adoption des nouvelles précautions techniques à la connaissance des modes de transmission du virus ou de sa sensibilité aux antiseptiques ; mais ils ne prennent pas en compte les perceptions subjectives des personnels paramédicaux sur l'applicabilité de mesures évoquées par des études qualitatives reatives à d'autres continents (Barbour 1994 ; Giami *et al.* 1994 ; Horsman *et al.* 1995 ; Berkowitz *et al.* 1996).

Pourtant les paramédicaux n'échappent pas aux divers aspects de l'épidémie : ni à son emprise directe — les taux de séroprévalence du VIH sont élevés parmi les adultes jeunes dont ils font partie —, ni aux bouleversements du fonctionnement des institutions sanitaires dans lesquelles ils travaillent. Des économistes, préoccupés par la diminution des effectifs infirmiers alors que la charge de travail est croissante dans les services de soin, ont abordé l'impact "macrosocial" du sida sur les infirmières sous l'angle de la gestion des structures de santé (Foster *et al.* 1995) ; mais les changements induits par le sida au niveau "micro-social" des structures sanitaires ont été peu analysés jusqu'à présent pour les paramédicaux en Afrique.

Partant de l'étude monographique d'un service hospitalier pédiatrique accueillant des enfants atteints par le VIH au Burkina Faso, cet

[1] Nous remercions Éric de Roodenbeke et Bernard Taverne pour leur lecture critique.

[2] Nous comprenons sous ce terme les infirmiers (surveillants, infirmiers diplômés d'Etat, infirmiers brevetés), en excluant dans cet article les agents de santé (filles de salle, manœuvres, secouristes et bénévoles) qui participent aux soins à l'hôpital, mais ne partagent pas le même statut.

article a pour objectif d'examiner l'évolution du rôle des infirmières perceptible dans les attitudes, discours et pratiques dans un service de soin, et dans les propositions des programmes de lutte contre le sida. Les données qui servent de base à ce travail ont été recueillies dans le cadre d'une étude de l'impact de l'épidémie de sida sur la lutte contre les diarrhées et malnutritions infantiles [1], dont l'approche, la méthode et les principaux résultats ont été décrits par ailleurs (Desclaux 1995).

Le contexte

Le Burkina est l'un des pays les plus affectés par l'épidémie en Afrique de l'ouest. Sa séroprévalence, estimée à 8 %, le place en troisième position après la Côte-d'Ivoire et le Ghana. À Bobo Dioulasso, 12,7 % des femmes enceintes étaient séropositives en 1995 (Anonyme 1995). Le service de pédiatrie du Centre Hospitalier National Sanou Souro de Bobo Dioulasso comprend 138 lits, dispose d'une équipe de 6 médecins, 14 infirmiers, 4 filles de salle et plusieurs agents, et accueille chaque année 15 000 consultants et plus de 4 000 enfants hospitalisés, ce qui correspond à une activité importante. L'hôpital est de rang national, il reçoit les enfants orientés par les hôpitaux de district de huit provinces (soit près de 3 millions d'habitants), et les centres de soins de la province du Houët (centres médicaux et centres de santé et de promotion sociale) sont censés lui adresser les enfants suspectés d'être atteints par le VIH.

Le premier cas de sida a été diagnostiqué dans le service de pédiatrie en 1986. En 1990-91, le taux de séroprévalence était de 4,7 % chez les enfants hospitalisés âgés de 1 à 3 ans (Tall *et al.* 1993) et de 14,5 % chez les enfants malnutris hospitalisés (Prazuck *et al.* 1993). Au moment où cette étude a été réalisée, environ deux enfants séropositifs au VIH étaient dépistés dans le service, en moyenne, chaque semaine. Ces enfants sont presque tous des enfants admis pour des pathologies associées (malnutrition sévère, infections cutanées, pneumopathie, diarrhée persistante) dont la gravité, l'intrication, le caractère récurrent ou la résistance au traitement évoquent une défaillance immunitaire. Lorsque ces signes sont constatés, un dépistage du VIH par les tests Elisa et Western Blot est proposé aux parents, mais n'est pas systématiquement réalisé du fait de son coût [2]. Aussi le nombre des enfants dont on connaît la séropositivité est largement inférieur au nombre des enfants infectés par le VIH accueillis par le service. Il n'existe pas de protocole standardisé de prise en charge du VIH, ni de programme spécifique de soutien médico-social dans le service, et la

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[1] L'étude sur "L'impact de l'épidémie de sida sur la lutte contre les diarrhées et malnutritions infantiles à Bobo Dioulasso, Burkina Faso" a été réalisée de 1992 à 1994. Elle a été financée par l'ANRS (Agence nationale française de recherches sur le sida.

[2] Seul examen paraclinique non compris dans le forfait d'hospitalisation pédiatrique, le test VIH coûtait 2 000 FCFA au moment de l'enquête et jusqu'en 1995, ce qui correspond à un dixième du montant du salaire minimum mensuel ; son prix a été réduit à 500 FCFA (1 F CFA = 0,01 FF).

prise en charge effectuée comprend essentiellement le traitement des infections opportunistes et le traitement nutritionnel de l'enfant. Les pédiatres sont confrontés d'une part aux aspects psychologiques du conseil qui dépassent leur rôle habituel, d'autre part aux problèmes économiques courants qui limitent la réalisation des traitements prescrits, enfin à l'échec thérapeutique face à cette pathologie. Les facteurs économiques expliquent en grande partie les "évasions" (ou sorties contre avis médical) d'enfants hospitalisés, et le recours toujours important aux praticiens du secteur traditionnel et aux médicaments du marché illicite (Desclaux 1996b). Les stratégies qui ont été mises en place dans le service face à l'épidémie de sida comprennent, au moment de l'enquête, la réalisation d'une session de formation du personnel et l'instauration de mesures de prévention telles que la restriction des indications de transfusion, l'introduction de matériel d'injection à usage unique et la généralisation de précautions dans les actes techniques. Pour préserver les enfants malades de la divulgation de leur atteinte par le VIH, les médecins du service ont décidé en 1991 d'éviter que les paramédicaux aient connaissance de ce diagnostic.

Le rôle des infirmières de pédiatrie face au sida

Avant l'épidémie de sida, les taux de mortalité infantile élevés dans le service confrontaient quotidiennement les infirmières au décès de leurs malades. Par l'accueil des enfants atteints de malnutritions sévères, la prise en charge de pathologies chroniques au devenir aléatoire était une activité habituelle. Enfin, la fréquence de maladies infectieuses telles que les méningites, les hépatites et les tuberculoses exposait les soignants à la contagion dans le cadre de leur travail. En quoi, dans ce contexte, la prise en charge du sida est-elle spécifique pour les infirmières ?

Le service de pédiatrie tient à la fois de l'hôpital, dont il a les caractéristiques fonctionnelles, et des services de Santé Maternelle et Infantile : les paramédicaux y sont en très grande majorité des femmes, et leur rôle comprend non seulement la réalisation des gestes techniques spécialisés (prélèvements divers incluant les ponctions lombaires, pose de voies veineuses, de sondes, transfusions, etc), l'administration ou la distribution des traitements, l'enregistrement des malades et des prescriptions, mais aussi les conseils aux accompagnants et "l'éducation des mères", individuellement ou collectivement (au centre de renutrition attenant au service). La réalisation des gestes techniques et l'"éducation des mamans" constituent les éléments fondateurs du rôle des infirmières telles qu'elles le décrivent. Par contre, l'alimentation, l'hygiène de l'enfant hospitalisé, ainsi qu'une part importante de la surveillance des traitements sont assurées par l'accompagnant. L'aide psychologique à l'enfant ou au couple mère-enfant ne fait pas davantage partie du rôle décrit ou revendiqué par les infirmières.

Avec les enfants

Pour la majorité des infirmières, la spécificité du sida tient au fait qu'elles ne sont pas "officiellement" au courant du diagnostic. Elles déclarent cependant : "*Les médecins ne nous donnent pas les résultats mais bien sûr on s'en doute*", "*On soupçonne*", "*On s'en rend compte*". Les termes utilisés évoquent une connaissance tantôt imprécise, tantôt très affinée, qui se fonde d'une part sur des indices obtenus dans le service, d'autre part sur l'expérience clinique et sur le savoir acquis par la formation en matière de sida, enfin sur des éléments "d'épidémiologie populaire". Lorsqu'un examen sérologique VIH est prescrit, les infirmières ou les filles de salle peuvent en avoir connaissance "accidentellement", en assistant à la consultation médicale, par le type d'examen paraclinique demandé (avec mention, codée ou pas, du test VIH), ou en accompagnant le malade ou son parent dans les services administratifs ou au laboratoire. Dans le service, le personnel évoque ces cas : "*On en parle entre nous*". Une information officieuse autour des enfants ayant subi un test, donc "suspects" d'être atteints, circule parmi le personnel du service. Les signes évocateurs du sida sont d'abord pour elles l'importance de la diarrhée ou la gravité de l'amaigrissement, la résistance au traitement, la notion de maladie ou de décès des parents, leur séjour en Côte-d'Ivoire ou leur appartenance aux catégories sociales "aisées" ou "éduquées" : "*Par exemple quand c'est un enfant de quelqu'un qui travaille, par exemple quelqu'un de la fonction publique, qui arrive pour malnutrition, automatiquement je pense à une possibilité de séropositivité. Parce que quand même, ce sont des gens qui comprennent... Ceux qui sont ignorants, je leur attribue la malnutrition, quand il y a les moyens de nourrir les enfants, là il y a doute*". Certains de ces critères infirmiers, tels que le retour de Côte-d'Ivoire, correspon-dent aux représentations populaires du sida, le sida étant appelé *Abidjan bana* (maladie d'Abidjan) à Bobo Dioulasso. L'amaigris-sement et la diarrhée correspondent aux signes cliniques les plus facilement perceptibles des critères de Bangui définis par l'OMS et utilisés par les médecins pour établir un diagnostic de sida (WHO 1989). Enfin, des critères comme la catégorie sociale telle qu'elle est comprise dans la dernière citation sont plus spécialisés, et résultent du savoir et de l'expérience professionnelle propre des infirmières. Comme un diagnostic populaire, ce diagnostic infirmier a été construit par l'assemblage d'éléments hétérogènes définis en grande partie par l'observation empirique et sélectionnés sur la base de leur sensibilité plus que de leur spécificité. D'usage interne au groupe des personnels paramédicaux, il n'est pas évoqué avec les médecins. Dans certains cas, il amène les infirmières à considérer comme "suspects" des enfants dont l'atteinte par le VIH n'a pas été envisagée par les médecins. Tous les enfants séropositifs leur paraissent *a priori* atteints, alors qu'entre leur naissance et 18 mois, environ deux enfants séropositifs sur trois sont indemnes, et seulement porteurs des anticorps maternels. Enfin, les enfants hospitalisés pour d'autres pathologies (paludisme, etc.) ne sont pas considérés comme "suspects" par les infirmières, alors que le taux

élevé de séroprévalence dans la population générale permet de penser qu'un certain nombre d'entre eux sont atteints par le VIH. C'est ce "diagnostic infirmier" qui détermine en partie les attitudes des paramédicaux.

Face à la maladie

De l'avis du personnel soignant, le diagnostic médical d'atteinte par le VIH modifie le propos de la prise en charge, dominé pour les infirmières par l'échec thérapeutique et le découragement. La multiplicité des pathologies et la difficulté à les traiter confrontent surtout les parents de manière répétitive au coût des traitements. L'intervention des infirmières est ainsi directement soumise aux capacités économiques des parents à acheter les produits pharmaceutiques prescrits. Leur impuissance face à ces contraintes qui limitent l'efficacité de leur travail retentit sur leurs attitudes, qui s'échelonnent entre la compassion et la condamnation des mères (Desclaux 1996a). Ces attitudes sont souvent ambivalentes et porteuses d'une charge émotionnelle importante, qui semble être observée dans des contextes très variés de soins infirmiers auprès de malades du sida (Giami et Veil 1992). Elles conduisent aussi à des stratégies d'évitement, qui consistent pour l'infirmière à ne pas interroger la mère sur les médicaments qu'elle n'a pas pu acheter pour éviter que soient révélées au grand jour la double impuissance du soignant et du parent, selon un schéma interactionniste (Goffman 1974). Cet évitement peut aussi dépasser le cadre de la communication entre une infirmière et une mère pour retentir sur des attitudes plus générales de résistance face aux tâches à accomplir, qui ont été décrites dans d'autres hôpitaux africains (Hours 1985). Pour certaines infirmières le coût de la prise en charge, qui ne pourra pas à terme empêcher le décès de l'enfant, est en contradiction avec l'intérêt de sa famille et remet en question l'utilité de l'hospitalisation. Même lorsque toutes les difficultés de la prise en charge hospitalière ont pu être résolues et ont permis un certain niveau d'amélioration clinique, les enfants demeurent, dans les représentations des infirmières, des enfants qui ne guériront pas, alors que les médecins du service observent des cas d'adolescents porteurs du VIH et asymptomatiques, qui remettent en question les pronostics médicaux pessimistes habituels en Afrique.

Avec les mères

L'intervention éducative auprès des mères occupe une place importante dans le rôle que s'assignent les infirmières, qu'elle ait lieu au cours de séances collectives ou dans la communication interindividuelle entre infirmières et parents, et dépasse le niveau d'une simple information. L'analyse des perceptions que les mères ont des messages délivrés autour de la malnutrition et des diarrhées infantiles banales montre que les notions apprises à l'hôpital leur permettent d'attribuer un sens aux événements pathologiques plus souvent qu'elles ne déterminent les pratiques. En cas d'atteinte par le VIH, les

messages éducatifs demeurent inchangés, passant sous silence le sida pédiatrique ou l'abordant de manière abstraite, l'objectif n'étant pas de permettre aux mères de suspecter ce diagnostic. Face au sida, les infirmières ne peuvent plus informer la mère sur les causes et le pronostic de la maladie, ni affirmer l'efficacité d'une conduite élémentaire à tenir. Leur perception très pessimiste du pronostic et l'absence de "messages" clairement identifiés qu'elles pourraient transmettre aux parents d'enfants atteints invalident leur rôle éducatif. Pour la mère, l'attribution de sens en rapport avec les concepts biomédicaux n'est plus effective.

De plus, outre le fait qu'elles ne connaissent pas "officiellement" le statut sérologique de l'enfant, les infirmières ignorent lesquels, parmi les parents, ont été informés de ce statut, tout en sachant que certains parents "soupçonnent" l'atteinte. Les stratégies de réponse des soignants consistent alors à évoquer la conduite à tenir en cas de diarrhée ou malnutrition "simples", à répondre de manière évasive, à éviter les questions : "*On ne va pas se familiariser beaucoup avec les malades*". De l'avis de la majorité des infirmières, les parents devraient être avertis du diagnostic pour permettre la communication dans le service. Mais cela ne suffit pas : la communication soignants-mères, de par la place importante qu'elle accorde à l'intervention éducative, ne peut avoir lieu sans la définition de "messages" destinés aux parents d'enfants atteints par le VIH, qui suppose de redéfinir le sens de la prise en charge médicale.

Face à la mort

Lorsqu'elle est évoquée verbalement, la mort d'un enfant fait l'objet de métaphores : "*Il n'est plus là*", "*Il est parti*". Ces précautions oratoires reflètent des usages attestés dans la plupart des groupes sociolinguistiques d'Afrique de l'ouest (Thomas 1982), auxquels les institutions sanitaires ne dérogent pas. Comme le décès de l'enfant, un mauvais pronostic fait partie des thèmes sur lesquels la communication entre parents et soignants est évitée, car celui qui annonce serait, selon les infirmières, considéré par les parents comme celui qui provoque le malheur. Les parents interrogent pourtant les paramédicaux sur le pronostic pour leur enfant. Dans l'impossibilité de donner un pronostic défavorable et d'évoquer les aspects biomédicaux de la maladie, les paramédicaux répondent aux questions et demandes indirectes des parents par ce qu'ils considèrent comme une forme d'encouragement et de "soutien moral", ayant pour fonction de maintenir une communication lorsque la plupart des thèmes habituellement abordés dans la relation de soins doivent être évités. L'importance d'un discours de ce type a été décrite dans d'autres institutions, telles qu'un hôpital de jour pour malades du sida en France (Boiron et Licht 1993) et une institution spécialisée dans la prise en charge du cancer au Québec (Saillant 1988). Au-delà des enjeux de la communication, le décès de l'enfant dans le service ne fait pas l'objet d'interventions de la part des soignants, à l'exception de la dépose du petit matériel médical (perfuseurs, sondes). Les parents

emportent alors le corps de leur enfant aussi rapidement que possible. Bien que les décès d'enfants y soient très fréquents, le service n'est pas considéré comme un lieu où la mort est acceptée et gérée, et la notion d'anticipation de la mort permettant "l'assistance en fin de vie" n'y est pas recevable.

Confrontées au VIH

S'il ne doit théoriquement pas influer sur les rôles, le risque de contamination par le VIH dans le service retentit en permanence sur les attitudes et les pratiques des infirmières. Les mesures de protection mises en œuvre dans l'hôpital correspondent aux "précautions universelles" recommandées par l'OMS (Anonyme 1988) : utilisation de matériel à injection jetable, procédures de désinfection, suppression du recapuchonnage des aiguilles, port des gants lors des actes sanglants, etc. Mais ces mesures sont soumises à des interprétations, favorisées par l'imprécision de la stratégie nationale dans ce domaine, par l'insuffisance de l'information des personnels paramédicaux et par les difficultés matérielles à appliquer les règles. La majorité des infirmières ignorent la valeur du risque statistique de contamination lors d'une piqûre avec une aiguille souillée par du sang contaminé, estimé dans les pays tropicaux à 0,49 % (Veeken *et al.* 1991). Ce risque leur semble majeur, et provoque une crainte permanente. Par contre, les infirmières semblent surestimer l'efficacité protectrice des gants, alors qu'il est établi que la précaution la plus efficace est le fait de ne pas recapuchonner l'aiguille utilisée. Mais pour elles, le port des gants est une protection (pour elles-mêmes) plus efficace que les précautions (à visée plus abstraite). Aussi, l'absence de gants ou leur nombre insuffisant (ou perçu comme tel) sont-ils ressentis de manière particulièrement aiguë par les infirmières, qui ne se sentent pas protégées par les autres mesures. Elles prennent donc des précautions supplémentaires, sélectives, vis-à-vis des enfants pour lesquels le "diagnostic infirmier" de sida a été porté ou dont la séropositivité est connue. L'impact de cette catégorisation porte d'abord, dans les discours, sur les attitudes, résumées par l'énonciation : "*On se méfie, on n'a pas la même réaction*".

Face à leur maladie

La crainte de la contamination est évoquée clairement par la quasi-totalité des infirmières. À la crainte d'une contamination "théorique", exprimée aussi pour d'autres pathologies telles que la tuberculose, s'ajoute avec le sida la peur d'avoir soi-même été contaminée à diverses occasions, fréquentes dans le contexte (piqûre avec une aiguille souillée, contact avec une plaie non protégée), et de ne pas encore le savoir. "*Tous les jours on a peur, bien sûr*". La peur est alimentée par la fréquence en milieu tropical de pathologies qui peuvent, par leurs symptômes, évoquer des infections opportunistes : "*Dès que j'ai une petite diarrhée, je me dis que c'est ça…*". Les tests sérologiques ne sont pas perçus par les soignants comme un moyen de

suspendre l'angoisse, et les soignants y ont très peu recours (Desclaux 1996d). L'atteinte d'une infirmière du service, son entrée dans la maladie au début de 1993 et son décès quelques mois plus tard ont ravivé cette crainte générale.

L'épidémie de sida a induit chez les infirmières des perceptions dominées par des sentiments d'impuissance (liée aux échecs thérapeutiques, au caractère insurmontable des difficultés financières et à l'impossibilité de mener une intervention éducative), d'insécurité (qui persiste malgré l'adoption individuelle plus ou moins précise des précautions universelles), et d'incertitude (concernant le risque de contamination, l'intérêt de la prise en charge thérapeutique des enfants, et l'objet de la communication avec les mères). Dans le service de pédiatrie, le sida n'induit pas de nouvel acte technique qui aurait permis aux infirmières de développer leur compétence et d'accroître la reconnaissance de leur profession. Leur rôle antérieur est mis en péril sur ses deux aspects principaux et le sida, qui n'est jamais clairement mentionné, "parasite" la communication avec les médecins comme avec les mères. L'exercice quotidien de leur profession s'écarte des normes théoriques nationales concernant le sida, qui mettent en avant une sécurité des actes en partie hors du contrôle des infirmières, et une intervention de "conseil psychosocial personnalisé" qui leur est impossible du fait de l'absence d'information sur les diagnostics.

Points de vue sur le rôle des infirmières face au sida

Les changements observés dans les perceptions, les attitudes et les pratiques du personnel paramédical se font dans l'interaction avec leurs "partenaires" professionnels que sont les médecins, l'administration hospitalière, les instances nationales de lutte contre le sida et les associations professionnelles. Ils doivent être mis en rapport avec les attentes de ces partenaires.

Le rôle des infirmières et les médecins

Du point de vue des médecins du service, l'intervention du personnel paramédical face au sida est dominée actuellement par deux aspects : l'adoption de précautions dans les actes infirmiers qu'ils estiment satisfaisante, et la question de la connaissance du statut sérologique des enfants et du secret médical. De l'avis des médecins, informer les paramédicaux du statut sérologique des enfants favoriserait la mise à l'écart de certains d'entre eux ; d'autre part, cette information serait divulguée dans l'équipe soignante et au-delà, car les paramédicaux ne respecteraient pas le secret médical, essentiellement parce qu'ils n'ont pas reçu de formation initiale sur les aspects éthiques du soin. Du point de vue des infirmières, les attitudes en matière de secret médical ne tiennent pas à un manque d'information ou à une absence de respect des règles éthiques qui seraient constitutifs de leur profession, mais aux difficultés de contrôler la circulation de l'information médicale dans des services hospitaliers fréquentés par de

nombreux malades et soignants, qui ne limitent pas suffisamment leurs propos, quelle que soit leur catégorie professionnelle.

Cette question centrale du partage de la connaissance du statut sérologique par l'équipe soignante se pose dans la plupart des services de soins. Elle a été discutée lors d'un atelier national, dont le propos était de définir des protocoles de prise en charge des malades [1] ; la majorité des médecins se sont alors prononcés en faveur de l'ouverture au principe du "secret partagé", dans le cadre de nouveaux programmes où les paramédicaux élargiraient leur pratique à des visites à domicile calquées sur l'expérience des pays africains plus avancés dans l'épidémie, ou des interventions de *nursing* calquées sur les pratiques des pays développés. En attendant ce développement, les médecins du service de pédiatrie préfèrent continuer à "garder le secret", seul moyen selon eux de garantir un traitement éthique de tous les enfants. Le rôle "d'éducation sanitaire" que jouent les infirmières auprès des mères doit, pour eux, être renforcé pour les enfants atteints par le VIH, et pourrait se prolonger par un soutien psychologique régulier à domicile ayant pour objectif premier d'assurer la régularité du suivi médical.

Mais selon les médecins du service, toutes les infirmières ne sont pas également susceptibles de remplir ce rôle. La communication avec les mères demande certaines aptitudes, mais plus encore, une attitude faite d'équité et de patience : "*avoir la volonté*", qui n'est pas, d'après eux, partagée par tous les agents de santé. Qu'ils l'expliquent par l'insuffisance de la formation initiale des infirmiers, par leur absence de motivation au moment de choisir une orientation professionnelle, ou par leur refus de partager leur savoir considéré comme un privilège, les médecins estiment que les infirmiers sont généralement peu motivés par la communication avec les malades. L'aptitude à communiquer ou à s'occuper des enfants les plus "décourageants" (les enfants sévèrement malnutris étaient déjà considérés comme tels avant le sida) est alors considérée comme un trait personnel, qui dépendrait de l'origine sociale des infirmières, leur engagement politique, leur appartenance ethnique, leur engagement religieux, leur personnalité ou leur expérience individuelle. Bien que soulignant le devoir que représente pour toute infirmière la communication avec les mères, constitutive de son rôle professionnel, les médecins, par souci d'efficacité, tendent à sélectionner sur des critères personnels celles qui pourront avoir accès à des informations et assureront l'éducation et le soutien psychologique.

Le rôle des infirmières et l'administration hospitalière

Depuis le début de l'épidémie, au cours des séminaires de formation, le personnel paramédical a fréquemment soulevé la question de la prise en compte du sida comme maladie professionnelle, et de son

[1] Séminaire national pour la standardisation de la prise en charge du sida. Comité national de lutte contre le sida, Direction provinciale de la Santé du Houët, Bobo Dioulasso, 4-8 juillet 1994.

indemnisation. Le risque de contamination en milieu professionnel a été discuté par les médias à plusieurs reprises, notamment autour d'un cas d'agression d'une infirmière par un malade [1]. Les instances nationales de lutte contre le sida ne se sont pas prononcées officiellement sur ce point, mais les porte-parole publics du comité avaient affirmé sa position sur ce problème : la contamination ne pourrait être considérée comme un accident du travail, ni le sida comme maladie professionnelle. Aucune procédure médico-légale (telle qu'un examen de dépistage) n'est définie en cas d'accident exposant un membre du personnel au sang contaminé. Interrogé sur les attitudes du personnel paramédical, le directeur du premier hôpital national déclarait lors d'un débat télévisé que les agents de santé atteints par le VIH "*travaillaient et participaient jusqu'à leur mort*" [2]. Le personnel hospitalier peut légalement bénéficier de la gratuité pour les consultations médicales, de l'accès aux médicaments génériques auprès de la pharmacie de l'hôpital, d'indemnités journalières en cas de maladie, mais l'État ne peut pas totalement honorer cet engagement et ne finance pas les médicaments en quantité suffisante. Aucune mesure spécifique n'a été définie concernant le sida, et l'absence d'aide matérielle, de la part de l'administration de l'hôpital, pour certains examens coûteux et pour les traitements qui n'existent pas sous forme générique, a été ressentie avec acuité par le personnel du service au cours de l'épisode douloureux de la maladie de leur collègue. Elle est interprétée comme une absence de reconnaissance de l'appartenance des infirmières à l'institution hospitalière, qui pourrait, selon elles, se matérialiser par quelques avantages. Pour elles, une infirmière malade se trouve proche de la situation d'un malade ordinaire, confrontée aux mêmes problèmes résumés par cette observation : "*Le sida n'est pas à la portée de nos salaires*". D'autre part, les "arrangements" pris dans le service pour diminuer la charge de travail de l'infirmière malade entre les périodes d'arrêt de travail n'ont été dus qu'à la volonté du chef de service, aucune disposition administrative n'ayant été prise dans le sens d'un aménagement des postes. La seule mesure administrative fut l'émission d'une note de service invitant les membres du personnel à se rendre à ses funérailles. Deux membres du personnel étant décédés du sida à quelques jours d'intervalle, un grand nombre d'employés de l'hôpital devaient se retrouver à deux reprises pour les funérailles de l'une des leurs, ce qui ne pouvait que favoriser la prise de conscience collective de leur vulnérabilité face à la maladie. La plupart des infirmières estiment que l'administration hospitalière ne respecte pas ce qu'elles considèrent comme des devoirs envers ses employés, et se perçoivent "*envoyées par l'hôpital pour s'occuper des malades, et abandonnées lorsqu'elles sont contaminées*".

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[1] Ouattara Souleymane, « L'agression d'une infirmière par un sidéen : crime ou geste de désespoir ? », *Sidwaya*, n°2089, 28 août 1992.

[2] Débat télévisé du 1er décembre 1992, Télévision Nationale Burkinabè.

Le rôle des infirmiers dans le Programme national de lutte contre le sida

L'analyse des plans successifs de lutte contre le sida (Anonyme 1987, 1990, 1993) montre une prise en compte précoce de la transmission iatrogène, avec des interventions de formation du personnel de santé sur ce point prévues dès 1987. À partir de 1990, le personnel paramédical a été impliqué à un autre niveau, celui du soutien psychologique des personnes atteintes. Le premier plan à moyen terme prévoit de déterminer quels professionnels de santé (incluant les infirmiers) seront impliqués dans les services hospitaliers dans le soutien psychologique, d'élaborer des recommandations concernant ce soutien, de mettre en place des rencontres avec des psychologues et psychiatres pour en déterminer le contenu. En 1992, le second plan à moyen terme ne définit pas d'autre objectif concernant le personnel paramédical, mais prévoit de "recycler les agents de la santé et de l'action sociale" et de "mettre à leur disposition une documentation sur le sida". Les faibles effectifs de psychiatres et psychologues ont limité la mise en œuvre de ces décisions administratives. Des sessions de formation ponctuelles, de contenus et de durées variables, ont été effectuées auprès des personnels de santé de certaines structures sanitaires, mais le travail de définition du rôle des personnels de santé n'a pas été mené au niveau national. Si la pratique des paramédicaux n'est régulée sur ce point par aucune circulaire administrative, le fascicule *Bien connaître le sida pour mieux le combattre* (CNLS 1991) est le seul document qui présente les recommandations qui ont été définies au plan national. Ces recommandations concernent les infirmiers :

> « Le personnel soignant doit changer ses habitudes et sa mentalité : ne pas condamner le malade, ne pas le rejeter, ne pas l'entourer de soins excessifs, avoir conscience des conséquences très importantes par rapport à la famille, aux amis, au milieu professionnel, etc.
>
> Le personnel peut constituer des groupes de soutien, car le travail avec les malades et les mourants face à l'impuissance devant la maladie peut conduire à des dépressions, des situations d'épuisement (repli affectif, hostilité, cynisme...) ».

Concernant le rôle professionnel des paramédicaux, les adaptations proposées visent à éviter des effets négatifs : ceux du virus (contamination, épuisement) et ceux "des habitudes et de la mentalité" des professionnels. Les catégories professionnelles impliquées et les spécificités liées aux contextes de travail, notamment celui de la pédiatrie, posant des problèmes particuliers (Cook 1994), ne sont pas précisées. Ainsi, les changements proposés sont-ils peu définis, et présupposent que les "habitudes et la mentalité" actuelles des personnels paramédicaux constituent un frein à la prise en charge, sans reconnaître à ces personnels des compétences propres en matière de sida. Les paramédicaux ne sont pas représentés au sein du secrétariat du Comité national de lutte contre le sida.

Le rôle des infirmières et les organisations professionnelles

Le rôle des infirmiers face au sida n'a pas fait l'objet de revendications de la part des syndicats infirmiers (Syndicat de la Santé animale et humaine, Syndicat autonome des infirmiers et des infirmières) à l'hôpital de Bobo Dioulasso, mais l'Association burkinabè des infirmières (ABI) s'est engagée dans la lutte contre le sida. Cette association a notamment créé un stand d'information pour la population, multiplié les conférences et les "causeries" à Ouagadougou et Bobo Dioulasso, et cofondé le premier centre de dépistage anonyme et volontaire du Burkina Faso. Ces actions correspondent pour les infirmières à un engagement, généralement bénévole, dans la lutte contre le sida, même si elles sont en partie réalisées pendant les heures de travail avec l'accord des responsables de leurs services. Cette association, qui rassemble les infirmières dans un contexte actuel de masculinisation massive de la profession, revendique une implication des soignants auprès de la population, héritée à la fois du principe d'assistance aux souffrants qui a été développé par la première école d'infirmières du Burkina Faso créée par le Père Goarnisson, et du principe d'engagement social hérité de la participation des infirmières au travail de l'Union des femmes burkinabè dans les "secteurs" (quartiers et villages) à l'époque sankariste. L'ABI milite à la fois pour une affirmation de cet engagement des infirmières dans le cadre de leur rôle professionnel, et pour faire reconnaître ce rôle auprès des institutions de lutte contre le sida.

Du rôle professionnel à l'implication personnelle

Les infirmières du service de pédiatrie ressentent comme un engagement très personnel l'exposition au risque de contamination dans le service, qui est indéniablement un risque vital, davantage perçu comme tel que les risques préexistants liés à d'autres pathologies. Ce risque peut provoquer des conflits entre responsabilités professionnelle et personnelle (telle que la responsabilité parentale, fréquemment évoquée) qui redoublent son importance : des infirmières déclarent par exemple qu'elles ne peuvent pas se permettre d'être malades tant que leurs enfants ne seront pas autonomes. Le risque d'être contaminé se prolonge par le risque fantasmé de devenir soi-même contaminant pour son entourage personnel : " *J'ai peur, pas pour moi mais pour ma famille* ". De nombreux autres aspects de leur travail impliquent aussi les infirmières sur le plan personnel. En l'absence de service de documentation organisé dans les structures sanitaires, s'informer suppose une démarche personnelle, qui n'est pas anodine pour les infirmières, car elles pensent qu'en demandant des informations sur le sida, elles pourraient être "suspectées" d'être elles-mêmes séropositives, dans un pays où la connotation "morale" associée au sida est encore très prégnante (Desclaux 1996c). Pour une grande partie du personnel paramédical, certains aspects de l'intervention auprès des enfants atteints par le VIH, tels que l'éducation sanitaire des mères et le soutien psychologique devraient aussi relever d'une option person-

nelle de l'infirmière et être effectués par des professionnels volontaires, qui recevraient éventuellement une formation complémentaire pour cela.

Le sida engage ainsi les agents de santé paramédicaux, plus que toute autre maladie, sur un plan personnel. Cette "personnalisation" de l'intervention s'effectue, sur certains points, au détriment du rôle professionnel, lorsque la participation de certains agents, choisis ou autodésignés, dispense d'autres agents d'accomplir les activités qui leur sont assignées. Sans régulation institutionnelle, cette tendance comporte un risque de différenciation officieuse d'un personnel de santé spécifiquement attaché à la prise en charge du sida, et donc d'une "fragmentation sociale" liée au sida, observée à plusieurs niveaux dans la société burkinabè.

Conclusion

Les infirmières ont le sentiment "*d'être aux premières lignes face à la maladie*", et cependant mises à l'écart du savoir et des règles qui fondent l'appartenance au secteur médical ; le droit à des privilèges qui marqueraient leur appartenance à l'institution hospitalière leur semble refusé. Le fait d'être mises en danger par les gestes techniques et incertaines sur le sens de leur intervention suscite chez elles un sentiment de disqualification. Soupçonnées de ne pas respecter les règles de l'éthique, n'étant pas assurées de bénéficier d'un traitement particulier en cas de maladie, elles ressentent une dévalorisation de leur statut. Dans les pays occidentaux, les infirmières ont, en rapport avec l'épidémie de sida, affirmé la réorientation de leur rôle professionnel en mettant en avant leur intervention en matière de *caring*, prépondérante par rapport au *curing* dans le cas du sida (Fox *et al.* 1991) [1] : elles ont développé l'approche globale du malade, le suivi des traitements, l'entretien des fonctions vitales et l'aide psychosociale, ainsi que l'accompagnement en fin de vie. Ces nouveaux rôles n'ont pas leur place dans un service de pédiatrie africain tel que celui dans lequel nous avons travaillé, pour plusieurs raisons : les moyens limités dont disposent les soignants ne leur permettent pas de développer des activités nouvelles ; la répartition habituelle des rôles entre paramédicaux et accompagnants décharge l'infirmière de l'entretien des fonctions vitales et d'une partie du suivi des traitements ; les difficultés de la communication relative au VIH limitent les possibilités d'aide psychosociale ; enfin, la mort reste hors du champ de la prise en charge hospitalière dans la culture biomédicale burkinabè. Pourtant, leur intervention dans d'autres pathologies de l'enfant — telles que les malnutritions, dont la prise en charge n'est pas très différente de celle du sida pédiatrique — et dans d'autres contextes, tels que les actions de l'Association Burkinabè des Infirmières, illustre les capacités et les rôles possibles des infirmières face au sida.

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[1] *Caring* : traiter dans l'optique de soigner, prendre soin ; *curing* : traiter dans l'optique de guérir.

Les études sociologiques ont montré comment les institutions sanitaires exigent pour fonctionner une catégorisation des individus qui en dépendent, opposant notamment malades et soignants, médecins et paramédicaux. Cette catégorisation repose sur la mise en scène de divergences entre ces groupes, non seulement par la définition des rôles, mais encore par des traits sociaux et moraux, et par la manière de se percevoir et de percevoir l'autre (Goffman 1968). Avec le sida, la menace permanente pour les paramédicaux de devenir eux-mêmes des malades et d'éprouver toutes les difficultés qu'ils observent dans le cadre de leur travail brouille cette catégorisation. Il semble nécessaire de définir des procédures en cas d'accident avec exposition au sang, justifiées sur le plan médical et importantes pour la reconnaissance du statut professionnel des paramédicaux [1]. Des mesures de soutien pour les agents de santé malades pourraient aussi être mises en place à travers des consultations médicales destinées au personnel. En envisageant ces procédures, l'institution sanitaire reconnaîtrait comme un risque professionnel les situations de transmission, actuellement perçues comme une atteinte personnelle qui renvoie l'infirmier au statut de "malade ordinaire". L'importance accordée actuellement aux gants reflète peut-être la nécessité de mettre en avant des "marques" identitaires, qui, de même que la blouse blanche, symbolisent cette distinction entre infirmiers et malades, actuellement menacée par le risque du VIH.

La distinction entre médecins et paramédicaux est affirmée par les médecins lorsqu'ils dénient aux infirmiers la capacité de respecter l'éthique. Avec le sida, les médecins ne se considèrent plus seulement comme des "spécialistes du diagnostic et de la décision thérapeutique", mais aussi comme des "spécialistes de l'éthique" veillant à l'absence de discrimination et au respect de la confidentialité dans les relations de soin. Ils affirment désormais cette "distinction éthique", alors que le rapport entre professions médicales et paramédicales reste sensible (Gobatto 1996), du fait notamment des conflits de légitimité qui ont eu lieu pendant la période de la "Révolution" (1983-1987) ; de plus, la population assimile souvent les infirmiers à des "docteurs" (de Roodenbeke 1993), ce que la masculinisation actuelle de la profession favorise. Relativement fragiles dans leur statut professionnel, remis en question par leur impuissance thérapeutique face au sida, les médecins semblent trouver dans l'éthique médicale une nouvelle légitimité professionnelle qui leur permet à la fois d'affirmer leur différence vis-à-vis des infirmiers et de maintenir leur relation avec les malades.

Dans ce contexte, les infirmières se montrent à la fois intéressées et sceptiques face aux demandes qui leur ont été faites par les médecins d'étendre leur travail à des activités de soin à domicile comprenant le *nursing* et l'approche psychosociale des malades, ou de développer des

[1] Ces procédures doivent comprendre au minimum la déclaration et l'enregistrement de l'accident, l'accès à un test sérologique pour le soignant et pour le malade dont le sang est en cause, la possibilité d'un suivi médical pour le soignant, l'examen de mesures à mettre en place au niveau du service pour éviter qu'un tel accident se reproduise.

actions de "santé communautaire" à l'image de celles des pays tels que le Zaïre et l'Ouganda. Pour elles, affecter les paramédicaux hors des services de soins sans considérer leurs compétences en matière de sida dans les formations sanitaires pourrait être une forme supplémentaire de disqualification.

En termes d'application, on ne peut que souligner l'urgence d'une définition précise du rôle professionnel des infirmiers face au sida par les instances nationales de lutte. Il existe certes des rôles professionnels imposés et des rôles choisis, et la répartition des rôles au sein d'un service peut être effectuée en tenant compte des aptitudes et des choix personnels et en fonction de l'autonomie professionnelle accordée à chaque catégorie. Mais ces choix doivent se situer au niveau local et s'adapter au contexte. Au niveau administratif comme au niveau de la définition des politiques de lutte contre le sida, les aspects éthiques, indissociables de l'aide psychologique, doivent être considérés comme faisant partie du rôle des paramédicaux et de leurs obligations. Il est aussi essentiel que la prise en charge des enfants atteints par le VIH soit clairement définie pour que les paramédicaux puissent en percevoir la fonction positive et les limites. La variété des contextes spécifiques d'exercice des infirmiers et leur assimilation par la population à "des docteurs" ont limité jusqu'à présent la reconnaissance de leur fonction spécifique, et empêché l'émergence sociale d'un secteur paramédical clairement identifié. Les difficultés actuelles liées au sida pourraient contribuer à la structuration d'un corps professionnel, à la condition que le rôle des paramédicaux face au sida soit davantage connu et reconnu, et fasse l'objet d'une réflexion à hauteur de celle qui a été menée pour les médecins.

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Alice DESCLAUX, *Des infirmières face au sida. Impact de l'épidémie sur les rôles professionnels dans un service de pédiatrie du Burkina Faso*

Résumé — Si l'épidémie de sida n'a pas épargné les infirmiers, son impact sur leurs pratiques, leurs rôles professionnels et leurs relations avec les autres catégories de soignants est encore peu décrit par les sciences sociales. L'étude ethnographique d'un service hospitalier de pédiatrie du Burkina Faso montre que la pratique des infirmières est dominée par l'incertitude concernant le diagnostic des enfants et l'impuissance face aux échecs des traitements. Leur rôle, jusqu'alors centré par les gestes techniques et l'éducation sanitaire auprès des mères, est remis en question par la peur de la contamination et par l'impossibilité de communiquer autour de la maladie de l'enfant. Leurs compétences propres et leur exposition au risque du VIH ne sont pas reconnues par les instances de lutte contre le sida. Cette profession semble "disqualifiée" par l'épidémie et les infirmières jouent de stratégies d'évitement pour poursuivre leur tâche dans un service très touché par le VIH. La prise en charge des malades est inévitablement affectée par la fragilité des paramédicaux.

Mots-clés : paramédicaux • rôles professionnels • pratiques de soins • pédiatrie • service hospitalier • Burkina Faso.

Alice DESCLAUX, *Nurses in the age of AIDS. Impact of the epidemic on their professional roles in a pediatric ward in Burkina Faso*

Summary — Nurses have certainly not been spared by the AIDS epidemic; however, social scientists have to date written little about the epidemic's impact on their practices, their professional roles and their relations with other medical staff. This ethnographic study of a hospital pediatric ward in Burkina Faso reveals that nurses' practices are dominated by uncertainty concerning the diagnosis of a given child as well as a sense of helplessness in the face of the failure of treatments. Their role, which up to now had focused on technical assistance and health education for mothers, has been called into question by the fear of contamination and by the fact that it is impossible to discuss the child's illness. Their particular skills and their exposure to HIV infection are not recognised by the stop-AIDS community. It appears that this profession has been 'disqualified' by the epidemic, and nurses employ avoidance strategies so as to be able to continue to go about their tasks in a ward highly affected by HIV. It is only inevitable that the care and support of those who are ill is affected by the fragility of the paramedical staff.

Keywords: paramedical staff • professional roles • care practices • pediatrics • hospital ward • Burkina Faso.

32. Nice guys, condoms, and other forms of STDs protection: sex workers and AIDS protection in West Africa[1]

Akosua Adomako Ampofo

Introduction

Relative to North America and Europe, estimates on the incidence of AIDS in Africa are still uncertain[2]. This notwithstanding, or perhaps *because* of this uncertainty, the spread of the disease on the continent has generated a number of studies on sexual relations (Adomako Ampofo 1993, 1994, 1996; Anarfi 1992; Ankomah 1990; Caldwell *et al.* 1989; Schoepf 1988, 1992). Many of these studies have followed the Knowledge-Attitude-Belief-Practice (KABP) format and focused on 'high-risk' behavior[3] among adolescents and single urban adults (Adomako Ampofo 1993, 1997a; Ankomah and Ford 1993; Ford and Norris 1991); the sexual behavior of prostitutes has come under special scrutiny (Adomako Ampofo 1995; 1997b; Moses *et al.* 1991; Painter 1992; Schoepf 1988). The demographic picture

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[2] The World Health Organization (WHO) routinely collects statistics on AIDS cases through voluntary reporting by national authorities. WHO believes that the total number of cases reported in Africa is underreported and estimates the number based on public health surveillance data and the use of an AIDS-estimation model. As of December 1992, WHO estimated a cumulative total of 2,5 million AIDS cases worldwide (compared to 612,000 reported) with a disproportionate 71 percent believed to have occurred in Africa (United Nations 1994). Many African researchers and physicians, however, believe this to be an overestimation (Latham 1993). Certainly, the AIDS situation in Africa calls for concerned action, however, for a continent where 'diagnosed' individuals have later been reported as having been 'cured', the data must be read with some caution.

[3] Risk in sexual relationships in the era of AIDS is typically measured in terms of non-condom use where multiple partners are assumed to exist.

of AIDS in sub-Saharan Africa[1] suggests the complex socio-cultural dimensions of both the disease and the sexual relations, which are acknowledged to be primarily responsible for its spread (Ankomah 1990; Caldwell and Caldwell 1993; Langstone 1989). Hence there is a need for a more specific understanding of people's interpretation of risk to themselves. Several studies indicate that there is widespread knowledge about the existence of AIDS and the sexual nature of its spread (Adomako Ampofo 1995; Ankomah and Ford 1993; Ghana Demographic and Health Survey 1993; Kenya Demographic and Health Survey 1993)[2]. Nonetheless, sexual behavior among many groups continues to be 'risky' (Akande and Ross 1994; Bertrand and Bakutuvwidi 1991; Dodoo and Adomako Ampofo 1996; Gold 1993; Ingham 1995).

Although studies among young people and single adults have generally examined mutually 'risky' behavior among partners, studies of prostitutes have tended to examine their behavior from the perspective of their risk to their clients/partners, neglecting an analysis of their attempts, and abilities, to ensure their own (or their partners) protection. A further important gap in the discourse has been an examination of the relationship between perceptions of well being, sickness and disease prevention, accuracy of AIDS-knowledge, a sense of personal risk, and AIDS-preventive behavior. Relying on data from a sample of Ghanaian sex workers in Ghana and Côte-d'Ivoire, this study examines two issues: firstly, the relationship between women's AIDS-related knowledge and their perceptions about promoting sexual health, and their (sexual) behavior; and secondly, how the strategies women employ are related to the material basis of their sexual relations. Specifically, how the women's perceptions regarding sexual health, and their economic situations, translate into behaviors. Focus is on why some women have adopted the use of condoms and others have not, and since women form the majority of AIDS cases in West Africa, and Ghana and Côte-d'Ivoire currently have the highest number of reported cases in the sub-region, focusing on their protection is crucial.

A brief background to the development of 'modern'[3] bio-medical health care in Ghana is presentend and followed by a summary on traditional beliefs about diseases and health care. Some theoretical considerations about health beliefs and condom use are suggested. Research data, methods and findings are described; and finally suggestions for future research and policy interventions are offered.

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[1] In East and Central Africa the male: female ratios of AIDS victims are almost equal, in West Africa in the early 1990s females outnumbered males about 3:1. The age group mainly affected is between 20-35, however, rates among teenagers are climbing, especially among females (WHO 1993; AIDS Control Programme Ghana 1994).

[2] This knowledge has been found to be lower in the Francophone countries of Central and West Africa than the rest of the continent (Ingham 1995).

[3] 'Modern' is used here to describe the form of health care that came with industrialization and Western technology.

The development of modern health care and traditional concepts of disease

The colonial medical system

The rudiments of a colonial medical service date back well into the nineteenth century. In the 1880s, the Gold Coast[1] medical department was set up. However, in the early years of colonial medical services, the primary mission of the staff was to protect the health of Europeans, as well as a few African soldiers and civil servants, rather than the health care of the general African population. In the early 1900s the governor expressed his dismay with the conservatism, racism and complacency of much of the medical staff (Patterson 1981). Although the physician population more than doubled between the early and mid-1900s, as a result of a high rate of population growth, the physician/population ratio remained high. In 1906 there were 41 government physicians and the population per physician was 47,073. In 1921 there were 43 government physicians and the population per physician was 59,302. By 1953 there were 97 government physicians, and the population per physician was 55,433 (Patterson 1981: 110-111, table 2).

African doctors had been employed in the colonial medical service since the nineteenth century (Patterson 1981), however, by the turn of the century, rising racism and the desire by Europeans to monopolize the higher positions blocked the careers of Africans in all branches of the colonial service. For example, Dr. Easmon was removed in 1897, and another able African Gold Coast physician, Dr. B. W. Quartey Papafio, was passed over in favor of a white candidate (Patterson 1981). Eventually, following governor Guggisberg's argument that Africans with medical degrees were less competent than Europeans, Africans were appointed to the separate rank of 'African Medical Officer,' with attendant lower salaries (Gale 1973).

Not surprisingly, none of this worked to endear modern medicine to the indigenous people. However, the majority of people living in the Gold Coast were unaware of the political and racial dimensions of the medical system. There were far more 'practical' factors which worked together to affect attitudes to modern medicine.

Factors inhibiting reliance on modern western medicine

Urban and sex bias

There was a clear urban bias in health care services, which persists to this day. By 1973 it was estimated that the number and distribution of hospitals and clinics was such that they could not offer any kind of service to more than, at best, 20 percent of the population (Sai 1973). Historically, a sex bias also existed in access to medical services, due, partly, to the fact that the colonial government provided free medical care for several almost exclusively male groups – soldiers, police, civil

[1] This was the colonial name of Ghana.

servants, and prisoners. More important, however, women were less likely to be educated or have direct contact with the British, hence they were more likely to feel distrust for Western medicine (Patterson 1981). Women were also probably less likely to be willing to submit themselves to examinations and intrusions by (white) male staff. Since women generally had the responsibility for not only their own health care, but also that of children and young adults, their attitudes were influential in the community.

Mistrust of the health branch

Although 'modern' medicine had gained some acceptance by the 1960s for certain curative aspects of health care, preventive medicine, as practiced by the Health Branch, resulted in more resentment than esteem among Africans. Complaints about the policies and conduct of the sanitary inspectors were frequent. Patterson (1981) reports that the (male) inspectors, would enter people's homes every few weeks, without giving prior notice, and examine the premises thoroughly. Water, which had been carefully collected and stored in barrels, would be poured away on the basis that stagnant water bred mosquito larvae. Women were frequently disturbed in their baths in the process of these sanitary inspections. People who were considered to have transgressed sanitation prescriptions were dragged to court and fined. Generally, the Health Care Branch practiced a lot of coercion but little education. The result was that the message was invariably thrown out with the messenger.

Traditional health beliefs

The response of Ghanaians to Western medicine at the turn of this century was generally cautious and pragmatic and was based upon their concepts of disease causation. In the context of African cosmology, illness is not conceived as just the result of pathological changes, which was the idea proposed by Western medicine. Rather, the supernatural is invariably invoked along with the main causal factors. Within this framework the concepts of the etiology of illness are far more behavioral than biological (Twumasi 1975). The traditional cosmology has no room for a purely naturalistic notion of illness, because there is no clear-cut conceptual separation of the natural or physical world on the one hand, and the supernatural on the other, as there is in so-called modern medicine. Health and illness are not isolated phenomena, but are part of the whole magico-religious fabric, and the physical signs of disease are frequently ascribed to supernatural sources (Owusu-Ansah, forthcoming). The malefic action of another, or the intervention by a supernatural power, may cause illness, which may be cured by resorting to the appropriate magico-religious formula, or by appealing to the supernatural power (Twumasi 1975). This worldview leads to startlingly different interpretations from those arrived at by modern science. For example while sanitary inspectors would pour out drinking water in homes for containing

mosquito larvae, Africans held that the presence of the larvae indicated that the water was not poisoned (*Gold Coast Independent* 1930).

This does not mean that African societies do not appreciate the natural causes of illness, or that they did not traditionally rely on physical causes and treatment. In fact, at the beginning of a disease no supernatural danger is felt and home remedies are given. It is prolonged and dangerous conditions that are generally ascribed to spiritual causes. The disease-causing agents generally include lesser gods, ancestral spirits, witchcraft, and violation of taboos that protect a society from pollution (Owusu-Ansah, forthcoming). Ordinary persons can only speculate as to which of these agents is responsible for their condition, thus expert advice is sought. In order to increase the odds of healing/protection, a pluralistic/pragmatic approach was applied and recorded often in the accounts of nineteenth century Asante for example. The prescriptions of local medicine men, Muslim holy men, and later Western missionaries and doctors, were combined in health care. Islamic remedies were particularly accepted in Africa because of the degree of similarity between the African and Islamic cosmologies–world views that both recognize a multiplicity of spirits. As expressed by Asantehene Osei Tutu to British Consul Joseph Dupuis, the royal interest in Islamic prayers and amulets was based on the conviction that "those objects had come directly from the higher god" (Dupuis 1824). In the hierarchical structure of the Akan spirit world, medicine that came from the direct word of the supreme being was understood to be more powerful than local ones thought of as only originating from intermediary powers such as the lesser gods (Dupuis 1824). The power of the Asante empire in the nineteenth century probably contributed to the important role attained by the use of (Muslim) amulets and charms in traditional health care in much of modern Ghana (Owusu-Ansah, forthcoming).

Generally, one can say that among Ghanaians there exists a desire to find quick relief, and an unwillingness to undergo lengthy treatments (Patterson 1981). Injections, for example, which provide quick relief, were and continue to be very popular[1]; prophylactics, on the other hand, had little success in the early part of this century and remain less popular[2]. While modern medicine generally requires prolonged and dedicated application, traditional medicines frequently work under less disciplined regimes. If the healing process sometimes suffers temporary relapses it, in most cases, provides symptomatic relief. There are also adequate explanations for instances where a cure is not found or healing does not take place –usually this is blamed on the antisocial conduct of the victim or some member of his or her family. Thus, where the diagnosis of an illness is viewed as the diagnosis of a social offence, the cure requires the (re)establishment of normal social

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[1] Yaws treatment for example was by an injection, which brought relatively quick relief and greatly enhanced the popularity of modern medicine. It also contributed to the belief in the efficacy of injections for almost any condition.

[2] Patterson (1981) reports that quinine treatment for malaria was largely unsuccessful until recent times because of its bitter taste and the fact that people did not take the medication regularly or consistently.

relations and allows for the maintenance of harmonious community and family relations. Modern medicine makes no room for such social explanations or cures.

Eventually the individual uses his or her limited powers of prediction and control to determine which is his or her best option (Twumasi 1975). Western medicine never gained total acceptance and traditional medicine continues to play a social, psychological and also a medical role (Acquah 1958; Kilson 1974). Many people take an eclectic approach, seeking a combination of elements of various systems, or sometimes by using Western medicine in 'traditional' ways (Nukunya *et al.* 1975).

Health belief models and condom use

Information, Education and Information (IEC) messages aimed at changing sexual behavior have generally taken a standard approach, without considering the unique socio-cultural conditions in which individual sexual relations are grounded. The Global AIDS prevention strategy has two foci vis-à-vis changing behavior and hence promoting 'safer sex' (1) promoting condom use, and (2) exhorting people to reduce the numbers of their sexual partners, better still, to 'stick to one partner.' Implicit in these messages is the assumption that people make 'rational' choices and that they have personal control over their sexual health. I will address these two assumptions separately.

Rational choice

Theories about health beliefs and behavior such as Rosenstock's Health Belief Model (1974) are based on the premise that individuals evaluate the level of threat associated with a disease and their own level of risk, and then assess the costs and benefits to them of taking the required action. These frameworks may have some limitations, however, when it comes to assessing sexual behavior. While engaging in 'safe sex' can be viewed as a preventive strategy as far as becoming HIV-infected is concerned, these strategies are not one-time or occasional inconveniences. When it comes to condom-promotion efforts, people interpret advice regarding sexually transmitted diseases (STDs), AIDS, and their own protection, through their own cultural lenses, sometimes avoiding or denying the conclusions posed by the dangers, other times reinterpreting the advise and rejecting the policy directions (Bledsoe 1990). Even among gay white males in the West, a so-called 'high risk' group, there is evidence that awareness of high prevalence is not a consistent predictor of risk-preventive behavior (Gold 1993). One factor that emerged from Gold's study among gay males and heterosexuals was that people rely on perceptible characteristics to infer infection. Gold argues that a partner's good looks, speaking style, the sign of a wedding ring etc, may activate a belief at the moment of possible sexual activity that the person is unlikely to be infected. A similar perception was found to account for

differences in condom use among groups of married men in Kenya (Dodoo and Adomako Ampofo 1996). Findings from a series of surveys carried out under the auspices of WHO in 15 countries[1] between 1989 and 1990 show that people are unaware of the asymptomatic stage of HIV transmission, while others believe that AIDS can be cured (Ingham 1995).

How people define disease, determine its symptoms, and manage its treatment is affected by cultural values and patterns. Social phenomena are constituted by the meanings actors employ to make sense of observed or experienced events (Locker 1981). Within this world of everyday life, a world that is both the scene and the object of our actions and interactions, people develop their own 'common sense knowledge' which may not fit the rational mold of science (Schutz 1962). This world is seen from within what Schutz calls the natural attitude; it is taken for granted as a world of well circumscribed objects with definite qualities; a world which is known and shared by others. This then provides the means for interpreting new experiences and determines people's actions regarding preventive/protective behavior. Since many Africans consider modern health systems as irrelevant for certain illnesses, especially if the causes are ascribed to immutable supernatural forces, exhortations regarding particular preventive strategies may not lead to the same reasoning that the IEC-promotion efforts expected.

Control over personal sexual health

For many women, having accurate information is not enough to bring about changed behavior since they do not have control over their sexual lives. It appears that increasingly many women in contemporary urban environments choose partners depending on the latter's abilities to support them financially. For Ghana this has been documented in a number of studies (Adomako Ampofo 1995, 1996; Anarfi and Fayorsey 1995; Ankomah and Ford 1993). Women seem to see this as one option to supplement their incomes in situations of declining alternatives. If only because of the increasing visibility of prostitutes in Ghana's cities, in spite of sporadic police crackdowns, it seems plausible to assume that commercial sex work is also on the increase. Where a relationship is predicated on financial considerations, women's ability to negotiate for so-called 'safer sex' may be somewhat limited. Furthermore, since condoms are a technology whose use women can only influence and not control, women's protection is largely dependent on their abilities of negotiation and influence, often with an unwilling partner (Heise and Elias 1995).

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[1] The countries were Central African Republic, Côte-d'Ivoire, Guinea Bissau, Togo, Burundi, Kenya, Lesotho, Tanzania, Zambia, Mauritius, Phillipines, Singapore, Sri Lanka, Thailand and Brazil (Cleland and Ferry 1995).

Study sites, data and research methods

Study sites: Ghana and Côte-d'Ivoire

The main aim of this study is to theorize about women's capacity to protect themselves based on beliefs about STDs and AIDS, and within relationships constrained by financial considerations. Women still form the majority of AIDS-cases in West Africa, and Ghana and Côte-d'Ivoire currently have the highest number of reported cases in the sub-region. By the mid-1980s, at a time when AIDS was alleged to be taking on epidemic proportions in East and Central Africa (Caldwell and Caldwell 1993; Latham 1993; Mulder *et al*. 1994), Ghana and Côte-d'Ivoire like most West African countries, appeared to have been spared from the scourge of AIDS. In 1986 the first cases were reported (42 in Ghana, 118 in Côte-d'Ivoire). From 1986 to 1987 there was a slow rise in the number of AIDS cases in both countries with less than 1,000 reported per year in either case. After 1988 the number of reported cases increased at an accelerated rate in both countries.

In Ghana, 83 percent of AIDS cases reported in the first year were female. During this period the overwhelming majority of cases were found among 20-29 year-olds (66 percent). Although after 1989 the female proportion of total AIDS cases in both countries had dropped by about 10 percent, in the late 1990s AIDS remains a predominantly 'female disease.' Focusing on women in countries with high and low levels of knowledge (Ghana and Côte-d'Ivoire respectively) permits some assessment of the impact of knowledge on protective behavior.

The sample population and sites

The data used in this paper come from a larger study carried out between September 1992 and July 1994 among 188 Ghanaian prostitutes and single women living in Ghana and Côte-d'Ivoire. The present analysis is limited to interviews with 131[1] prostitutes living in three cities, Accra, Kumasi (Ghana) and Abidjan (Côte-d'Ivoire). These cities were chosen because all three are in highly urbanized, commercial-settings. All three have also had small settlements of prostitutes since colonial times, and their commercial basis has seen the emergence of other kinds of sex work in recent years. Abidjan was included in the study for three additional reasons. Firstly, there is some evidence that Ghanaian women have been working as prostitutes in that city from as far back as the 1940s (Kouassi 1986). Secondly, more recent studies suggest that Ghanaian women feature prominently among prostitutes working in Abidjan (Painter 1992). Thirdly, many residents of Abidjan travel fairly regularly between both countries and

[1] Forty-six single women (not sex workers) are excluded from the analysis; 11 interviews with sex workers were excluded for reasons such as incomplete data, poor recordings etc.

connections have been suggested between this and the introduction of AIDS to Ghana (*New African* 1993).

Definitions

Traditional Western definitions of prostitution obscure the complexity of sexual relationships that exist in Africa. Most deal primarily with concepts of promiscuity as defined by having several partners. An additional idea is that of the non-emotional nature of the relationship and payment for purely sexual services (see for example Little 1975). In Africa, however, prostitutes may be found who perform 'domestic' services for clients, developing close relationships, and women who do not consider themselves to be prostitutes may establish sexual relationships primarily for financial support[1]. In this study a female prostitute or commercial sex worker refers to a woman who engages in sexual acts, including those which do not actually involve vaginal copulation, on a more or less regular basis, with individuals of the opposite sex other than an established partner, such as a husband or boyfriend, for a consideration which has a pre-defined monetary value. Services of a non-sexual nature may be performed and emotional involvement may or may not be present[2]. The terms prostitute and sex worker are used synonymously. A distinction between clients and other partners was made on the basis of the respondent's own classification and whether the woman expected/demanded support/payment specifically for *sexual* services.

Three different categories of prostitutes, which apply to both Côte-d'Ivoire and Ghana, were identified. It was necessary to interview women from each of the different categories because I expected that they would differ by demographic characteristics, operating modes, client selection criteria, and charges, all of which could be associated with knowledge and behavior. Drawing distinctions between categories, especially *Roamers* and *High-Class* in Abidjan, was not simple. In such instances, respondents were separated on the basis of the predominant form of operation.

— *Roamers* are women who, as their name suggests, *roam* from place to place in search of clients. These venues range from hotels and nightclubs, through open areas such as lorry parks, to secluded street corners. They are often not 'full-time' prostitutes and may be apprentices learning a vocation, students, traders, or have some other source of income outside *sex work*. Usually their charges are lower than for the other categories of prostitutes.

— *High-Class* prostitutes, hereafter referred to as High-class, is the name I give to the group of women who, because of the nature of their dress, clients, location of operation, and level of sophistication appear to be financially better off than their colleagues. They are also more likely than other groups to have foreign (higher-paying) clients.

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[1] Arguably, this latter situation can be said to be true for many non-prostitutes the world over.

[2] Same-sex prostitution is, as far as I am aware, non-existent among African women, and none of the respondents engaged in sexual relations with other women.

— The *Seaters*, or *Tuutuu*[1] as they are traditionally known, operate from their homes, sitting in front of their doors to receive clients. Seaters are older women, mostly widowed or divorced, who have completed childbearing.

The following analysis is based on the interviews of 45 High-class, 39 Roamers and 47 Seaters.

Methodology

A variety of non-random methods were used to select women from the different categories. Particular locations where the women worked were identified using information from Public Health officials, media reports, and personal knowledge of the Principal Investigator (PI) and the interviewers. Respondents were primarily selected on the basis of availability once a location was visited. On some occasions women themselves took the initiative in approaching an interviewer; on other occasions a woman who had been successfully interviewed would introduce the interviewer to a colleague. With all the Seaters in Ghana, and all the respondents in Abidjan, a person who had had some contact with the women in the context of an AIDS-education project was utilized to gain entrance. With the Seaters this was necessary because many had been subjects in Public Health AIDS IEC efforts, and I did not wish to create the impression, neither among the women, nor among the health workers, that a new health project was being presented[2].

Respondents were informed about the objectives of the study, told that the interview would be recorded, and assured of anonymity and that they could discontinue the interview at any time if they so chose. Free and willing consent was considered crucial. Women who consented to be interviewed chose a pseudonym, which was used throughout the interview and ensuing analysis. Once concluded the respondents were paid an honorarium, provided with condoms and/or educational audiotapes. The refusal/discontinuation rate was lower than anticipated and was primarily because women did not have the time for an interview or felt they might lose a potential client to a colleague (N=5). In two locations fear expressed by one respondent that interviewers were from the media or police spread to her colleagues and those particular locations thus became inaccessible. Overall, the women approached were willing and interested, and in one location even made a donation to the interview team before we had an opportunity to pay the honoraria. At various stages of the study I worked with one female and three male interviewers. There appeared no consistent pattern to differences in subject's responsiveness, or content of information, by interviewer's sex.

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[1] The name originates from colonial times, when the women's charge was two shillings and two pence, hence Tuutuu.

[2] In Abidjan, it was especially necessary to rely on introductions because we had almost no knowledge about where Ghanaian sex workers lived and/or worked. Furthermore, Ghanaian women in the city were extremely cautious about talking to strangers.

The study instrument

Since AIDS prevention efforts need to target changes in attitudes and behavior, the study followed a Knowledge-Attitude-Belief-Practice (KABP) format. A structured interview-guide rather than a questionnaire was used to permit the exploration of issues central to the concept of 'safer sex' behavior.

The interview started out with less intrusive questions related to the respondent's demographic background in order to promote a degree of comfort between interviewer and subject. The main interview included questions about women's sexual experiences/relationships; attitudes and feelings regarding sex; marriage, pregnancy, abortion and child-bearing histories; contraceptive knowledge and use; condom use; AIDS-awareness; knowledge about HIV-transmission routes; beliefs about AIDS and protection methods; incidence of STD symptoms; and knowledge about prevention and treatment of STDs.

A facesheet covering basic personal details of the respondent, and a trajectory mapping out the main landmarks of her life (in terms of education, occupations, relationships, pregnancies and births) was also filled out. The data were analyzed using the computer software *Ethnograph*.

Reliability and validity

The present analysis is limited to female sex workers, and the nature of the study makes generalizations to the larger population difficult; however, the women are in no way unique. Although they come from predominantly lower socio-economic backgrounds, they cut across ethnic, religious, and educational lines. Some are not 'full-time' prostitutes and others are 'seasonal' prostitutes. Without exception they long for a life outside prostitution and are primarily concerned about making a living for themselves and/or their children. Since economic hardship can push a woman from any sector of the economy into prostitution, the findings are applicable to the larger population

As Ferry *et al.* (1995) describe regarding a series of World Health Organization KABP surveys, there is no simple, standard, or even satisfactory way of validating data on sexual behavior. There are problems of definition of concepts, respondent recall, and respondent willingness to divulge sensitive and sometimes painful information. Nonetheless, in assessing the relationship between socio-cultural factors and KABP, it is arguably more important to examine the plausibility of overall patterns and relationships. Although I concede that studying sexual relations is challenging, I believe that the issue of the validity of reported behavior was overcome to a large extent by cross-checking answers with information from a series of (pilot) Focus Group Discussions.

Demographic characteristics of the sample, entry into prostitution, and STD-knowledge

Age

Majority of respondents are under the age of 35 (93 out of 131; 71 percent) however, important differences are noted among the three categories of sex workers. Most Roamers and High-class are under age 25 (39 percent and 38 percent respectively) while the majority of Seaters are between ages 31-45 (68.5 percent). Mainly divorced or widowed, one of them explained to a female interviewer (in her early thirties) that:

> "We don't allow young girls here. As you [interviewer] are sitting here now, if you come to me I won't take you because I wouldn't like you to come here and waste away since you don't have a child. Unless the woman has been married before and has had all her children, or wives who have been abandoned by their husbands and don't have anyone looking after them … those are the ones we accept here."

Educational status

Although a few of the respondents have secondary education, generally their highest level of education completed is Middle school; however, just as many dropped out as completed. The breakdown is as follows: no education 26.7 percent; some primary 30 percent; some middle 33.6; some secondary 6.1 percent; vocational training 4.6 percent. Even among the High-class, only 4 out of 45 (11 percent) have some secondary school education. A major reason given for dropping out of school is pregnancy or lack of financial support from the family. Seaters have the least education (and 53 percent have never attended school).

Marital status

Five women (4 percent) are currently married under customary law[1], and a further three (2 percent) describe consensual unions. Those who are customarily married live separated from their partners and have virtually no contact with them. Fifty-four (41 percent) of the women state that they have boyfriends.

Dependents

Eighty-eight (67 percent) of the prostitutes indicate that they have at least one living child. Most women have between one and three children (16 percent, mainly Seaters, have four or more children). Seventy-nine (60 percent) women also have other dependents, usually a sibling's child, or a mother. Seaters have more dependents than any other category of women.

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[1] Ghana operates a plural legal system, including customary law and the "Modern" system inherited from, and developed since, colonialism. Couples can be married under customary law or under the ordinance which is usually preceded by customary marriage.

Occupational status

Only four women (3 percent) have never had any occupation other than prostitution. The majority were traders before they entered sex work (N=66; 50 percent); the rest were farmers, hairdressers, seamstresses, or involved in running a 'chop bar' or selling cooked food. Seven women (5 percent) were housemaids or baby sitters (6 in Abidjan), five (4 percent) had previously been in salaried employment, two (1.5 percent) were bar girls (in Abidjan), and one was a traditional birth attendant. However, at the time of the study only fifteen women (11.5 percent) had any occupation or regular source of income apart from prostitution. For 90 percent of respondents sex work was their main source of income at the time of the study, although some indicated that they had seasons when they concentrated on trading, using income earned from sex work as capital. A few High-class suggested that sex work was a means to supplement income from other employment and so provide themselves and/or their children with a better life style.

Entry into prostitution

The subject of the factors pushing the women into commercial sex work is taken up in detail elsewhere (Adomako Ampofo 1995) however, it is important to describe the situation briefly here since there is some relationship between (entry into) specific forms of sex work, and risk perceptions and behavior.

The entire sample frame their responses to questions about their entry into sex work in economic terms. The reasons offered include failure of a business, debt, and non-support from partners (or, among younger women, parents and guardians). Frustration over inability to adequately care for children is frequently mentioned. The collapse of income-earning opportunities has been largely responsible for most respondents' entry into commercial sex work. The modern city economy in many sub-Saharan African countries puts women at a disadvantage in terms of education and jobs. Several writers agree that recent Structural Adjustment Programs may have severely worsened the economic situation for women. Farmers and traders, which most respondents were prior to entering prostitution, have been particularly hard hit (Anker *et al*. 1988; Clark and Manuh 1991; Elson 1991; Palmer 1991).[1] At the same time they are being edged out of the informal sector, women face institutionalized attacks such as 'clean up' campaigns by city authorities to rid the streets of 'illegal' traders. One

[1] As a result of a combination of internal and external factors, the period between 1984 and 1992 was one of rapidly worsening economic conditions in Ghana. This eventually led to the implementation of the World Bank-imposed Structural Adjustment Programme (SAP). Ghana's SAP, like most in Africa, has included trade liberalization, the sale of state-owned enterprises, and laying-off of workers (euphemistically called 'redeployment'). As governments implement SAPs many individuals in the formal sector continue to lose jobs through these 'redeployment' efforts, with women frequently the first victims since they have fewer skills.

of the clients of an Accra Roamer blamed the city's metropolitan authorities (AMA) for women's entry into prostitution, "You know, most of these our sisters are traders and when they are trading their things are scattered (by the AMA guards)... So when you want to go for your things you must pay C15,000 to C20,000"[1]. If she hasn't got then she would say, "I'm a woman, if all this will be happening it would be better to put these things aside (trading) and use myself (euphemism for sex work)".

If, at the same time that women are losing access to economic opportunities, husbands and partners are less supportive financially, this constrains them when it comes to feeding, clothing and educating their children, and many respondents state clearly that they see no options for themselves other than sex work. Respondents frequently described their situation as *ahokyere* (literally to be 'tied up' or 'completely constrained'). Twenty-two year-old Adwoa's story is typical. A 'week-end' Roamer in Kumasi, she has little formal education and used to sell yams to support herself after her parents died a few years earlier. One day she made a heavy loss and subsequently fell into debt. Eventually she began working as a prostitute in order to be able to pay off her creditor. "If within the week I am able to get about C6,000, or, say, C8,000, I use four on food and put four down and save it (for my business) "that's what I have been doing little by little". Adwoa says that (of course) she does not like sex work, but, she argues, at least she does not have to steal or depend on anyone to feed or clothe her. It is interesting, however, that for Adwoa and many other Roamers and High-class, long-term survival is still framed in terms of dependency on male support, preferably through marriage to a caring man. Says Adwoa, "If God permits and I get a loving person who can take care of every need I will stop coming here".

STDs and AIDS: knowledge and treatment

Knowledge about the existence of STDs and AIDS is virtually universal among the sample. Almost all the respondents know the traditional STDs such as gonorrhea and syphilis, associating them with the typical symptoms. AIDS is associated with 'growing lean'. However, knowledge about the way that the HIV-virus is transmitted is not altogether accurate. Although transmission is generally reported in terms of sexual transmission, through blood transfusions, cuts, and needle-sharing, some respondents are uncertain whether the virus can be transmitted through kissing an infected person, drinking from the same cup or via mosquito bites. Upon more detailed questioning, 71 percent of respondents (N=93) indicate accurate knowledge about

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[1] At the time of the interview one thousand Ghanaian Cedis, C1,000, were approximately equivalent to US$1. Minimum monthly wages within the civil service, for example cleaners, ranged from C24,000 - C30,000. The CFA, was double the value of the Cedi: CFA1,000 being approximately US$2. Ivorians were also better paid; the same cleaner might earn CFA30 - 50,000 per month.

HIV-transmission (67 percent of High-class, 66 percent of Roamers, 76 percent of Seaters)[1].

Respondents were asked different questions in order to find out if they had ever had an STD. In some interviews it was possible to ask women directly if they had ever suffered from any of the STDs they had themselves spontaneously mentioned. More usually, however, respondents were first asked if they had ever experienced any of the following symptoms: itching of the vagina, pain when passing urine, a vaginal discharge, and unusual pain during sexual intercourse. Twelve sex workers admitted to having ever had an STD when asked directly; a further 83 incidents of any one of the other symptoms were also recorded. In view of the fact that admission of having an STD is considered to be shameful, the response rate is quite high. Reported incidence of STDs is higher among Roamers and High-class than Seaters, and, apart from High-class in Kumasi, is also higher among women in Abidjan than those in Accra and Kumasi.

Respondents have a variety of ways of treating STDs and this is important for any analysis of AIDS-preventive behavior. The use of local herbs as both prevention and cure for STDs is common. Women stress their efficacy, complaining that in the 'good old days' it was not necessary to think about injections or going to the pharmacy. Yet others rely on prayers and other ritual processes since illnesses are attributed to supernatural causes. Sakyibea, 36 years old and formerly a High-class, but now a Roamer in Abidjan, reports a number of symptoms suggesting she might have AIDS-related illnesses, especially considering her own admission that she rarely uses condoms with her clients. At the time of the interview she has been ill for a long time and explains her worsening condition thus, "When I was sick I was sent to a *Mallam* (a man who is combination of priest and healer, traditionally Islamic). When we went I was told that my sister - we had a misunderstanding over money and she cursed me, I was to stop the curse but I didn't. I was supposed to perform some rites but since I didn't have the means that is why I am still sick".

Many respondents are quick to pay a visit to the pharmacy or hospital for an injection or prescription of penicillin if they notice any symptoms they associate with STDs.

Risk perceptions and behavior

Although 'safe sex' should be a mutual responsibility between sexual partners, as Hart (1992) notes, socio-economic and actual perceptions do not encourage males (clients) to think of themselves as responsible. Thus women carry both the burden of responsibility for protecting themselves and their sexual partners, and they also face undue pressure to have sexual intercourse without using condoms.

Condom use among the prostitutes is quite complex and goes beyond mere considerations of protection from disease. Sex workers

[1] Information was unavailable for 23 percent of the sample.

are themselves not too keen on condoms because they create tension between sexual partners, are uncomfortable to use, dull the client's sensitivity and thus prolong the sex act unnecessarily —generally make their work difficult, the women complain. Nonetheless, the most frequently mentioned form of protection against STDs is the condom. A hundred women (76 percent) indicate that they use condoms at some time with their clients, their partners, or both. Condom use is highest among the Seaters (88.2 percent), followed by High-class (74.1 percent), and then Roamers (67.3 percent). Upon further questioning, however, only 54 percent of prostitutes admit to using condoms with their clients *all* the time (Table 1) and only 7 (5.3 percent) *always* use condoms with their partners. Among Seaters, High-class and Roamers, 61 percent, 59 percent, and 38 percent respectively indicate they *always* use condoms with clients (among Seaters in Accra and Kumasi the proportion is as high as 82 percent). Condom use is lowest among Roamers in Abidjan, and highest among Seaters in Ghana. In general this can probably be explained by the younger age and low educational status of Roamers which translates into less power to negotiate condom use, and the lack of access to information among women in Abidjan. Although Seaters have less education than women in any other category, in Ghana they are also the women who have received the most AIDS-IEC through the Ministry of Health.

The ensuing analysis is directed towards a description of the way in which phenomena are assigned to categories. The data suggests four major categories (Table 1) under which attitudes toward, and therefore forms of protection against HIV-infection among the respondents can be examined. Women in categories 2-4 sometimes gave more than one response regarding protective behavior. For purposes of the analysis I have assigned respondents to categories according to what appeared to be their single most important attitude/behavior.

1. ***Women who recognize they are at risk and use condoms***

This group of women, who insist they use condoms *all* the time, forms the largest of the four categories. They want to protect themselves and their clients and partners and consider condoms the most reliable means to achieve this. Although this suggests a reason for optimism, this category only forms 54 percent of the whole sample (Table 1, row 1). Furthermore, although they form 70 percent of the Ghana sample, they make up only 22 percent of the Abidjan sample (Table 2, row 1). In some of these cases (number uncertain) the efficacy of condom use may also be compromised by the application, of lubricants such as shea butter or petroleum jelly.

When asked if they would consider having sex without a condom if a client offered more money respondents in this category are unambiguous that this carries with it a risk far greater than any amount of money could make up for. One woman exclaims, "If you are going to follow money then you have a bargain with death!"

Table 1: *Risk perception and protection among sex workers by work category, Accra, Kumasi and Abidjan (Column percent in parentheses)*

Risk and Protection	*Roam* Accra	Abidjan	Kumasi	*Seat* Accra	Abidjan	Kumasi	*High* Accra	Abidjan	Kumasi	Total
	N=10	N=15	N=14	N=16	N=16	N=15	N=16	N=14	N=15	T=131
1	4 (40)	9 (60)	2 (14)	13 (82)	13 (82)	3 (20)	14 (88)	8 (57)	5 (33)	71 (54)
2	-	-	6 (43)	1 (6)	-	5 (33)	-	4 (29)	4 (26)	20 (15)
3	4 (40)	4 (26)	3 (21)	1 (6)	1 (6)	3 (20)	1 (6)	2 (14)	1 (06)	20 (15)
4	1 (10)	1 (6)	3 (21)	-	1 (6) [2*]	4 (27) [4*]	1 (6)	[2*]	5 (33) [3*]	16 (12)
NA	1 (10)	1 (6)	-	1 (6)	1 (6)	-	-	-	-	4 (3)

*These respondents, despite their attitudes to risk perception insisted they used condoms with all their partners and are thus included in category 1 and not 4.
Source: Author's interviews 1993-1994.
1.Women who recognize they are at risk and use condoms.
2. Women who acknowledge their risk but feel unable to negotiate condom use.
3. Women whose judgments regarding a 'risky' partner are based on perceptible characteristics.
4. Women who feel they can protect themselves through means other than condoms.

Table 2: *Risk perception and protection among sex workers in Ghana and Abidjan*

Risk perception and protection	Ghana N	Ghana percent	Abidjan N	Abidjan percent
1. Women who recognize they are at risk and use condoms	61	70	10	23
2. Women who acknowledge their risk but feel unable to negotiate condom use	5	6	15	34
3. Women whose judgments regarding a "risky" partner are based on perceptible characteristics	13	15	7	15
4. Women who feel they can protect themselves through means other than condoms	4	5	12	27
NA	5	5	-	-
Total	87	101*	44	99*

*Due to rounding off totals do not add up to 100 percent.
Source: Author's interviews 1993-1994.

Another explains the importance of the condom for her, "My sister, it is true that poverty is a curse ... with these diseases and my coming here, at least seeing my children every day, don't I like it? But as it is, just because of someone's 1,000C (cedis) or something I'll die and leave them at an early age! Sister, is that fair? As for me I think that the condom helps us a lot" (Yaa, Roamer, 40, Kumasi).

Fifty-six-year-old Afua, a Seater in Accra, insists she always uses the condom with her clients. Asked if she would accept C5,000 if the client did not wish to use a condom she retorted, "Where will that person get the C5,000? If that person gives me all that money what will he eat himself ... he should go to his wife. When there was nothing like AIDS it was 'free', there was nothing like the use of condoms, now that we have the disease everyone has to use the condom".

Some of these women claim they can tell when a client has an STD and that men who are unwilling to use condoms have something to hide and must on no account be entertained. Possible infection is protected against by studying the type of penis a man has, "If it's a soft penis you use one (condom), if the penis is hard you use two" (Stella, High-class, 29, Accra). To be absolutely sure they are protected against condoms that tear some women say they always use two condoms, others look for sturdier, more expensive brands. If a condom tears during the sex act they interrupt this to replace it, even though they could infuriate a client. Says one respondent, "If you only use it always (the condom) you can do whatever you like till God calls you home, but if not you will die before your time". Retorts another, "I'm suffering because I don't have anybody to look up to (support her). So if I come across a man I wouldn't let him have sex with me without using the condom" (Roamer, 40, Accra). These women have no illusions about their clients. Stella, the afore mentioned High-class says, "I ask the man to use condom, he say when if I didn't trust myself but he trust himself. I say that I trust myself as you trust yourself but I didn't trust you".

Among Seaters, separating the effects of intent to protect against STD/HIV-infection from cooperative work ethics is not easy, however. In one location of Seaters in Accra the Queenmother[1] has done a lot of educating on condom use among the women under her. Consequently, if any woman is found to not be using condoms with her clients she is reprimanded. Patricia, a 35-year-old Seater in Accra confirms the high rate of condom use. She believes that it is unlikely that any client will find a woman who will agree to have sex without a condom. Condom use among Seaters in Kumasi is also high, for the same reason —there have been regular educational sessions among the women. Fifty-year-old Akosua explains, "I didn't use it initially, I started just about two weeks ago when I returned for the last time. I was told (by Queenmother) on my arrival that everybody was supposed to use the

[1] The Queenmother, generally an older woman who is no longer actively working as a prostitute, 'oversees' the work, calls meetings, ensures that proper work ethics are applied, and generally cares for the women under her. She receives no formal recompense for this.

condom so if I wanted to continue with the work then I should use it". Andrew Osei who works with the AIDS Control Programme (ACP) in Ghana, confirmed that as a result of periodic and regular educational sessions among the Seaters, condom use is high (personal communication, 1993). He cites the example of a woman who was accused by a colleague of taking a client whom another colleague had rejected because he refused the condom. This woman was warned strongly by the Queenmother, and the ACP took the opportunity to reinforce its messages.

Condoms are also used during sexual encounters with regular partners, because the women concede that these men may be seeing other women and that, "men cannot be trusted". A typical response: "It's possible he doesn't know the work the girl does, like me, coming here at night without his knowledge. Or it could be the girl has another boyfriend somewhere who may also be quite promiscuous. So by all means when he comes I have to make sure that I use the condom. You can't sit and deceive yourself that with a boyfriend you are safe and so you won't use the condom" (Comfort, High-class, 23, Accra).

Here are women who are convinced that their own protection depends on consistent condom-use. They are committed to their own protection, that of their clients, and, in some cases, even mention the fact that their clients have wives and it would be unfair for them to contract an STD. "You may have a disease, I don't know, and at the same time I may have a disease and you wouldn't know and we may exchange diseases; probably your wife is at home, so you send her a disease from town" (Seater, 35, Accra).

Since condom use is highest among Seaters (in Ghana), women with the least education as a group, it is plausible to conclude that targeted IEC efforts are more effective in changing behavior than relying on general educational levels and exposure to the mass media. This is not to downplay the effects of formal education in empowering women to acquire knowledge which can change attitudes and behavior, but rather, to suggest that education, per se, is not a sufficient condition for changed behavior.

2. Women who acknowledge their risk but feel unable to negotiate condom use

These women acknowledge the dangers of contracting STDs/AIDS and their own risky behavior; however, for various reasons they feel powerless to insist on the use of condoms. This is either because non-condom sex can earn much needed additional income, or, even ensure that a woman does not lose a client altogether. Furthermore, some clients/partners turn violent when the issue of condoms is raised. Generally, risk is viewed in terms of the probability of becoming infected if the respondent uses a condom *some of the time*.

Fifteen percent of respondents fall into this second category (Table 1, row 2) with the majority being in Abidjan. Indeed, while this category only makes up 6 percent of the Ghana sample, it is the largest category in Abidjan (34 percent; Table 2, row 2). Intuitively this

makes sense since these women are living far away from home and probably face more (economic) pressure to survive and provide for themselves and their families.

Thirty five-year-old Florence has worked as a 'part-time' prostitute in Ghana, and was convinced to come to Abidjan by a friend. Pregnant with her sixth child at the time of the interview, she finds it extremely difficult to make ends meet. Because she needed the money she continued receiving clients, without using condoms and sometimes even during her menstrual period, through the sixth month of her pregnancy, stopping thereafter due to her enlarged abdomen. Currently selling cooked food, she earns less than 1,000 CFA a day. Florence was suffering severe abdominal pains when passing urine, though it was difficult to tell the actual cause of this. She agrees that her behavior is risky but explains her actions in terms of her extreme financial need —she cannot afford to insist on using condoms and risk losing clients.

For a woman in this category the offer of more money for non-condom sex is especially powerful because she frequently has fewer clients, sometimes only one the whole day. She rationalizes that she can use a part of the extra income to buy additional or better health care. Charges for a Roamer in Abidjan could increase from about CFA 5 - 10,000 to about CFA 7 - 20,000 per client, out of which a woman might spend CFA 500 - 2,000 to buy drugs to protect her against STD infection. Although the risk of HIV-infection is acknowledged, this is viewed in relation to the risks associated with having no money —especially for women in a foreign country. A woman *may* become HIV-infected if she does not use a condom, however, if she has no money, she *will* not be able to provide for herself or her children.

Even a woman determined to use condoms may relent if she is physically threatened. Although Agnes is a woman who uses condoms all the time, I include her story here to highlight the pressures women face to give in to men's preferences. A High-class in Abidjan, she had not had a client the whole day. At 2.00 am, a man approached her and they went to an hotel. When she offered the condom he said he was not a child to use one and offered her CFA 25,000. Agnes said she would even accept a mere CFA 5,000 if he would only use the condom. The client begged, saying he was willing to pay more if she would agree to have sex without a condom. She retorted that even for a million CFA she would not. The man became angry, shouting that he would not have sex with a condom, and threw her out - at 3.30 am. Agnes was almost beaten up by gang members, she could have been robbed or raped on the streets of Abidjan, but she has seen two colleagues die of AIDS and says, "as for the condom, I'll use it".

Some respondents also report having been beaten up by boyfriends when they insisted on using the condom. Presumably, among women whose partners do not know that they are sex workers, this is motivated by the partner's suspicion that she is being unfaithful. Fear of disrupting a relationship makes many women comply. One must conclude, then, that even though women in this category may

acknowledge the risks involved in non-condom sex, their financial need and relative powerlessness puts them in a catch-twenty-two situation where they are damned if they insist on condom use, and damned if they don't.

3. Women whose judgments regarding a 'risky' partner are based on perceptible characteristics

For women in this category, protective behavior is determined by a client's appearance; how 'clean' or 'good' he is; whether he is a regular client, a boyfriend, or a 'stranger'. If a man looks 'healthy', or he is a 'good man, or you just like him', then he is not considered to be a (health) risk. This category makes up 15 percent of the sample and Roamers, the youngest women, are the largest within this group (Table 1, row 3). Presumably these respondents are more naive and vulnerable to the notion that a nice-looking man cannot *really* be sick or a carrier of a deadly virus. This is also the category with no noted difference between the Ghana and Abidjan samples (Table 2, row 3). Says 29 year-old Esther, a Roamer in Kumasi, "You see, there is a guy here called Bright, as for him if he says he will not use it (the condom) I will gladly have sex with him because he is a nice guy". Says Gloria, an Accra Roamer, "If the person is clean or neat I don't insist (on the condom)". Laughingly she tells the male interviewer, "Somebody like you, no problem".

Condom use (or lack thereof) also has to do with familiarity. With strangers, foreigners (especially 'white men' who many respondents say are responsible for the inception of AIDS), and a man a woman does not care for she will be 'careful' and use a condom. "If you are my boyfriend I can have sex with you with a condom *if I don't love you*", says a Kumasi Roamer in her twenties (emphasis mine). Says another "If I don't like you and I don't want your blood to enter my blood I use it (the condom)" (Roamer, thirties, Abidjan). However, with men she 'likes' this woman will agree not to use a condom if this is what he prefers. Indeed, non-condom sex is especially common with boyfriends. The typical response when asked why they do not use condoms is simply, "He's my boyfriend!" implying that the question is a ridiculous one.

That as many as 15 percent of respondents fall into this category is cause for concern, especially when one considers that many men eventually become regular clients, and hence familiar to the women. After a level of rapport has been built between a woman and her client, when she comes to realize that the man is not 'sick', it is not difficult to imagine her consenting to have sex without a condom. Clearly, the possibility of asymptomatic transmission of the HIV-virus is still inconceivable to many women.

4. Women who feel they can protect themselves through spiritual and other means

This category includes women who believe that AIDS can be treated, or who attribute HIV-infection to supernatural causes and

fatalistic ideas and as such view protection/cure as requiring spiritual interventions.

Forty-two-year-old Esther, a Seater in Abidjan, when asked whether she had had any major illnesses in her life responds, "Since I came here I have really suffered. I was not really sick, but you see they say that when you come here initially men like you, so there was this lady here called Mansa, she '*jujued*' (cursed) me and anybody who saw me said I had AIDS. I grew very lean. My body was virtually finished, my buttocks, my legs, I couldn't walk ... I was taken to an *Ewe* herbalist, he cured me. The woman did it again. It has happened three times..."

Esther also blames STDs on another's *juju (juju* can simultaneously be a curse as well as a form of protection or empowerment)*:* "Since I came to this house 18 people have been 'jujued' ... and these young girls ... when that happens they have sores in their vagina..."

This fourth category make up 14 percent of the sample, mainly Roamers, except in Abidjan where Seaters and High-class predominate (Table 1, row 4). Making up the smallest category among the sample in Ghana (5 percent), women with beliefs in spiritual causes and protection of STDs/AIDS are the second largest category in Abidjan (27 percent; table 2, row 4). Thirty-nine-year-old Akua, a Seater in Abidjan, is quite fatalistic, and says, "With diseases you cannot tell. If God ordains that you will be attacked by this particular disease you will have it. In Ghana they say AIDS, over here they say SIDA (French acronym for AIDS), but I have not seen any since I came here. It is a curse, I believe it is a curse (emphatically)".

Akua explains why she thinks what people call AIDS is really a curse, citing the hypothetical case of a woman who has an affair with the boyfriend of another woman who invested in her and brought her to Abidjan: "For instance someone brought me here. She may have a partner but still engage in this high-time life and may be the one responsible for my upkeep. Then she realizes you are seeing her man and warns you not to go there anymore. I may be stronger than her, so then I insult her or beat her up. I will be affected if she should curse me because she has spent a lot on me, you see. She may have cursed you with a river or lake so then you start to defecate, vomit, and still don't tell the truth (about the man). Then you are taken to Ghana, when you get there they say you have AIDS. Then you grow very lean, it is all a curse, it is not that disease (AIDS). Whoever says that is lying".

Nana is a 45-year-old Seater in Kumasi who also believes AIDS is a curse. According to her AIDS has become a problematic disease to be contended with in Ghana because of "those who go to Abidjan ... to cheat people, and they are cursed, and those white men ... and when they begin to grow lean people conclude that it is AIDS ... it is a curse, ... but it may also have been brought about by demons".

Thirty-five-year-old Rose is a Seater, in Abidjan. She believes that AIDS is associated with diabetes and witchcraft. She believes this because her aunt, a diabetic, grew very lean after she was ill with diabetes. "It was diagnosed at Korle-Bu (largest hospital in Accra) as

diabetes", she says, "but she had grown very lean ... The disease has got something to do with witchcraft, when these things happen they say it is SIDA". Afua, a High-class in Kumasi says, "Now because of the word of God I see it as a satanic disease. In that situation God is the healer ... if it is His will that I should get AIDS then I will get it ... If God says I will die at *Saturn* (name, not real, of an hotel in Kumasi) even the use of the condom does not matter".

Many respondents place their trust in traditional healers, herbalists or *mallams*. Ablah, a 33-year-old Seater in Abidjan explains that you need to "have incisions with black powder to protect yourself from contracting *gbadza (*local term for an STD, probably gonorrhea) and other diseases". As a result of having had these incisions she considers herself immune to STDs asserting she has never had one.

Closely linked with women who ascribe AIDS to supernatural causes are those who feel they can protect themselves from STDs/AIDS by using various medications. Some rely on antibiotics and other drugs, usually purchased without a prescription ... Says one woman, "It all depends on me, it is I who must all the time protect myself ... All we can do will be to pray God that I don't meet anyone with the disease". The morning after having sexual intercourse with a client she takes antibiotics, and every couple of months she has her blood checked for the HIV-virus. So far the doctors tell her she has no infections and she believes her strategy to be effective. Esther, the Roamer who does not use condoms with 'nice guys' says, "If you are a prostitute, you should take a lot of medication ... *super multivite* and *ampicillin (*names of vitamins and antibiotics). Because if you take the *ampicillin* you urinate a lot and that is good for you". Women in Abidjan frequently felt that urinating after the sex act would rid the body of poisons and disease. Another respondent in Kumasi uses the (contraceptive) pill as a form of protection against STDs; "I use *Secure*, it has the instructions that when you use it and have sex with a man who has any disease it will let you pass everything out." Asked whether she was taking it on a doctor's prescription she answers, " I heard it on the TV and when I go to the drug store to buy it I ask about it before. I read the instructions written on it". Yet other respondents rely on the 'medical knowledge' of local druggists, persons who are frequently not qualified pharmacists. A Roamer in Abidjan explains, "I normally go to the pharmacy and I tell them I am a *hustler* (euphemism for prostitute) and I don't want any strange disease so they should get me some medicine".

Local herbs are another popular form of protection, especially among Seaters, and women in Abidjan. The difference between Seaters in Ghana and women in Abidjan is that the former use these *in addition* to, the latter *instead of,* condoms. Many of these local preparations are inserted in the vagina or are used as vaginal douches, injections or enemas. Urinating immediately after sexual intercourse or after using these preparations implies a cleansing of the body ("you would urinate and even if the man has any disease you would not have it"). Frequently these local preparations are combined with 'modern' medicine, "I use enema, then everyday I take three capsules of

ampicillin, multivite and B-complex —it is standard medicine", explains an Abidjan High-class.

Fatalism, faith in the power of the supernatural, and belief in the efficacy of other drugs, or combinations of all these influence protective behavior strategies among this category of women, and they believe in using herbs, talismans, and *juju*, to protect against STDs and AIDS.

Discussion and conclusion

This article has shown the particular vulnerabilities women face regarding HIV infection through (1) the lack of *accurate* knowledge regarding the nature of the disease, and (2) their compromised ability to control their own sexuality because of the power imbalances between them and their clients/partners.

Protection from STDs, especially HIV-infection, depends on a number of factors, the foremost being knowledge about, and acceptance of, AIDS as a deadly disease with no cure. This cannot be if people are to be convinced that there are (as yet) no known traditional means of either protection or cure. Women who are persuaded that they can become HIV-infected through sex, and by anyone, no matter how healthy he looks, are less likely to engage in 'unprotected' sex. This will be despite precarious financial situations, or a client/partner's physical threats. If behavior continues to be 'risky,' not because people do not know *about* AIDS, but because they ascribe the disease to non-physical causes, or because of a misperception that one can tell an infected person from their appearance, then IEC messages need to move beyond condom-use campaigns. An imperative of IEC efforts, therefore, is the need to stress the asymptomatic stage of HIV-infection, and that carrying the disease can be unrelated to physical appearance for years. Clearly, special efforts at AIDS-education need to be undertaken in Côte-d'Ivoire.

On another level, controlling the spread of AIDS requires that we acknowledge the inequities in gender relations. There is a lot of discussion these days about 'empowering' women to use condoms, especially female sex workers (World Bank 1990), yet little recognition of the problems women face in insisting on condom use. For some women their lack of power relative to their clients and/or partners compromises their ability to do so. For most of these women, the implications of even a *single* act of 'unprotected' sex is moot since without the income from prostitution —including sexual acts where the client may refuse to use a condom— they would be destitute. Furthermore, even if a client does not refuse to use a condom, the possibility of receiving more money for agreeing to sexual intercourse without a condom, makes the prospect of eventually being able to escape from sex work all the more probable. Unless genuine efforts are made to improve women's material conditions so that they have comparable access to resources as men do, and are no longer dependent on supplying sexual services for their livelihood,

exhortations to stick to one partner may be irrelevant even if they appreciate their risk. It must be recognized, however, that even in their disadvantaged situation some African women have always found strength in collective organizations. As seen from the efforts of the Seaters, one of the means to empowering women obviously lies in harnessing the energies found in their organizations, and using these to devise *collective* protection strategies.

In order to 'empower' women, men will also have to be motivated to change their ideas about sexuality —ideas that the use of condoms is not masculine and sex with condoms cannot be enjoyed. This also needs to be a focus of IEC efforts, especially since condoms are a technology whose use women can only influence, but not control. Such an approach will go a long way towards making men feel more responsible about the sexual health of their partners. IEC messages also need to be examined to determine to what extent they reinforce traditional sex-stereotypes and gender roles.

Although survey results suggest widespread knowledge *about* AIDS and how the HIV-virus is transmitted, further micro-level studies are necessary to determine how these responses are related to health and religious belief systems. Attempts at transforming behavior require a realistic appreciation of the factors that inform risk-perception and protective behavior at the individual level. Without this, IEC campaigns aimed at promoting condom use will continue to have only marginal success. On a general level, there is a need for more detailed research on sexual relationships. We need to establish how much people actually know about HIV/AIDS, their sources of information, their levels of confidence in the various sources, and what sense they make of such information. We need to know to what extent they are simply repeating what they have heard through the media, and how much have they really conceptualized an illness which has no cure, but at the same time is not associated with witchcraft and malevolent spirits. We still do not know enough about contemporary concepts of sickness and disease as related to HIV-infection and AIDS, nor the factors which lead individuals to select particular options regarding protection. In view of the importance given to the role of traditional medicine, further research on people's health belief systems is crucial. Intervention strategies need to be constructed on a realistic assessment of the determinants of risk-taking behavior among different groups.

The media may have been successful in getting the message *about* AIDS into communities; it would seem, however, that greater success is achieved where a population group receives regular and consistent information over a period of time, as has been the case with Seaters in Ghana. This can be done through the many groups and organizations people are members of —schools, churches, clinics, youth and women's groups, market women's associations, etc.

No amount of AIDS education can change a woman's disadvantaged financial situation, however, women cannot even begin to become more empowered to take control over the health issues of their lives if they not armed with accurate knowledge. Because of women's

general disadvantaged position in society, they are frequently those with the least access to this information and special efforts need to be made to target women without stigmatizing or 'scape-goating' them.

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Akosua Adomako AMPOFO, *Nice guys, condoms, and other forms of STD protection: sex workers and AIDS protection in West Africa*

Summary — The last two decades have seen the presentation of a variety of Information, Education and Communication (IEC) efforts aimed at changing sexual behavior with the hope that this will slow down the rate of the spread of AIDS. Neglected has been an analysis of how cultural factors influence the interpretation of this information, and consequent behavior. This chapter reports on a study of face-to-face interviews among Ghanaian sex workers. Rather than focussing on risk factors to clients, as has been the tendency, the chapter examines the women's perceptions regarding their abilities to protect themselves, and how this is related to beliefs about disease causation. Also examined is the relationship between the women's behavior and the economic basis of their sexual relations. Four types of perceptions and their related behaviors are analyzed, and the implications discussed. The findings indicate that possessing knowledge about 'risky behavior' is a necessary condition, but not a sufficient one, for changing behavior. The women do not simply absorb information and modify their behavior according to information supplied by 'experts.' More important is the reflection of the knowledge against the context of their beliefs. Furthermore, although accurate knowledge can offset economic precariousness for some of the women, for others their economic dependence on men makes them passive negotiators.

Keywords: traditional health beliefs • AIDS-related knowledge • high-risk behavior • safer sex • condom use • women's HIV-vulnerability.

Akosua Adomako AMPOFO, *"Nice guys", condoms et autres formes de protection contre les MST : travailleurs du sexe et protection contre le sida en Afrique de l'ouest*

Résumé — Durant les 20 dernières années, on a remarqué des efforts en matière d'IEC (Information, Education, Communication) pour changer les comportements sexuels, avec l'espoir de ralentir la propagation du sida. On a négligé d'analyser la manière dont les facteurs culturels influencent l'interprétation de cette information, et les comportements qui en résultent. Cette contribution présente une étude menée à partir d'entretiens individuels avec des travailleuses du sexe ghanéennes. Plutôt que de se concentrer sur les facteurs de risque des clients, comme cela a été

la tendance, ce texte évoque la manière dont ces femmes perçoivent leur capacité à se protéger, en relation avec les croyances sur les causes de la maladie. Sont aussi examinés les liens entre le comportement des femmes et les fondements économiques de leurs relations sexuelles. Quatre types de perceptions et de comportements associés sont analysés, et leurs implications sont discutées. Les résultats indiquent que le fait d'avoir des connaissances sur le "comportement à risque" est une condition nécessaire, mais non suffisante pour changer de comportement. Les femmes n'assimilent pas l'information et ne modifient pas simplement leur comportement selon l'information fournie par les ""experts". Plus importante est la réflexion de la connaissance face au contexte de leurs croyances. En outre, alors que, pour certaines de ces femmes, une connaissance appropriée peut compenser la précarité économique, pour d'autres, leur dépendance économique par rapport aux hommes les rend passives dans la négociation.

Mots-clés : croyances traditionnelles sur la santé • connaissances sur le sida • comportements à haut risque • sexualité à moindre risque • utilisation du condom • vulnérabilité des femmes au VIH.

33. Perception of AIDS among University students in Nigeria.

Implications for AIDS prevention programmes

Edlyne E. Anugwom

Background

The acquired immunodeficiency syndrome (AIDS) is now a global scourge of mankind. It has been reported in almost all areas of the world. In Africa, the prevalent AIDS scourge is the pattern 2 which is transmitted through heterosexual relations and intercourse (Howlett *et al*. 1989). But while the spread of the HIV responsible for AIDS has come under great control in the advanced or Western nations, the developing countries, especially in Africa, are still battling with the acceptance of the gross reality of the pandemic. No wonder the AIDS threat is gradually becoming a thing for the developing nations. All over the world, health workers and researchers have agreed that prevention is a major avenue towards curbing the pandemic. In fact, until a reliable cure is found, prevention remains the most effective weapon against AIDS (Batchelor 1984).

Prevention is achieved mainly through education and enlightenment of the populace on the adverse consequences of AIDS. In Nigeria, the task of enlightenment has been embraced by government agencies and a few non-governmental organizations. This enlightenment exercise may have created an awareness of the existence of the disease but its real nature and life threatening consequences may still remain conjectural for a majority of the populace. Hence, while media and other forms of enlightenment has been significant, the extent to which the populace actually feels that AIDS is a real threat remains unknown. Moreover, simplistic messages and information about AIDS alone is inadequate in the struggle against the pandemic (McPherson 1996). Therefore, there is need to ascertain the perception of AIDS by Nigerians. Education and enlightenment on prevention of AIDS aims at changing the attitudes of the recipients of such education to the threat of the virus. As a result, it targets a change in both perception and behaviour. But it is likely that enlightenment programmes which are situated within the purview of the perceptions of those being enlightened would achieve more results in behaviour change than those that gloss over the prevalent perceptions of the population.

In this regard, AIDS prevention programmes should take adequate cognisance of the perceptions of the virus by the people. Generally, heterosexual intercourse is the primary mode of HIV/AIDS transmission

in Africa where it accounts for 70-80 percent of all cases (Hayward 1990). Heterosexual relations are usually undertaken by the sexually active members of the population. In this case, young adults or youths are more involved in heterosexual relations than other members of the population. Hence, this group becomes the ideal target of any AIDS prevention programme. And one setting where this target group of young adults can be located is at the tertiary institutions of learning, especially the universities. In view of the relative freedom and active sex lives of university undergraduates, AIDS prevention programmes become necessary for them. But such programmes may go a long way in reducing the spread of the virus, if they are informed by a knowledge of AIDS-related perceptions of such a target group.

From the foregoing, this study is aimed at discovering the prevalent perceptions of AIDS by university students in Nigeria. And from this standpoint, examine the implications of these perceptions for AIDS prevention programmes in the country. This was borne out of the conviction that assessing people's knowledge attitudes, beliefs, and practices (KABP) related to sexuality and AIDS is a good starting point of any prevention programme.

The AIDS pandemic

Recently a new concern about the violation of human rights through AIDS prevention programmes have arisen. In evaluating the human rights implications of HIV/AIDS preventive measures, Kirby (1996) sees such strict measures as compulsory testing, obligatory screening of risk groups, criminal punishment for spreading infection and quarantine as ineffective, counter-productive and positively harmful in the global struggle against STDs in general and HIV in particular. This is because according to him, AIDS prevention entails behaviour change which is difficult to achieve when the social environment is not conducive. The central place of behaviour change to AIDS prevention is also emphasized by Cochran and Mays (1989) and Osborn (1986). Behaviour change is very important when it is realized that AIDS even though a physical or biological disease depends for its transmission and spread mainly on the volitional behaviour of people (Ward *et al*. 1989). Kirby (1996) and Hauserman (1996) are however particularly concerned with the need to ensure that human rights are protected in relation to HIV/AIDS programmes.

Cochran and Peplau (1989) have discovered that the perception of being at risk, especially among men, is a factor in change of attitude towards the virus. Though they argue that women mostly change sexual behaviour mainly as a result of previous experience rather than cognition or perception. Perception influences prevention since prevention depends on behaviour change which is largely volitional. One way of addressing the influence of perception on prevention may be to situate prevention programmes in the social milieu of the people. Niang (1995) reports that a study in southern Senegal shows that local channels, groups and practices can be effectively and ingeniously used in AIDS prevention programmes. Prevention messages are particularly important. Even though there is need

to state this within the social milieu of the receivers of such messages. According to Ornelas-Hall (1990) AIDS messages must take cognisance of the social realities of individuals and groups.

The above observation is akin to the argument of McPherson (1996) that simplistic messages to control risk and the assumption that information alone enables women to protect their health is not adequate. This is especially the case for women with little or no power in their relations, hence there is need for strategies relevant to the circumstances of these women. AIDS prevention also requires applying intervention. Effective intervention according to Slutkin (1993) may involve such things as condom marketing, well-programmed use of mass media and advertising, peer projects to reach the most at-risk population and systems to diagnose and treat people with STDs that enhance HIV transmission.

Hence prevention programmes in Africa, especially in more affected regions, should aim at enlightening women on the risks they face and on the need for them to take active part in AIDS related activities and concern (*Exchange* 1995; *Safe Motherhood* 1995; Williams 1993; *World AIDS* 1993; Mahmoud *et al.* 1990).

Even though, condoms recur in all genuine efforts towards AIDS prevention, some writers and researchers have raised issues with them (Slutkin 1993; Finger 1993). Shreedhar (1994) reports that Indian condom markets are awash with inferior condoms. These condoms are easily busted, not lubricated and easily fall to bits. The poor condom quality is attributed to two factors viz lack of consumer pressure and scarcity of reliable quality control. Inferior condoms may give rise to deep-seated resentment against their usage especially by first-timers. Condom of quality is important in view of the fact that it is one of the most effective means of AIDS prevention. In view of the spread of AIDS, condoms make sense (Dixit 1993). A way of encouraging condoms use may be, according to Donald and Ferreros (1990), through social marketing which is a method of promoting awareness of supply and distribution that complements many health delivery systems. While condoms are becoming popular and social marketing is encouraging condoms use to prevent transmission, a new concern has emerged on how to sustain such efforts (Manuel 1993). As a preventive measure the condom appears to be very effective especially where religiously adhered to. Rajanapitayakorn (1993) reports that a 100 percent condom use campaign in Bangkok, Thailand may have slowed the spread of the infection there.

As part of preventive efforts, public education will help in assuaging the problem of AIDS (Batchelor 1984). AIDS education in schools seems very necessary. In the views of Sy *et al.* (1989), this may be implemented as part of a carefully planned and comprehensive school health education curriculum. This suggestion may be timely in Nigeria where Raufu (1993) reports that despite statistics showing that Nigeria is on the brink of an AIDS epidemic, many Nigerians still scoff at the idea that the disease has eaten deeply into the fabric of society.

Method of study

The population of study is the student population of four universities in South-Eastern Nigeria. The universities are: University of Nigeria, Nsukka; Nnamdi Azikiwe University, Awka; Enugu State University of Science and Technology; and Abia State University, Uturu. The students were sampled during the course of a week-long AIDS awareness campaign organized by two AIDS NGOs in Nigeria. A sample size of 400 students were randomly selected from the students who attended the event (100 students from each university). In order to ensure equal gender participation in the study, efforts were made to sample as many female students as possible.

The research instrument was simple self-administered questionnaire constructed to ascertain the awareness and perception of AIDS by the students. Hence the questionnaire contained questions on awareness of the disease; source of awareness/information on AIDS; reality of the AIDS disease; use of prevention; type of precaution preferred and problems associated with it, etc. Since no hypothesis was stated due to the exploratory nature of the study, data analysis was carried out through the use of simple descriptive statistics. As a result, percentages and tables were employed in illustrating relationships between variables of interest in the study. It is hoped this will facilitate easy comprehension of research results. Moreover as Behrend (1954) have argued, in analyzing data, the most efficient and at the same time simplest available method which is appropriate to the subject matter should be used.

Students and perception of AIDS in Nigeria

A pertinent starting point for presentation of findings in a study of this nature may be an examination of the socio-demographic characteristics of respondents. This then will provide the background for other findings of the study. As the study population is made up of students, this may entail illustrating their courses of study, as well as age and sex. Respondents were drawn from four faculties viz Science (20 percent), Social Science (30 percent), Arts (30.7 percent), and Business (19.3 percent). Respondents studying Law were merged with those studying Arts since there were only a few of them in the study sample.

Our data reveal that all the respondents are in their youth. Also, a predominant number of them are in the 21-30 age bracket. This shows that university student in Nigeria rightly constitute an AIDS prevention programme target group, especially when it is realized that the disease usually affects those between the ages of 20-40 (Batchelor 1984). Moreover a significant number of females (37.5 percent of total sample size) were sampled. This ensured that a sort of gender balance is achieved.

To ascertain the perception of the students regarding the reality of the AIDS pandemic they were asked if they believe that AIDS is really in existence. Surprisingly enough, 30 percent or 120 of the respondents of both sexes saw AIDS as not really in existence. This is worrisome when

one pits this sort of revelation against the fact that the respondents are university students who are supposed to be very informed. All the same, all the respondents have heard of the existence of the disease in Africa, even though they all have not actually seen an AIDS patient before except on the television. In addition to this, most of the respondents stated that they have only seen white people afflicted with AIDS. None of them has seen a black person afflicted and 80 (20 percent) of them cannot remember exactly the race of AIDS victims they have seen on the television.

This may not be entirely astounding when it is discovered that a significant number of the respondents (280 or 70 percent) see AIDS as an invention of the Western nations to put Africa in place.

Therefore, the respondents mostly see AIDS as part of the politics of development and Western nations are using the pandemic to put Africa in place. This revelation vindicates the contention of Raufu (1993) that Nigerians scoff at the idea of the reality of AIDS and see it as Western-inspired propaganda. Such a perception of AIDS may not be unrelated to colonial experiences of Africans in which everything bad was attributed to the blacks by the whites. While the efforts of educated Africans to counteract such an orientation, particularly in the socio-political arena are commendable, its carry-over to a major health threatening situation in really a source of concern. Also this type of perception puts a big question mark on the effectiveness of AIDS enlightenment and prevention campaigns in Nigeria. And as Cochran and Peplau (1989) rightly observed the perception of being at risk is a factor in change of attitude. Obviously, a change of attitude and behaviour is germane to any sustainable AIDS prevention efforts.

In a bid to discover the coping ability of the respondents in case of rapid AIDS disaster, they were asked to classify death from AIDS either as un-natural or normal. This stems from the belief that those who see death from AIDS as normal may be in a better position to cope with its disaster than others. At the same time, those in this category may be less receptive of AIDS prevention messages. The result shows that 125 (31.3 percent) of our respondents see death from AIDS as unnatural, while 278 (68.7 percent) see it as normal.

Further to this, the respondents that see nothing abnormal in dying from AIDS were asked to state reason why they feel so. A majority in this category of respondents (105 or 38.2 percent) see death and cause of death as pre-ordained; 62 respondents (or 22.6 percent) see death as a thing for everybody; and others (83 or 30 percent) see death as either usual or see cause of death as unimportant.

In view of the fact that all the respondents have heard of the existence of AIDS in Africa and most of them have also heard of preventive messages or seen anti-AIDS posters, they were asked whether they take any form of precaution in their sex activities. The responses are shown in the following table 1, from which it can be seen that a significant number of the respondents, who are typical of Nigerian students, do not take the AIDS threat serious enough. It is disappointing that out of a sample of 400 students, 160 (40 percent) of them do not take any form of precaution against AIDS.

Table 1: *Distribution of respondents by attitude to precaution*

Attitude	No. of respondents	Percent
Take precaution	195	(48.7%)
No precaution	160	(40%)
Abstinence	45	(11.3%)
*Total*400	(100%)	

This supports the argument of McPherson (1996) that simplistic messages and information alone is not adequate. There is need for effective intervention programmes in the mode put forward by Slutkin (1993). The result in the above table becomes more insightful when the respondents who take precaution were asked to state which precautions they use. It was discovered that a majority of respondents who take precaution (110 or 56 percent) use condoms or encourage partners to use condom. Also quite a significant number of respondents (72 or 37 percent) keep to one partner as a form of precaution or prevention, while 7 percent of the respondents could not state the form of precaution they employ. However, an important fact emerged when respondents, that use or encourage partners to use condoms, were asked to state why they do this and the most severe problem they face in using condoms (whether from the products or from partners). The results are presented in the table 2:

Table 2: *Distribution of respondents by reason for condom use by problem of condom use. Number and percent*

Problem	AIDS	Pregnancy	STDs	Total
Restriction of pleasure	6 (5.5%)	12 (11.0%)	8 (7.3%)	26 (23.8%)
Breakage	3 (2.7%)	8 (7.3%)	10 (9.1%)	21 (19.1%)
Partner suspicion	3 (2.7%)	4 (3.6%)	10 (9.1%)	17 (15.4%)
Cannot ejaculate	4 (3.6%)	16 (14.5%)	3 (2.7%)	23 (20.8%)
Others	2 (1.8%)	5 (4.5%)	4 (3.6%)	11 (10.0%)
No problem	2 (1.8%)	10 (9.1%)	0 (0%)	12 (10.0%)
Total	20 (18.2%)	55 (50.0%)	35 (31.8%)	110 (100%)

It appears that only a small number of the respondents use condoms in a bid to avoid AIDS infection. On the contrary, majority of them use condoms to avoid the risk of pregnancy or contacting other STDs like gonorrhoea, herpes, syphilis etc. All the same, use of condoms for whatever reasons will still be effective against AIDS infection. The table also shows the range of problems which respondents identified with using

condoms. Some of these problems may be psychological especially where the person is just starting to use condoms. Admittedly, inferior or sub-standard condoms which somehow get into the market may be prone to such defects as breakage and lack of lubrication (Shreedhar 1994). In spite of these, use of condoms still remain one of the most effective preventive measures against the AIDS scourge. Their usage in Nigeria and other developing countries is imperative in view of the fact that, by the year 2000, as many as 40 million people could be infected, 90 percent of them in the developing world (*World AIDS* 1993).

Concluding remarks

This exploratory study discovered amongst others, that the AIDS perception of Nigerian students is ill-informed. Hence they see AIDS as a development propaganda; a significant number also see AIDS as not really in existence, and do not bother themselves with any form of precaution. Some of these discoveries are as insightful as they are disturbing. They seem to call for a realignment of AIDS prevention programmes to tackle the problem of wrong or unjustified perceptions.

One way of doing this may be, as Sy *et al*. (1989) suggested, to incorporate AIDS education in the curriculum of schools in Nigeria. So far, this is not the case. In the universities, AIDS education may be made part of the General Studies or Foundation Studies courses. Even though, it should have no influence on students' GPA, they would all the same be required to take the course and pass it before graduating. Also, effective intervention in the ways pointed out by Slutkin (1993) may be desirable especially peer projects to reach the most at-risk population since this would suit the lifestyle of university undergraduates. There is also need for condom manufacturers in Nigeria to explore ways of increasing the excitement or arousal that one gets on putting on a condom. This may tackle the problem of pleasure restriction and ejaculation difficulties. In addition, enlightenment programmes may state the need for partners to educate each other on the desirability of condoms. This form of dialogue may deal with the issue of suspicion.

Perceptions which may be products of historical reality, environment and culture affect one's behaviour and attitudes to the AIDS threat. Nigerian students schooled to view Western oriented programmes with suspicion are likely to see the AIDS threat as one more card in the trick bag of developed nations. This perception, earlier noted by Raufu (1993), needs to be tackled if meaningful results are to be achieved in prevention efforts. Therefore, the government and AIDS NGOs should do more in terms of effective prevention programmes which ought to start from disabusing the minds of Nigerians of wrong notions and terminate in the promotion of 100 percent condom use by all Nigerians. A 100 percent condoms use campaign have proved effective in slowing the spread of AIDS elsewhere (Rajanapitayakorn 1993). It is worthy of mention at this juncture that the time lapse between when this study was conducted in 1995 and now may have produced some remarkable changes in perception of AIDS among the students. Thus events in the last two years in Nigeria

may have deeply affected the perception of AIDS by students. Nowadays, some University campuses are centres of anti-AIDS activism organised by the students themselves. Some of these groups as the AIDS Prevention and Control Organisation (APCO) have carried their campaigns beyond the campuses to other target groups in the population. A number of other factors are also responsible for this. These are the increased sensitization of students through the media, the activities of NGOs and an increase in the level of HIV affliction in Nigeria among others. Moreover, the demise of the popular musician, Fela Anikulapo-Kuti, through the disease turned out to be a sort of turning point in the orientation of most Nigerians to the AIDS reality. All the same, pockets of confusion and doubts still exist all over the country, thus making continuous enlightenment a necessity.

It is to be expected that the issue of perception of AIDS in Africa is very crucial to prevention efforts. According Mongo (1995), the perception of the disease in East Africa has been a major obstacle to its prevention. Traditional beliefs and fetish practices have stood in the way of an objective assessment of the menace. In a similar frame of reference, Kittel (1996) has reported that AIDS prevention efforts in such African countries as Zimbabwe, Malawi, Zambia and South Africa should ideally start from remoulding the impressions of people —victims and relations— about the disease. Be that as it may, Nwamba (1995: 61) after a study of the epidemic in Ghana, states succintly that, "as is usually the case with afflictions, in Africa as a whole, traditional beliefs and practices have punctuated most of the genuine efforts to tackle the AIDS menace".

Finally, finance which has been the major constraint militating against NGOs and government agencies AIDS campaign (Raufu 1993) should be addressed. In this regard, the Nigerian government and other corporate bodies in the country may be given the message of Merson (1993): "Spend now or pay heavily later". Money must be expended on mass prevention programmes which should be clearly informed, mostly by the results of social science research in order to achieve desired results. The time to act is now.

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Edlyne E. ANUGWOM, *Perception of AIDS among University students in Nigeria. Implications for AIDS prevention programmes*

Summary — This study conducted in 1995 looked at the perception of the AIDS disease among students in four Nigerian Universities. It discovered *inter alia* that a lot of confusion and misinformation still shrouds the students' perception of AIDS. One of these is that they see it as a development related phenomenon being used by Western nations to put Africa in its place. Also a significant number (40 percent) do not take precautions. A significant number of condom users among them expressed misgivings ranging from its restriction of pleasure, breakages to acts of suspicion on one's partner. Our study reveals a tendency to see AIDS from cultural and racial angles and a need for a realignment of AIDS prevention programmes in Nigeria.

Keywords: perception • AIDS • implications • prevention • students • enlightenment • disease • Nigeria.

Edlyne E. ANUGWOM, *Perception du sida chez les étudiants d'Université au Nigeria : implications pour les programmes de prévention du sida*

Résumé — Cette étude menée en 1995 analyse la perception de la maladie du sida chez des étudiants de quatre universités du Nigeria. On a remarqué en particulier beaucoup de confusions et de mauvaises informations qui sont à l'origine de perceptions embrouillées du sida chez ces étudiants. Entre autres, on trouve l'idée que le sida est considéré comme un phénomène lié au développement qui est utilisé par les nations occidentales pour mettre l'Afrique à sa place. Aussi un nombre important (40 %) d'étudiants ne prennent pas des précautions. Une proportion importante d'utilisateurs de condoms a exprimé des réserves et des doutes allant de la restriction de plaisir au fait de ne pas avoir confiance en son partenaire. L'étude a révélé une tendance à voir le sida sous un angle racial et culturel et a mis en relief le besoin de repenser les programmes de prévention du sida au Nigeria.

Mots-clés : perception • sida • implication • prévention • étudiants • information pour éclairer • maladie • Nigeria.

34. Male circumcision: practice and implication for transmission and prevention of STD/HIV in Central Kenya [1]

Beth M. Ahlberg, V.N. Kimani, L.W. Kirumbi, M.W. Kaara, I. Krantz

Introduction

The aim of this study was prevention of HIV/AIDS among young people. The point of departure was the scenario of adolescent sexual and reproductive health in Kenya with high rates of early and unwanted premarital pregnancy, induced abortion and related complications, school drop-out and sexually transmitted diseases. In Kenya young people live in a paradoxical situation of prohibition and silence on matters of sexuality.

Our assumption was that breaking the silence and creating dialogue or space for people to address the prohibitive silence is an important prerequisite for preventing the spread of STD/HIV. We thus applied an open design and started by mapping the community to identify relevant community groups and networks, generate locally based knowledge, meanings and issues around which further research could be carried out as well as explore tools and use them to facilitate dialogue and preventive behavior in the community. The term *Mwomboko* which is used in a local poem 'words of wisdom' (Ngugi Wa Thiong'o 1987) and is also a local dance of young people where a couple moves two steps forward, stoops and makes a turn was discovered during this mapping process. *Mwomboko* was thereafter symbolically used to denote a movement involving data collection using interactive analytical methods, each stage of analysis defining the movement in the next step.

Circumcision unexpectedly emerged from the school data as a major concern of young people. Since circumcision is an old custom, it became necessary to carry out more systematic research to find out why it was of

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such concern to the young people as well as find out its meaning, how it is organized and linked to sexuality.

The relevance of circumcision to HIV/AIDS

Circumcision has been implicated as a risk factor in the transmission of HIV. It is for example, argued that sexual intercourse causes lacerations and bleeding in women who have undergone clitoridectomy and infibulation thus increasing their risk of infection (Linke 1986; Gunn *et al.* 1988; Padian 1987). Furthermore, in both female and male circumcision, use of instruments during the operation without proper sterilization has been implicated as a possible transmission route. Results from surveys at STD clinics (Hira *et al.* 1990) have, however, indicated that male circumcision may lower transmission of STD including HIV. This has led to the conclusion that male circumcision should be considered a necessary line of action especially in Africa where condom use is low (Johnson and Laga 1988; Bongaarts *et al.* 1989; Marx 1989; Caldwell 1995).

There might be an argument for male circumcision for hygienic reasons especially in poor areas where most studies seem to have been carried out. However, to institute a widespread cutting of foreskins as a preventive measure against the spread of HIV, is not only to ignore the meanings and practices associated with the ritual, but it is also to assume that:

> "the African countryside and its peoples are in some way immune to change and that cultural practices such as circumcision (or no circumcision) and degrees of sexual permissiveness are fixed for all time. Such a view ... is not too different from assuming that the populations of the African countryside beat to a kind of heart of darkness" (Conant 1995: 109).

For the circumcised and the uncircumcised, associated practices may be more critical in the transmission process than just the presence of a foreskin. This paper presents findings from studies in Central Kenya indicating that male circumcision in its current form is closely associated with practices, and is organized in ways which have implication to the spread of STD/HIV.

Subjects and methods

Murang'a District of Central Kenya, an agriculturally high potential, densely populated area inhabited by the Kikuyu people who practice male circumcision universally is the study site. Data was gathered from primary and secondary school youth, health workers, parents and teachers in one of the six administrative divisions comprising Murang'a District.

The school youth

Questions were generated from 4,365 girls and boys in 15 primary and 14 secondary schools, purposefully selected using the administrative zonal units of the Ministry of Education.

The youth in classes 6-8 (11-17 years) in primary schools and forms 1-4 (14-20 years) in secondary schools were encouraged to write anonymously, questions they would otherwise feel too ashamed or afraid to ask their parents, teachers or other adults. They could use any of the three languages —Kikuyu (mother tongue), Swahili and English, the last two of which are taught in schools.

To avoid interrupting the school routines, we made a single visit to each school. This meant having all the pupils in one hall. Most school halls are poorly furnished, and pupils had to bring their bulky desks. Although we stressed the need for privacy in answering the questions, the sitting arrangement was not conducive for such privacy. The questions generated nevertheless reflect varied concerns of the school youth in this area. Equally important was the style of expression and the language used. Where questions are quoted in this text, we have tried to have them in the form they were originally expressed.

Circumcision emerged from this data as a major concern of the school youth. Since male circumcision is an old custom, it was surprising that the school youth expressed such concern over it. From the questions, it became clear that the adolescents were undergoing a practice they did not fully understand. It thus became necessary to investigate other social groups and networks particularly the health workers, teachers and parents who in one way or the other are relevant in the ritual of circumcision.

The health workers

We mainly focused on the private clinicians, a health system existing at the periphery despite being an important and rapidly expanding resource. Private clinicians comprising of clinical officers, nurses and nurse midwifes, located in shopping centres and markets all over the area perform most of the operations on boys.

A survey of all the 35 private clinicians in one administrative division provided information regarding which clinicians perform the operation, their workload and periods when they operate. More qualitative information was gathered during three workshops with private clinicians (Krantz *et al*. 1995). This elicited information on the operation, the management of the wound, the use and care of instruments, the organization of circumcision, the information given to the initiates and the persons involved particularly the *mutiri*. A *mutiri* is counsellor of the initiate and is an important person in the ritual of circumcision. Elderly clinicians in particular contrasted the traditional operation they themselves went through and the type they currently perform at their clinics thus providing insights about changes in the ritual.

The parents and teachers

We reached the parents through the parent/teacher association in which all parents belong to by virtue of having children in a school. Since many teachers are also parents, those who could join the discussion sessions were encouraged to do so.

We presented the following summary of our observations as the point of entry for interaction with the parents:

> "We have asked your children to ask those questions they would be ashamed or fear to ask you as a parent or adult. The questions indicate that your children have little knowledge about even the simplest facts about their bodies; they have a lot of wrong information and myths regarding sex but are actively involved in sexual activity even though you stress they should wait until they are married. Moreover, your children are very concerned about the ritual of circumcision and wonder why they go through it. They have a peer (*muriika*) for *a mutiri* (counsellor) and they organize their own rituals; for example buying road licence, undressing the wound before the time they have been advised by the doctor, causing the erection of the penis and applying medicines they buy at the shop or market. The initiate is advised to have sexual intercourse (*kuhurwo mbiro*) immediately after circumcision in order to fully become a man. He is instructed by the *mutiri* and other peers on how to negotiate with girls for sex. As parents you are involved only in providing money for the operation, for medicines (which are unnecessary) and for food during the convalescence period. You know little of what goes on in the small rooms (*thingira* or *kiumbu*) which you offer the initiate and his peers".

Parents were then asked whether this is a true representation of what they and their children are experiencing; what they thought were the causes; and what they thought could be done to improve the situation. The ensuing discussion then focused on the organization of circumcision now and in the past, the changes taking place and possible preventive interventions.

Findings

Circumcision as a concern of adolescents

Overall, 580 questions concerning circumcision were asked by 455 (15 percent) of the youth in primary and 91 (7 percent) in secondary schools. The dominant concern was what circumcision is and why young people have to go through it. Most of the questions were asked by boys, probably because circumcision is universal for boys.

As far as female circumcision is concerned, there seem to be a great deal of confusion mainly because some girls undergo the operation while others do not. Questions were also moralistic asking whether female circumcision is good or bad. Compared to male circumcision, where the question is simply why boys are circumcised, the concerns about female circumcision were expressed in a variety of ways as indicated below:

> "Why are girls circumcised? Why are girls not circumcised? Is it bad for a girl to be circumcised? Why did girls stop being circumcised in some areas and in others they still do it? Why is circumcision of girls discouraged? Why has the government prohibited clitoridectomy and traditionally it was done?"

The questions also indicated other types of concern, for example, the role of circumcision in fertility and sexuality. There seemed to be

confusion and lack of knowledge about the role of circumcision in fertility. Some questions suggest that the adolescents simply want to know whether there is a link between circumcision and production of sperm or the possibility to impregnate as the following questions illustrate:

> "Can an uncircumcised boy make a girl pregnant? Can an uncircumcised boy fertilize? If a person isn't circumcised can his sperm produce a baby? Can a 15 year old uncircumcised boy make a girl pregnant? Can the foreskin of uncircumcised boys hinder sperm secretion?"

Another set of questions indicate that the youth have a general impression that an uncircumcised boy (*kihii*) cannot make a woman pregnant.

> "Why is it that when an uncircumcised boy fucks a girl she can't conceive? Why is a boy unable to cause fertilization unless he is circumcised? How is it that an uncircumcised girl can conceive and an uncircumcised boy cannot make a girl pregnant?"

There was concern over the link between circumcision and sexuality and more specifically sexual pleasure. The fact that some girls do not undergo the operation while others do seem to have created confusion on the issue of sexual pleasure as well. Questions concerning circumcision and sexual pleasure were asked by more mature boys 15-20 years. While a few questions indicate that uncircumcised girls are regarded as more pleasurable, the major concern seems to be to find out who gives more sexual pleasure —the circumcised or the uncircumcised woman.

> "Why dont circumcised girls enjoy sex i.e., why do guys prefer uncircumcised girls? Is there any difference between a circumcised and uncircumcised girl? Who is better to have sex with a circumcised or an uncircumcised girl? Does a girl without a clitoris reach orgasm while having sex? Who enjoys sex most between circumcised and uncircumcised? Who is the best girl to marry between circumcised and uncircumcised?"

There seem to be an impression that an uncircumcised boy cannot erect and cannot penetrate. Circumcision itself seem to be linked to development of sexual pleasure and desire and there seem also to be a belief that circumcision causes the development of secondary sexual characteristics and increase in sexual desire.

> "Why do girls say that circumcised penises are sweeter than the uncircumcised? Why does an uncircumcised person not know how to penetrate his penis through the vagina and reach the uterus? Why is it that a boy who has not undergone circumcision cannot enter through the vagina when mating? For good penetration of the penis through the vagina, why must a boy be circumcised? When a boy goes for circumcision why does he begin loving girls? Why do boys desire sex after circumcision? What makes a boy after circumcision increase his desire for sex? Why do boys be friend girls after circumcision? Is it true that when a girl gets circumcised she gets big breasts?"

The youth are concerned with the behavior changes that take place after circumcision as well.

> "Why is it that when a girl gets circumcised she pretends she cannot give a boy to do her? Why do people boast after they are circumcised? What happens at circumcision to make boys change their behavior so much? Why does a boy after getting circumcised no longer sleeps in the same house as his parents? When a boy is circumcised why can't girls go to his hut? How would I tell my parents that I want to go for circumcision?"

These questions indicate the meanings adolescents associate with circumcision. They furthermore express the level of knowledge on sexual matters, conception and fertility. It is clear that the youth have little knowledge, and a great deal of misinformation and myths. The way the questions are expressed moreover indicate that there is a silence about circumcision. To be able to locate the concerns of young people, the seeming confusion, the silence, the changes taking place and the implication of these to transmission of STDs including HIV/AIDS, past and contemporary forms of the ritual of circumcision in the Kikuyu society are presented.

Male circumcision in the past

Prior to the colonial and Christian missionary intervention at the turn of the century, all boys and girls went through the ritual of circumcision. The ritual was associated with acquiring of social status for the initiate and his parents. The boy would come off age after which he was expected to behave as an adult. He could then be called upon to perform important duties such as defending the community, participating in dances and *ngwiko*, a type of controlled sexual activity which allowed newly initiated girls and boys to sleep together, to explore and enjoy each other without penetration, as one elderly teacher explained:

> "*Andu metikiritio kugwika ciero ciika* (people were allowed to play with thighs only)".

The parents had their status elevated after the circumcision of their children, the mother moving from the low status *Kang'ei* to high status, authoritative *Nyakinyua* age group (Ahlberg 1991) and the father moving up the various ladders of council of elders (Kenyatta 1938).

The organization of circumcision

Circumcision was an important event for the initiates, their families and the entire community. It was an elaborate ceremony that brought individuals, relatives, and the community together. As the start of adulthood for the initiate, care was taken both to impart the socially prescribed knowledge and discipline. The ceremony including preparation, seclusion, the operation and the convalescence took a long time.

After the operation, there was great jubilation including singing, dancing, beer drinking and exchange of gifts. This was one time when

women were allowed to collectively and publicly participate in dances, songs and chants which in normal circumstances would be considered extremely obscene. It was one occasion the society allowed public obscenity meant to teach the new adults what was expected of them in their sexual life.

When the time for initiation approached, the parents identified a respectable and knowledgeable man to be the *mutiri*, a counsellor who was supposed to prepare the boy for initiation, take him through the operation by physically supporting him from behind, nurse the wound and guide him thereafter.

On the day of circumcision, the boys in groups were taken to the river very early in the morning and were dipped in the cold water after which they were circumcised. The cold water served as local anaesthesia as well as a vasoconstrictor to reduce bleeding. The *mutiri* supporting the boy from behind encouraged him not to cry even if the pain was unbearable, because it would lower respect and status for him and his family.

After the operation, groups of initiates lived together, in a separate house with the *atiri* (pl.) supporting them both physically and emotionally. During the time, they were well fed and learned from the *atiri* until they emerged (*kumira*) as adults.

Sexual activity after circumcision

Part of the education for the initiates was how to relate to women and how to maintain discipline in sexual matters. The newly initiated girls and boys were involved in dances and were allowed to sleep together the whole night and to engage in *ngwiko*.

Although full sexual intercourse at this period was not allowed, in their relation with girls, there still were attempts by men, or rather, men were expected to try their luck on the girls. The most commonly used form of wooing girls into sexual intercourse was to scare them that unless they agree to *Kuhurwo mbiro* (a metaphor referring to wiping off the soot that gathers around the cooking pot), they would never give birth, sexual intercourse with their husband would be extremely painful or the husband might die during the first intercourse. The girls then were equally empowered to resist this by their peers, older girls and their *atiri*. During discussions, many women talked about this as a common experience during their time as this quote indicates:

> "Even in the past men cheated newly circumcised girls that if they did not agree to have the soot (*mbiro*) cleaned before marriage, their husbands would die during the first intercourse. My friends and I were cheated only to find from older girls who were already married that it was a lie".

Peer pressure was part of the mechanisms used to maintain the proscribed sexual discipline among girls and boys. In addition to the peer pressure, taboos and prohibitions and the belief that the breach of conduct could lead to a break down of harmony and social balance leading to catastrophes and disease, were extensively used to guide people in their daily life. When there was a breach of conduct or even a suspected one for example, a full sexual intercourse during *ngwiko*, heavy punishment

was meted to those involved. Girls had a way of finding out which of their agemate may have had full sexual intercourse. If, during dances, a man showed a favourable attitude to a girl, she was suspected by the others of having given in to the man. She was ostracised or fined (Ahlberg 1991).

Moreover, as women in this study have explained, if by chance the girl had full sexual intercourse, she could not enter her mother's house because by having sexual intercourse, she herself became a full woman (*mutumia*) and no house was allowed to have two women. She could only enter, after an elaborate ceremony through which her sexual activity became public knowledge.

Given the strict rules and associated punishments, the attempts by men must have been part of the open discourse in sexuality in this community and a test of the moral discipline. The society was in addition organized in ways which minimized the possibility of breaching the codes of conduct. *Ngwiko* was for example, collectively organized. Groups of youth involved in *ngwiko* slept together in one room. This discouraged those who may have been tempted to have full sexual intercourse. This is one practice the Christian missionaries forbade as they could not visualize young people sleeping together without sexual intercourse (Ahlberg 1991 and 1994).

Circumcision in the contemporary society

All boys undergo circumcision with the operation still marking entry into adulthood (*kugimara*). However, its form and organization has changed.

The operation is mostly performed during school holidays. December is more popular because, being a longer school holiday, boys have sufficient time to heal. Furthermore, it is a period when boys after graduating from primary school are awaiting to join secondary schools. It is important that they are circumcised because uncircumcised boys are punished and bullied by the older boys in the new schools. Boys from areas where male circumcision is not practiced are similarly bullied and forced to circumcise if they join secondary schools in this area. Thus, apart from the academic qualification for entering secondary schools, there is a demand for social adulthood defined through circumcision.

Unlike in the past, involvement of adults and the community in general and the related sexual education of the initiates has diminished. As the school data indicates, the most frequent question is why the operation is done.

Furthermore, the role of the *mutiri* has changed. Parents no longer identify the *mutiri*. This means that the criteria where parents in the past chose a person who commanded respect and was knowledgeable on codes of conduct has been abandoned. The link between the youth and the adults during this important period is therefore weak.

The boys choose their *mutiri* usually from those who went through initiation the preceding season. Families may identify an elder to whom the young boy may be sent for advice. This is however a one time interaction. The rest is left to an agemate.

The operation is now commonly done in the private clinics. Of the 35 private clinicians surveyed, 17 (49 percent) circumcise. The operation is largely done by male clinicians, although female clinicians can employ males to operate in their clinics. One female clinician who had established respect and trust with the community could however operate the boys herself. The role of the traditional circumciser (*muruithia*) and perhaps also the rituals he performed has equally diminished.

The initiate is escorted to the clinic by his agemate *mutiri* for circumcision on the material day. After the operation, the clinician dresses the wound and instructs that the dressing should not be removed before the seventh day. The initiate is then escorted back home. According to the private clinicians, the instruments used for circumcision are sterilized first in a detergent and thereafter boiled. This procedure is done after every operation. The chance for transmitting HIV through the instruments is according to the clinicians very remote.

The convalescence period

As in the past, the initiate is given a room or house (*thingira* or *kiumbu*) detached from the parents. One parent discussed how she had to move her son's bed into the granary adjacent to her house as it would have been difficult for him to be inside the main house. Food is taken to the initiate in most cases by the mother or a sister. According to parents, the mother only hands over the food and is actually even by tradition not expected to enter the room. Initiates whose parents do this, risk punishment. Parents have therefore little knowledge of what takes place in the small rooms.

Usually the boy is visited by relatives and friends who may bring him some gifts, but they too are only visitors to the parents. Although we have not done systematic research, there is indication that some dancing and singing is being revived especially in the urban areas. This does not however carry the same meaning in terms of educating or instilling sexual discipline to the initiates. Rather, it is more for the identity of the adults in a fast changing environment.

During the convalescence period, the *mutiri* is around to take care of the initiate. In addition, circumcised agemates of the initiate and at times those of the *mutiri* visit regularly. The convalescence room or house is thus more or less occupied by the young people who offer advice on what the initiate should do to fully become a man.

The care of the wound

The wound according to clinicians should not be interfered with before seven days, by which time it should be healed. However, it is a normal practice for the *mutiri* to remove the dressing sometimes only on the second day and sprinkle powder from antibiotic capsule or a crushed tablet of cotrimazole (*suta*) on the wound.

It seems the *mutiri* is still performing the duties he was supposed to do when the wound was required to be cared for and dressed at home. The

difference now is that to maintain their role, they have to undo what the health professional has done.

The pain inducing rituals

Other practices include sexual arousal until the initiate achieves an erection. In addition, initiates are forced to drink lots of water and tea in order to urinate many times. These practices result in the swelling, pain, bleeding, and delayed healing of the penis. The clinicians implied that infection of the wound and bleeding are not uncommon.

There was teasing in the past, and certainly, boys who had been naughty were usually teased into erection and pain. But this did not apply to everybody as seems to be the case today. Bearing pain was part of becoming a man in the past. Compared to the traditional operation popularly known as 'going to the river' where cold water was the only anaesthesia, hospital circumcision is less painful because the initiates are fully anaesthetized. The operation is thus considered to be less painful and is similarly accorded lower status. Given this, the new rituals of instilling pain on the initiate are understandable.

Most parents told of their experience with these new pain inducing rituals. It is one of the few times some parents have attempted to intervene. However, such intervention may result in more bullying of their son and many parents expressed the dilemma of intervening. One mother reported how she heard her son groan in pain only to find out that his penis was swollen from unnecessary erection. She became furious and ordered the young men out and never to return.

Buying a road licence

A ritual that seem to have developed is one where the initiate is expected to buy 'a road licence', through offering a chicken, cigarettes and beer[1] The initiates are popularly referred to as '*thigara*' cigarete. The road licence allows the newly initiated man to socially interact with other circumcised men and talk to girls without risking punishment or bullying.

***The ritual of* kuhurwo mbiro**

Perhaps most important as far as transmission of STD/HIV is concerned is the ritual of *kuhurwo mbiro*. As pointed out above, this is a metaphor symbolizing the cleaning of soot which gathers around a cooking pot. The metaphor was however used by men to woo women into sexual intercourse. It was thus women not men who had to have soot cleaned.[2] Although men used the tactic to woo women, full sexual intercourse rarely took place, because of the strict rules and mechanisms for maintaining the proscribed sexual discipline as discussed above. The

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[1] Hard drugs —*ciakurebia* are also known to be used for buying the road licence.

[2] One can understand such a metaphor when applied to girls because it is them who use the cooking pot after marriage.

metaphor has now been appropriated by men and with the breakdown of social controls, soot is cleaned through full sexual intercourse.

Although we have not carried out systematic research, there are indications that because of the peer pressure to have sex as part of becoming a man, combined with the difficulties of negotiating for sex with girls in their age-group, newly circumcised boys increasingly turn to older women, including, those with wider sexual networks. The risk of exposure to STD and the AIDS virus is thus great.

During the convalescence period, the initiate is trained by the *mutiri* how to negotiate for sex. This is normally dramatized, the initiate being asked to pretend that the *mutiri* is a girl and should negotiate (*kuha*) with her for sex. If he makes a mistake, he is corrected until he gets it right.

Discussion and conclusions

Male circumcision is still universal among the Kikuyu people. The ceremonies that marked the occasion and imparted knowledge and discipline however no longer exist. The open discourse, combined with strict social controls have been replaced with a silence that still prohibits premarital sexual activity.

With no mechanisms to maintain the codes of conduct and the expected sexual discipline, the prohibition by adults exist in a vacuum. Moreover, some rituals have been transformed to suit the contemporary period and new ones have emerged. *Kugimara* through circumcision currently implies assuming the status of an adult who is actually expected at least by the peers to engage in sexual activity soon after the operation. The initiates are thus instructed on the art of negotiating for sex. The boy is instructed or socialized on how to express love to a girl in his negotiation with her for sex. There thus exist two types of conflicting moral regimes. Parents and adults in general cherish the value of no premarital sexual intercourse while the young people live within a moral regime which says yes to sexual intercourse if people are in love or as part of becoming a man.

While the *kugimara* process in the past, largely involved integrating the emerging adult men (*ciumiri*) into the society, through the elaborate system of imparting and maintaining the accepted values, codes of conduct and discipline, the contemporary form seems to separate young people from the rest of the society. This has created dilemmas at home and in school. Many parents expressed the paradoxical situation they find themselves in for being expected to discipline their circumcised sons. However, according to the rules of circumcision, the initiates are adult men, although agewise they are still minors who require parental care and disciplining. The parents in fact expressed fear of either being beaten by their sons or forcing them to run away from home if disciplining is attempted.

The challenges of disciplining newly initiated men is experienced at school as well. Most primary schools discourage circumcision, the main reason being that boys become uncontrollable. Women teachers especially expressed the difficulties they face in disciplining circumcised

boys. Circumcised boys feel that female teachers are just like any other women with whom they can have sex. Our attempt to separate boys into circumcised and uncircumcised in order to create groups with similar characteristics for focus group discussion in primary schools was turned down. The headmasters argued that schools were working hard to discourage such divisions.

The impact of the silence on sexual matters is indicated in the school data. The adolescents for example, link secondary sexual characteristics to circumcision. This is perhaps not surprising because, the operation is performed at the age of spermache, when there is a physiological increase in the production of male sexual hormones resulting in increased sexual desire. The society in the past had identified this as the right age to impart knowledge on sexual morality to control sexual desire. *Ngwiko* was introduced and practised during this time, to satisfy the sexual needs of young people, but also confront them with real life situations which they had to learn to manage. Today, the adolescents are left thinking that it is circumcision which causes their physiological development, hence the belief that uncircumcised boys cannot impregnate.

In the contemporary period, circumcision takes place in clinics where sterilization of instruments is possible. Transmission of HIV through shared instruments is reduced. The danger lies more in the emerging youth sub-culture, particularly the belief that to fully be a man, sexual intercourse must follow soon after circumcision. One young man who is popular as a *mutiri* claimed that he always advised the initiates to have sexual intercourse only after three months. Asked why three months, he simply said this was a long time.

In this context, the idea that circumcision should be promoted as a preventive measure may be extremely counter productive. Thus, before cutting foreskins as advocated, the meaning of circumcision, its organization and associated practices and dynamics should be understood.

In the course of the research process, we realized that male circumcision is also an ice-breaker for discussing taboo subjects such as sexual pleasure in men and women. Circumcision thus became an appropriate tool for discussing matters of sexuality largely because, as a universally accepted practice, circumcision is relevant to both women and men of all generations. Elderly people in the groups enthusiastically discussed and contrasted the ritual of circumcision in the past with the contemporary practice. The discussions became a confrontation between the past and the present where younger generations were blamed for misbehavior and elderly people for relinquishing their responsibilities. In the process, the entire group critically reflected on the changes taking place and their impact on sexual behavior among the young people. Parents started to comprehend the complex social context within which the adolescents were living and its contribution to some of the problems they are going through.

It was fascinating for parents to discover or recognize that what they regarded as intact consisted, in reality, of only skeletons of the traditional customs. The initiates were for example, still offered by parents, a separate room or house. To the surprise of the parents, it was in these rooms and not the discos in the market centres where their children learn

and actually were introduced to smoking, drinking and premarital sexual activity.

While there are obvious indications that circumcision is associated with practices and new rituals which have implications for the transmission of STD/HIV, a number of possibilities for prevention were also identified. As a universally accepted practice in this part of Kenya, different forums — schools, chiefs public rallies, church services etc., could be used to inform about the dangers of the new rituals associated with circumcision. Private clinicians who perform a great deal of the operation and are also located in the villages constitute a resource through which sex education messages could be organized and disseminated to the initiates and their *atiri*. The *atiri* can also be trained and used as peer educators in youth outreach programmes.

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Beth M. AHLBERG, V.N. KIMANI, L.W. KIRUMBI, M.W. KAARA, I. KRANTZ,
Male circumcision: practice and implication for transmission and prevention of STD/HIV in Central Kenya

Summary — With no vaccines or effective cures, effecting sexual practices that reduce the risk of being infected with HIV/AIDS is the only meaningful option. Yet, any attempt to effect sexual behavior change requires a rather deep understanding of the relevant factors and their link to the transmission of the virus, the social and cultural factors that shape sexual practices and the contexts within which they are placed. This paper focuses on male circumcision ritual as practiced in Central Kenya. Using empirical data gathered during 1992-96, we discuss the meaning of male circumcision, its organization, recent changes and implication to transmission as well as prevention of HIV/AIDS. We have observed that the societal changes taking place have reduced the involvement of the adults in the ritual in ways which have implication to the transmission of STD/HIV. With the decreased involvement of the adults, and the increasing silence, adolescents have assumed a great deal of the responsibility. Peer pressure to engage in sexual intercourse soon after circumcision is enormous.

Keywords: male circumcision • sexual behaviour • HIV/AIDS transmission • prevention.

Beth M. AHLBERG, V.N. KIMANI, L.W. KIRUMBI, M.W. KAARA, I. KRANTZ,
Circoncision masculine : pratique et impact sur la transmission et la prévention du sida dans la région centrale du Kenya

Résumé — En l'absence de vaccins et de soins efficients, la seule option sensée est de promouvoir des pratiques sexuelles susceptibles de réduire le risque d'infection par le VIH/sida. De plus, toute tentative en vue de réaliser un changement de comportement exige une compréhension bien plus profonde des facteurs pertinents et de leur lien avec la transmission du virus, en particulier des facteurs sociaux et culturels qui façonnent les pratiques sexuelles et les contextes dans lesquels elles se situent. Cette étude traite des rituels de circoncision masculine pratiqués dans le Kenya central. A partir de données empiriques collectées entre 1992 et 1996, elle traite de la signification de la circoncision masculine, de son organisation, des mutations récentes et de son rôle aussi bien dans la transmission que dans la prévention du VIH/sida. On a observé que les changements sociaux en cours ont diminué l'implication des adultes dans ces rituels ce qui a pu avoir un impact dans la transmission des MST et du VIH. Suite à cette diminution de l'implication des adultes, et à leur silence croissant, les adolescents ont assumé une grande part des responsabilités. Cependant la pression des pairs à engager une vie sexuelle active tôt après la circoncision est énorme.

Mots-clés : circoncision masculine • comportement sexuel • transmission du VIH/sida • prévention.

35. Stratégies d'entreprises dans le dépistage et le licenciement des employés vivant avec le VIH à Abidjan (Côte-d'Ivoire)

Laurent Aventin

Introduction

L'ampleur de l'épidémie de VIH et son impact sur la population ivoirienne posent dans les années 90 de nombreux problèmes au-delà des aspects de santé publique. 31 963 cas de sida ont été notifiés à l'OMS au 19 juin 1996 en Côte-d'Ivoire (OMS 1997 : 197). La prévalence du VIH chez les femmes prises en charge en consultation prénatale à Abidjan est estimée à 13,7 % en 1995 (Sylla-Koko *et al.* 1995 : 289), puis à 16,2 % deux ans plus tard (Diallo *et al.* 1997). On observe que les tranches d'âges de la population les plus touchées correspondent à celles de la population active : d'après l'étude de Sylla-Koko *et al.* (1995), la prévalence la plus élevée se situe chez les 25-29 ans (17,1 %). De Cock montre qu'entre 1988 et 1989, toute population confondue, la majorité des cas d'infection par le VIH à Abidjan appartient, par ordre décroissant, aux classes d'âge 30-39 ans, 20-29 ans et 40-49 ans. Dès 1989, l'infection à VIH est la première cause de mortalité chez les hommes et la deuxième chez les femmes à Abidjan (De Cock *et al.* 1990 : 793). Le monde du travail est donc directement concerné par cette épidémie qui menace les ressources humaines d'une économie déjà fragilisée par la crise (Bamba *et al.* 1994 : 10-18).

L'Afrique bénéficie d'une industrie encore jeune, moins de trente ans. Celle-ci est marquée par la dualité du paysage économique ; d'un côté les petites et moyennes entreprises locales gérées de manière traditionnelle, de l'autre, quelques grosses sociétés qui fonctionnent selon les modèles importés (Henry 1993 : 17). Cette industrie est encore fragile notamment en Côte-d'Ivoire qui sort d'une période de récession. Bien que la croissance économique et démographique de ce pays reste forte (Lopez-Escartin 1992), la prévalence élevée du VIH (Soro *et al.* 1992 : 117-121 ; CNLS-CI 1995 : 1-3) provoque le décès précoce de la population active nécessaire au développement industriel du pays. Le décès prématuré du personnel d'entreprise pose des problèmes aux dirigeants, notamment lorsqu'il s'agit d'employés qualifiés. Le coût de la maladie, des absences pour maladie et des décès est plus ou moins élevé selon le niveau des politiques sociales adoptées par les entrepreneurs. Il est probable que les coûts occasionnés par la maladie

constituent un facteur qui perturbe le fonctionnement de l'entreprise et incite les employeurs à faire dépister les demandeurs d'emploi, le personnel, pour limiter ainsi le nombre d'agents infectés par le VIH.

Les employeurs du secteur privé sont confrontés à l'absentéisme de leur personnel ou aux décès qui, selon eux, sont provoqués par le VIH/sida. Les réactions sont probablement nombreuses et ne peuvent pas toutes être identifiées et recensées ; cependant la discrimination est une des formes majeures de la rupture sociale associée à l'infection à VIH (Tindall et Tillett 1990 : 255). L'objectif de cette recherche est de mettre en évidence les pratiques discriminatoires (WHO/GPA 1994 : 10-12) visant à écarter de l'entreprise les salariés et les postulants à l'emploi infectés par le VIH. Les divers témoignages recueillis font état de ces faits et laissent penser qu'ils sont "courants" et non pas exceptionnels. Il est cependant impossible, avec les méthodes d'investigation mises en œuvre, de préciser l'ampleur des phénomènes de discrimination sur le lieu de travail à Abidjan. Le droit ivoirien ne dispose pas d'une législation particulière pour protéger les personnes infectées par le VIH, notamment sur leur lieu de travail (Dédy 1996 : 620-622), comme cela est le cas en France avec la loi de 1990 (Laborde 1991 : 615-618). Concernant l'embauche, il n'existe aucune interdiction nationale juridique de dépistage des postulants à l'emploi, ni même des agents lors des visites médicales annuelles. Seules les recommandations officielles du Comité National de Lutte contre le Sida (CNLS), organisme dépendant du Ministère de la Santé, vont dans ce sens, sans pour autant proposer des sanctions lorsque des pratiques discriminatoires sont constatées. Ainsi le Code du Travail et la Convention collective interprofessionnelle restent les seuls textes sur lesquels peuvent s'appuyer les plaignants pour justifier le caractère ou le motif illégal d'un dépistage VIH à leur insu ou d'un licenciement déguisé.

Les rumeurs de licenciements abusifs pour cause de sida sont nombreuses à Abidjan, parmi les juristes, les médecins, les responsables d'entreprise, les associations de personnes séropositives et les employés. La plupart de ces acteurs tiennent souvent un discours en demi-teinte afin de n'impliquer personne directement et dans le but de se protéger d'éventuelles représailles. La difficulté dans la vérification des témoignages reste entière. Cependant, les cas évoqués dans cette étude ont fait l'objet de recherches en 1995 et 1996 auprès des employeurs, des médecins d'entreprise et des personnes atteintes par le VIH qui ont subi le préjudice d'un refus à l'emploi ou d'un licenciement pour raison de santé. Deux méthodes distinctes mais complémentaires ont été mises en œuvre, afin de tenir compte du caractère délicat du sujet. Le travail en collaboration avec des médecins d'entreprise, lors d'une étude sur l'impact économique du VIH/sida dans trois industries d'Abidjan, a permis de rencontrer d'autres médecins exerçant dans des établissements où des cas de pratiques discriminatoires auraient été constatés. Ce premier réseau de relation devient un outil de connaissance des éventuelles affaires de discrimination sans que les noms des personnes considérées comme abusées ne soit donné, à l'exception des personnes qui sont devenues

membres d'associations de séropositifs et qui rendent ainsi publique leur infection par le VIH. La deuxième étape de la procédure consiste à contacter ces personnes, à prendre connaissance de leur version des faits avec documents à l'appui (lettre de licenciement, notes syndicales, feuilles de salaire, certificats médicaux…). Enfin, un entretien avec la direction des entreprises concernées ou du personnel, a permis de recueillir l'interprétation des faits de l'employeur et de la comparer au témoignage des personnes licenciées. Parfois les enquêtes se sont poursuivies auprès de collègues de travail ou de responsables syndicaux lorsque les informations semblaient incomplètes ou inexploitables. La seconde méthode consiste à suivre dans ses démarches l'un des membres actifs de l'association de séropositifs, le "Club des Amis" qui s'occupe de l'accueil des malades. Le certificat de séropositivité est demandé pour être membre de l'association ; notre contact était régulièrement en relation avec les médecins d'entreprise pour demander une copie du certificat, car souvent le dépistage des employés était effectué à la demande du médecin d'entreprise. Ainsi, l'association nous a permis de rencontrer quelques médecins d'entreprise parmi la dizaine que nous avons interviewés. Les praticiens se livraient volontiers en présence du membre actif de l'association, peut-être parce qu'ils considéraient le Club des Amis comme un relais de l'entreprise pour les malades. Plusieurs cas de discrimination ont pu être étudiés de façon précise grâce au témoignage préliminaire des victimes ou des médecins d'entreprise.

Secret médical, absence de formation en médecine du travail et influence des dirigeants d'entreprise

Etapes dans la rupture du secret médical

La question du secret médical est certainement la clé ou du moins l'un des points fondamentaux de la compréhension des pratiques discriminatoires à l'encontre des personnes infectées par le VIH sur le lieu de travail. En Côte-d'Ivoire, les acteurs de lutte contre le sida, appartenant à des organismes nationaux ou internationaux et surtout composés de médecins, se plaignent du non-respect du secret médical concernant la confidentialité autour du dépistage du VIH dans de nombreuses structures sanitaires de la ville d'Abidjan. Ce constat est d'autant plus vrai dans le cadre de la médecine du travail, qu'il implique l'exposition du salarié infecté à une discrimination de l'employeur ou des collègues de travail (Yao N'dré 1992 : 2-5).

Médecine du travail en Côte-d'Ivoire

Un médecin responsable du département de médecine du travail du CHU de Yopougon [1] précise qu'en 1995, il n'existe que 5 ou 6 médecins diplômés d'un Certificat d'Etudes spécialisées en médecine du travail, obtenu en Europe ou aux Etats-Unis. « Sur le marché on a

[1] Le troisième CHU de la ville d'Abidjan se trouve dans la commune de Yopougon.

donc peu de médecins qualifiés en médecine du travail. Généralement, ce sont des médecins généralistes ou spécialisés qui vont faire des vacations en entreprise. Alors bien sûr, ces médecins ignorent certains contours et aspects de leur travail et cela pose d'énormes problèmes ». Le même interlocuteur, professeur à la Faculté de médecine, précise qu'il s'agit de problèmes liés au secret médical. Une de ses étudiantes a effectué une enquête auprès d'une trentaine de médecins d'entreprise parmi lesquels 30 % ont affirmé qu'ils communiquent les résultats médicaux à leur employeur (Akka 1995). Parmi les entreprises citées on retrouve les plus grandes employant les rares médecins diplômés dans la spécialité. Certains d'entre eux affirment que les praticiens non spécialisés ont tendance à considérer leur employeur comme leur chef de service clinique. Il n'existe pas de formation en médecine du travail en Côte-d'Ivoire alors que le marché et donc la demande existent. La situation est d'autant plus paradoxale qu'il existe une législation en vigueur émanant de la loi de 1952 sur la médecine d'Outre-mer, qui a été reprise en 1964 puis en 1967 par un décret réglementant aujourd'hui la médecine du travail [1]. Le développement industriel a connu une forte croissance depuis l'indépendance du pays, et a entraîné, de la part des entreprises, une demande de médecins, qui sont attirés par le secteur privé. Certains médecins ne vivent que de la médecine du travail, comme salariés ou vacataires dans plusieurs établissements ; ils sont donc dépendants de leurs employeurs qui exigent parfois d'eux la communication d'informations médicales sur les employés. Quelques médecins ont dit qu'ils transgressent le secret médical occasionnellement, expliquant qu'ils prenaient le risque de perdre leur place s'ils ne coopéraient pas, car d'autres médecins plus "compréhensifs" prendraient rapidement leur place ; les seuls pouvant se permettre de faire de la "résistance" sont les quelques diplômés en médecine du travail qui peuvent prétendre avoir des compétences et une qualification que les autres n'ont pas. Les entreprises qui les emploient [2] le font dans le cadre d'une politique sociale élaborée qui nécessite les compétences d'un médecin spécialisé. La majorité des entreprises, plutôt des Petites et Moyennes Entreprises (PME) n'ont pas ces exigences sociales (Aventin et Gnabéli 1996 : 1-10) et emploient des médecins non spécialisés en médecine du travail au même titre que n'importe quel cadre.

Relations employeur / médecin du travail et transgression du secret médical

Dans ce contexte, les relations entre employeur et médecin du travail sont hiérarchiquement régulées dans l'entreprise. Le médecin bénéficie d'un statut particulier qui lui confère le droit de ne pas communiquer de données médicales nominatives concernant les employés. L'employeur peut demander des statistiques médicales, mais

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[1] Décret 67-321 du 21 juillet 1967. *Journal Officiel de Côte-d'Ivoire* du 9 juillet 1968, n°33.

[2] Ce sont très souvent des entreprises de type international.

celles-ci doivent rester anonymes et ne pas compromettre l'identité des employés atteints de pathologies. Dans le cas de l'infection à VIH, on comprend aisément que ce qui intéresse l'employeur, c'est l'identification des employés dépistés et infectés par le VIH, afin d'effectuer sa gestion prévisionnelle du personnel. Ce réflexe est unanime, même si les employeurs se déclarent attachés au respect du secret médical. D'autres font cependant pression sur le personnel des services médicaux, et si parfois certains médecins ont résisté malgré des menaces, d'autres collaborent de fait (Aventin 1995 : 7-8) et certains le revendiquent. Pourtant, comme en France [1], ils sont responsables sur le plan civil et pénal du respect du secret professionnel (Zajac 1995). Nous prendrons l'exemple d'une grande entreprise industrielle implantée dans de nombreux pays en Afrique de l'ouest dans la transformation de l'acier. Cette unité de production compte 450 employés et son médecin, salarié dans cette entreprise depuis 1982, nous a accordé un entretien à propos d'un cas de discrimination suivi avec le "Club des Amis".

L.A. Quand vous dites que vous avez informé la direction de la maladie de M."Y", normalement celle-ci ne devrait pas le savoir ?

XX Si... si, si, si.

L.A. Et le secret médical ?

XX Non, non il faut informer l'employeur compte tenu des absences répétées. Il faut que l'employeur sache pourquoi depuis six mois ce monsieur ne peut pas travailler.

L.A. Il vous suffit de dire qu'il est malade sans nommer la pathologie.

XX Quelle maladie ? Il faut donner le diagnostic. Ah ! si, si, si. Etant donné que je suis le médecin, dans tous mes arrêts de travail, je précise le diagnostic. Il a un repos de tant de jours, le diagnostic probable est le suivant.

Cette situation, bien qu'illustrative, n'est pas exceptionnelle. Parmi l'échantillon étudié, trois autres praticiens agissent de la même manière, même s'ils n'osent pas l'affirmer aussi ouvertement. Le médecin dont les propos sont reproduits ici semble rejeter jusqu'à la conscience des aspects déontologiques liés à la profession médicale. Il se présente au contraire comme un agent au service exclusif de son employeur, de façon plus ou moins volontaire ou contrainte, et non rigoureux dans l'assistance aux patients. Il utilise l'exigence des dirigeants de l'entreprise comme si cela lui conférait une protection personnelle, comme si la transgression du secret médical n'engageait que la responsabilité de son employeur. Le fait qu'il ne cherche pas à masquer sa collaboration avec la direction — il la présente comme une évidence non susceptible d'être interrogée — peut être interprété comme le signe probable d'une pratique ordinaire, qu'il partage avec des confrères de son entourage. Cependant d'autres praticiens, mieux

[1] Nous comparons parfois la situation juridique en Côte-d'Ivoire à celle de la France. D'une part, c'est celle que nous connaissons le mieux, d'autre part les textes de loi ivoiriens datent de la colonisation française ou sont encore très largement inspirés du droit français.

informés des risques qu'ils encourent en ne respectant pas le secret médical, prennent des précautions visant à se protéger.

Relations entre entreprise et hôpital ou laboratoire d'analyses médicales

La transgression du secret médical ne s'effectue pas seulement dans la relation médecin-employé ou médecin-employeur. Elle existe également à la faveur de collaboration entre employeurs et personnel des hôpitaux ou des structures sanitaires publiques et privées ou encore avec le personnel des laboratoires d'analyses médicales. Ces collaborations ont pour but le dépistage du VIH chez les salariés, élément indispensable pour les employeurs désireux de mener une politique particulière vis-à-vis du personnel infecté par le VIH. Nous avons pu identifier au moins trois types de pratiques différentes :
1) l'hospitalisation d'un employé malade. Le médecin du travail va s'informer sur la pathologie du patient, s'il n'y a pas de communication de données médicales entre le médecin d'entreprise et l'employeur, ce dernier envoie une autre personne se renseigner, l'assistante sociale ou le délégué du personnel qui, par relation ou moyennant finance, obtient les informations convoitées concernant l'employé hospitalisé ;
2) l'utilisation du Centre National de Transfusion Sanguine (CNTS). « A Abidjan, le centre de transfusion sanguine reçoit régulièrement des demandes de chefs d'entreprise visant à prélever du sang parmi leur personnel » (Fottorino 1994 : 4). Lors de dons de sang, le CNTS pratique des sérologies VIH pour des raisons évidentes et le résultat au test est une information convoitée par l'employeur ;
3) lorsque le médecin d'entreprise suspecte une éventuelle infection par le VIH lors de pathologies évocatrices chez un patient, il demande à celui-ci de se faire dépister ou parfois de se rendre dans tel laboratoire d'analyses médicales. Il est probable que certaines entreprises ont des accords avec des laboratoires privés pour faire dépister les employés et les demandeurs d'emploi en utilisant un langage plus ou moins codé. Des témoignages de médecins d'entreprises ou de responsables de laboratoires vont dans ce sens, bien qu'il soit difficile d'apporter la preuve de ces pratiques. Lors des entretiens, quelques uns refusaient d'aborder le sujet et d'autres se sont contredits dans leurs déclarations.

Pratiques de dépistage du VIH dans l'entreprise

Le dépistage à l'embauche

Les conditions d'application des procédures d'embauche avec examen sérologique lors de la visite médicale préalable sont révélatrices des inquiétudes de l'employeur vis-à-vis de l'infection à VIH. L'exclusion des postulants infectés nécessite une opportunité pour l'employeur de faire un dépistage VIH qui est grandement facilité par

la visite médicale d'embauche où est effectué un bilan de santé du candidat. Elle nécessite un passage devant le médecin d'entreprise qui doit effectuer un bilan de santé. En principe, cet examen ne comporte pas de prélèvement sanguin, sauf si le médecin d'entreprise le juge nécessaire, par exemple pour un candidat diabétique. La législation en vigueur reste floue sur ces aspects et certains médecins, sur la demande de l'employeur, font pratiquer un test VIH à l'insu du candidat. Les médecins ou les laborantins, acteurs dans cette procédure, trouvent les arguments nécessaires pour justifier un prélèvement sanguin. Par ailleurs, le candidat éclairé est en droit de refuser cet examen mais sa position de demandeur d'emploi ne l'autorise pas à rejeter les exigences d'un employeur potentiel. Lorsque le candidat est parvenu au stade de la visite médicale dans le processus d'embauche, il a réussi diverses étapes de sélection qu'il ne souhaite généralement pas perdre en refusant une prise de sang. D'autant plus que l'employeur est légalement autorisé à sélectionner un autre postulant sans justifier son choix auprès du candidat non retenu. Ainsi, l'employeur qui souhaite ne pas embaucher les personnes infectées par le VIH, peut aisément refuser de sélectionner un candidat qui ne se soumet pas à l'examen sanguin. C'est d'autant plus vrai que l'entrepreneur peut interpréter le refus de l'examen par le candidat comme un aveu de son infection par le VIH. C'est ce qui s'est passé pour le recrutement d'un cadre d'après le témoignage d'un médecin d'entreprise qui nous a dit pratiquer le dépistage au recrutement. Le postulant ayant refusé de faire l'examen sanguin, le médecin a téléphoné à un confrère travaillant pour l'ancien employeur de ce "candidat réfractaire" (dont le nom était précisé dans un formulaire qu'il avait dû remplir) qui lui a fourni les informations désirées. Il avait été licencié pour le motif illicite d'une faute professionnelle parce qu'il était porteur du virus. D'après le médecin, le candidat correspondait parfaitement au poste requis, mais a été écarté après que l'employeur eut pris connaissance de son infection par le VIH. Le rapport de force entre l'employeur et le candidat est largement à l'avantage du premier et d'un point de vue juridique, il n'existe pas de protection contre ces abus. Seule une circulaire officielle [1] qui tient lieu de recommandation est diffusée dans les entreprises. Les recommandations internationales de l'UNESCO (UNESCO 1990 : 127-134) de l'OMS et du BIT (OMS/BIT 1988) obligent les employeurs à rester discrets dans leurs pratiques sans pour autant les modifier.

Le dépistage du personnel employé

Il existe différentes stratégies de dépistage collectif du personnel. La plus honnête consiste à proposer au personnel un dépistage gratuit dans l'objectif de permettre au médecin d'entreprise de suivre plus précocement les personnes infectées. Cette proposition, sous forme de vote anonyme de l'ensemble du personnel, a été faite par la direction

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[1] Circulaire n° 53/95 sur les recommandations de l'OMS. Abidjan, 8 mars 1995. Ministère du travail, service de l'inspection médicale.

d'une multinationale du secteur agro-alimentaire à ses employés. Les réponses positives à la proposition de dépistage ne dépassèrent pas 10 % ; le responsable du service médico-social constate l'échec de cette politique : « On s'est dit qu'on allait faire le test à ceux qui veulent et puis on a pensé que de toutes façons, ça ne mènerait à rien. Ou c'était tout le monde sans donner les résultats bien sûr, ou rien du tout, puis on s'est dit que, même si on a des résultats chiffrés, on les communiquera au personnel et ça va entraîner des suspicions. Cela nous aurait plutôt apporté des problèmes, certainement ». Il paraît inévitable que les employés n'aient pas confiance dans l'utilisation qui peut être faite des résultats de ces examens par la direction de l'entreprise. La question méritait-elle d'être posée aux employés ? Nous n'avons pas rencontré ce type de situation dans d'autres entreprises surtout depuis "l'affaire SIR" (Société ivoirienne de raffinage). En 1995, le scandale éclate dans les journaux, la direction de la SIR a fait dépister son personnel et licencie les personnes infectées par le VIH [1]. Ces faits semblent étroitement liés à une affaire politique qui consisterait à démissionner le directeur de cette entreprise publique pour nommer une personne plus proche du pouvoir. Le responsable du service contentieux et licenciements d'un syndicat de travailleurs de Côte-d'Ivoire a confirmé que l'affaire est politique, mais que les faits sont exacts. Le gouvernement se serait servi des médias pour encourager le départ de l'entrepreneur : « On avait des camarades, l'employeur a demandé que tous les employés fassent un examen médical concernant le VIH, mais il ne leur a pas dit cela ; seulement que c'était un bilan de santé. Une fois qu'il a eu la liste des personnes infectées, il les a convoquées et leur a proposé un départ volontaire pour ne pas enfreindre la loi. Cette affaire a fait un tollé, il y a des gens qui se sont plaints, des camarades sont venus nous voir à la centrale. On leur a dit qu'ils devaient faire comme ils voulaient, partir s'ils étaient fatigués ou malades, et rester s'ils avaient encore des forces. On est allé voir l'employeur et celui-ci nous a dit que ce n'était pas possible parce qu'ils étaient sur la liste des départs volontaires alors que l'employé en question nous a dit avoir refusé de signer cette liste. On est allé voir l'inspection du travail, on ne s'est pas entendu et finalement l'employé a été licencié ». D'autres témoignages, émanants de l'UGTC (Union générale des travailleurs de Côte-d'Ivoire) une autre organisation syndicale ayant été confrontée au conflit, confirment que les faits auraient été utilisés à des fins politiques. La vérification de ces événements encore trop récents reste cependant difficile.

Certains employeurs, plus prudents, chercheront à éviter l'annonce d'un dépistage qui est mal reçu par le personnel et utiliseront des subterfuges parfois ingénieux, à savoir par exemple l'utilisation du Centre National de Transfusion Sanguine (CNTS). Certaines entreprises avaient pour usage de faire appel au CNTS pour tester tout le personnel afin d'obtenir pour chaque travailleur une carte de groupe

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[1] C. Etou, "Le personnel veut la tête du DG". *La Voie* n° 982, 3 janvier 1995, p. 5 ; S. Fofana, "Les employés demandent le départ de Daouda Thiam", *Le Jour,* n° 20, 5 janvier 1995 : 9.

sanguin. Le prélèvement est présenté comme étant obligatoire à l'ensemble des employés pour des raisons de sécurité. La carte de groupe sanguin permet à chacun de se faire transfuser rapidement en cas de grave accident du travail. « Le gain de temps pour identifier le groupe sanguin d'un blessé peut être vital » confie un médecin d'entreprise [1]. Le CNTS ne fait pas payer ses prestations en échange des dons de sang fournis par les employés. L'apparition de l'épidémie de sida bouleverse les règles du jeu, et certaines entreprises font soudainement appel aux services du Centre pour l'élaboration de cartes de groupe sanguin à leurs employés. Connaissant la nécessité de tester les dons de sang afin d'éviter toute transfusion contaminée, le médecin d'entreprise réclame les résultats auprès du CNTS, sous prétexte de mieux surveiller médicalement les personnes infectées par le VIH ou de leur prescrire les traitements appropriés le plus tôt possible. L'employeur est alors en mesure de connaître ces résultats par l'intermédiaire du médecin. L'employé abusivement licencié peut difficilement identifier et prouver une relation de cause à effet entre son licenciement et son statut de personne infectée ; faudrait-il encore qu'il soit informé de son infection par le VIH ? Cette situation représente la meilleure garantie pour l'employeur car il serait difficile d'apporter la preuve d'un licenciement déguisé.

Stratégie de licenciement des personnes découvertes "infectées par le VIH" dans l'entreprise

Le licenciement déguisé

L'incitation au départ volontaire de l'employé infecté par le VIH

Pour les employés infectés par le VIH, les situations sont diverses ; tous les cas possibles ne peuvent être énumérés et analysés ici. Nous étudions dans cette partie la situation de "l'arrangement", c'est-à-dire la "négociation" entre l'employé et l'employeur. Le terme de négociation n'est pas le plus approprié, car il implique entre les deux parties un équilibre aboutissant à une discussion et une entente. Ce que nous appellerons départ volontaire de l'employé est entaché d'une certaine obligation tacite, et constitue davantage une décision des dirigeants que de l'employé. L'organisation des entreprises repose souvent sur un système paternaliste, particulièrement dans les PME et les "affaires familiales". Dans un tel milieu où, de surcroît, les syndicats sont parfois absents et la main-d'œuvre peu qualifiée, les employés éprouvent, peut-être plus qu'ailleurs, des difficultés à faire valoir leurs droits. Voici le cas d'un employé, ouvrier dans une entreprise

[1] Un autre médecin ayant pratiqué dans les services d'urgence médicale affirme que la carte de groupe sanguin reste un prétexte pour connaître le statut sérologique des employés vis-à-vis du VIH. En effet, en cas de transfusion sanguine lors d'un accident, le test du groupe sanguin est systématiquement appliqué au préalable pour des raisons de sécurité, même si le blessé détient une carte donnant cette information.

métallurgique, aujourd'hui décédé des suites de sa maladie. Il était membre d'une association de séropositifs. Nous avons enquêté à partir de son témoignage auprès de son employeur, de ses collègues de travail et des membres de sa famille. Cette personne était arrivée au stade de la maladie, ses absences au travail étaient répétitives, mais toujours justifiées par un arrêt de maladie du médecin de l'entreprise. Il a été convoqué par la direction qui lui a proposé un million et demi de FCFA [1]. Cet employé travaillait dans l'entreprise depuis 16 ans. Il est néanmoins probable qu'il avait atteint un niveau d'incapacité au travail, car, d'après ses collègues et le médecin d'entreprise, il avait du mal à se tenir debout. Cet exemple permet en fait d'observer le rapport de force entre un employé et ses dirigeants. La décision était donc prise de le faire partir, le responsable du personnel l'a convoqué et lui a demandé de quitter la firme parce qu'il avait le sida, bien que le médecin ne lui ait pas fourni de certificat d'inaptitude au travail. L'employé a refusé et voulait continuer son activité. D'après ses collègues, il refusait la somme proposée par la direction dont il jugeait le montant trop faible. Lors de la deuxième convocation dans le bureau du responsable du personnel, les délégués syndicaux lui ont conseillé de prendre l'argent et de partir. Il a finalement accepté à la demande pressante de la hiérarchie. Ses collègues ont précisé qu'il n'était pas volontaire au départ, alors que c'est le motif inscrit dans l'acte de rupture du contrat de travail sans autre précision. Ils ont également souligné qu'il ne pouvait plus travailler. Nous avons pu obtenir l'acte de rupture de contrat entre l'entreprise et l'employé qui précise explicitement que M. "H" quitte l'entreprise et perçoit une somme de 1,5 million de FCFA pour solde de tout compte. L'acte est rédigé par l'entreprise et l'article 6 précise que « Chacun des soussignés s'engage à exécuter la présente transaction de bonne foi et le défaillant s'obligerait à payer à l'autre, à titre de clause pénale, la somme de 3 millions de FCFA ».

Ce cas est intéressant non pas dans le cadre de l'illégitimité du licenciement de l'employé qui aurait pu être légalement justifié par un certificat médical d'inaptitude au travail, mais pour les étapes de la procédure caractérisées par un abus de pouvoir et des actes illégaux. L'article 6 de la transaction ne peut pas être appliqué et il pourrait être retourné contre le rédacteur de ce contrat, c'est-à-dire l'entreprise qui cherche à se protéger illégalement contre un acte de licenciement déguisé. Aucun article contractuel entre deux tiers n'est au-dessus des lois et s'il était prouvé que le licenciement est abusif, cet article ne viendrait pas protéger celui qui l'a rédigé.

Dispositif de surveillance de l'employé et licenciement pour faute grave

Le licenciement déguisé est probablement le moyen le plus utilisé dans le monde du travail pour exclure un employé jugé indésirable par la hiérarchie, quel que soit le motif réel. Cette méthode a été rapportée par la majorité des médecins d'entreprise interrogés sur la

[1] 1 FF = 100 FCFA = 1/5 US $.

discrimination relative au VIH/sida. L'employé infecté par le VIH, parfois en bonne santé, peut faire l'objet d'une surveillance accrue sur son lieu de travail, surveillance effectuée par un contremaître, un responsable de secteur, des ouvriers ou des cadres. Ce "réseau de surveillance" a une mission d'observation, en collaboration avec la direction, ou plus généralement la direction du service du personnel. L'observation de l'employé indésirable se poursuit jusqu'à ce qu'il soit prouvé qu'il a effectué une ou plusieurs fautes qui justifient un licenciement. Pris au piège, l'employé se voit exclu de son lieu de travail en toute légalité et sans une indemnité, ce qui est tout à fait avantageux pour l'employeur. On peut se demander cependant pourquoi l'employé commet des fautes ? Intervient alors le rôle du règlement intérieur que tous les employés ou presque transgressent régulièrement. Cela est toléré dans la pratique : les retards, les accès interdits dans certains locaux, la réception de personnes extérieures à l'entreprise, les absences non justifiées... Ces aspects sont souvent tolérés bien que proscrits, mais les personnes indésirables feront l'expérience de la rigueur de ce règlement intérieur qui peut s'avérer rigide s'il est suivi à la lettre. Le règlement trouve alors une toute nouvelle utilité qui n'est plus d'organiser ou d'harmoniser le travail mais d'exclure des individus de façon sélective et subjective. Le prétexte de la faute lourde reste tout de même la méthode la plus efficace et la plus rapide pour les agents qui connaîtraient parfaitement le règlement intérieur et qui prendraient soin de ne pas le transgresser. Un médecin du travail qui exerce dans plusieurs entreprises portuaires nous a rapporté le cas d'un cadre en bonne santé, mais infecté par le VIH. Son employeur connaissait son statut sérologique et a provoqué la faute lourde en lui donnant une charge de travail dont il savait qu'elle ne pouvait pas être accomplie dans les délais. Il a été renvoyé pour incompétence et non-respect du temps imparti dans le cadre de sa mission.

Le droit protecteur et ses limites

Discrimination ouverte et corruption

Les cas de discrimination ouverte, c'est-à-dire sans aucune précaution de déguisement, existent également, bien qu'ils tendent à disparaître car les messages d'information sur le sida diffusés à Abidjan insistent sur la non-exclusion des personnes infectées. Cependant nous avons recensé des cas où l'embauche a été refusée pour motif de séropositivité au VIH. Un autre cas de figure est celui du chef d'une entreprise ivoirienne, filiale d'un groupe d'Amérique du Nord, qui a été licencié quand ses supérieurs hiérarchiques d'outremer ont appris qu'il était malade du sida. Il demandait à son médecin de toujours cacher sa maladie devant les responsables hiérarchiques américains qui effectuaient régulièrement des missions de contrôle à Abidjan. Le chef d'entreprise de cette PME performante ne pouvait plus cacher les signes de sa maladie et un responsable du groupe a découvert son état de santé. L'entrepreneur a été licencié sur-le-champ avec une faible indemnité vis-à-vis de ses droits. Ils ont placé la personne malade dans une petite maison louée pour lui en attendant la

mort. Le médecin de l'entreprise qui nous a rapporté ce témoignage s'est occupé de lui pendant trois mois jusqu'au décès. Il venait lui changer journalièrement ses perfusions. Lorsque le malade les a menacés de porter plainte, le responsable américain a dit « qu'il s'en foutait et qu'ils avaient les moyens de payer ». Le patient est décédé trois mois plus tard sans avoir porté plainte, car d'après le médecin, il savait qu'il ne gagnerait pas son procès. La méfiance que l'ancien chef d'entreprise, victime de discrimination, et son médecin montrent à l'égard de l'institution judiciaire s'appuie sur la croyance d'une corruption généralisée des juges : "ils avaient de l'argent pour payer les magistrats et gagner le procès" précisait le médecin de la PME. Certains juristes nous ont ouvertement parlé de ces pratiques qui selon eux sont courantes. Ils connaissent les magistrats intègres ; c'est la raison pour laquelle ils refusent les affaires dont ils savent que des pots-de-vin ont été versés au bénéfice de la partie adverse. Certaines victimes de licenciement abusif ont confirmé ces pratiques et jugent que la plainte contre l'employeur est inefficace. D'autres raisons ont également été avancées et concernent la discrétion de leur situation. Un procès est public et ils ne souhaitent pas que des membres de leur famille ou des amis sachent qu'ils sont atteints du VIH par crainte d'être rejetés par leur entourage. Outre la méconnaissance des droits du citoyen et les moyens de les faire valoir, l'ensemble de ces paramètres expliquent probablement la rareté des plaintes pour les cas de discrimination des personnes infectées par le VIH en Côte-d'Ivoire.

La difficulté de la preuve

L'autre élément décisif dans un recours en justice pour protester contre un licenciement déguisé réside dans l'obligation pour le plaignant d'apporter la preuve du préjudice subi. On comprend aisément, au regard des méthodes qu'utilisent certains employeurs pour congédier les salariés infectés par le VIH, qu'il s'agit là d'une difficulté de nature à décourager, dans les faits, le recours au droit et aux lois. Les victimes de pratiques discriminatoires peuvent faire appel aux syndicats, leur demander d'intervenir auprès de l'inspection du travail et porter plainte au tribunal du même nom. Nous n'avons cependant recensé qu'une seule affaire défendue en justice : le licenciement abusif pour cause de séropositivité avait alors été reconnu [1] et dédommagé.

Le syndicalisme d'entreprise

Les syndicats semblent relativement discrets ou peu sensibilisés sur le thème du VIH/sida. Nous différencions le rôle des centrales syndicales, dont les représentants affirment défendre les intérêts de l'employeur lorsqu'il s'agit de discrimination à l'égard de l'infection par le VIH, et l'intervention des délégués locaux dans les entreprises.

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[1] Affaire Kouadio Koffi / Société Coco Service. Audience publique ordinaire du 2 février 1993 et audience du 21 juillet 1994 en Cour d'Appel d'Abidjan. Sur l'historique de ce cas, voir Dédy Séri (1996).

Dans la première situation, nous n'avons trouvé aucun cas de suivi d'affaire publique concernant un licenciement relatif au statut sérologique de l'employé, à l'exception du précédent. Cependant, le plaignant ne semble pas avoir été soutenu par un syndicat. Par contre en entreprise, nous avons relevé des témoignages concordants sur le comportement de certains représentants syndicaux. Elus par leurs collègues de travail, ils ont, entre autres, un rôle d'intermédiaire obligatoire entre les employés qu'ils représentent et la direction. Les licenciements font partie des décisions de la direction qui ne se négocient pas, hormis le montant des indemnités. Le délégué syndical aurait peu de pouvoir de médiation dans ces situations. La position de l'employeur est d'autant plus renforcée qu'il aura pris la précaution de faire circuler la rumeur sur la maladie d'un tel dans l'entreprise, s'assurant ainsi le soutien du personnel et donc celui de ses représentants pour le départ d'un employé jugé indésirable. L'utilisation de la peur des agents vis-à-vis d'un collègue infecté par le VIH et soupçonné d'avoir le sida est ici utilisée dans un but détourné : la justification d'un départ de l'entreprise. L'UGTCI (Union générale des travailleurs de Côte-d'Ivoire) et Dignité, deux des principaux syndicats du pays, n'ont pas de position officielle sur la question des pratiques discriminatoires relatives au VIH/sida. Cependant, des membres du bureau de ces syndicats nous ont précisé que d'autres sujets étaient prioritaires, comme le droit de grève, la revalorisation des salaires ou l'amélioration des conditions de travail.

Conclusion

Le malade à qui il peut être reproché d'avoir contracté le sida (Caprara *et al*. 1993 : 1233) engendre des frais médicaux auxquels l'employeur participe parfois financièrement. Par ailleurs, la probabilité de décès après l'apparition de signes cliniques évocateurs du sida est élevée après deux années s'il n'y a pas de soins spécifiques à l'infection à VIH (Mocroft *et al*. 1997). A cela s'ajoute un rejet par les autres employés qui peuvent refuser de travailler avec une personne qu'ils jugent à tort contagieuse. Aux yeux de l'employeur, ces contraintes sont parfois une raison suffisante pour se séparer des employés infectés par le VIH. D'une part, il est important de développer et pérenniser l'information et l'éducation sur le lieu de travail, de sensibiliser l'inspection du travail sur le thème du VIH/sida afin de sanctionner et de décourager le dépistage et le licenciement des salariés d'entreprise. D'autre part, le conseil de l'ordre des médecins de Côte-d'Ivoire, ainsi que les instances juridiques pourraient jouer un rôle de prévention, de surveillance et de sanction notamment dans les situations de non-respect du secret médical. L'absence actuelle de procédures judiciaires face à la discrimination sur le lieu de travail des personnes infectées par le VIH relève essentiellement de la difficulté pour le plaignant d'apporter la preuve d'une malveillance. Face à cette situation, on constate que les autorités ivoiriennes favorisent l'approche préventive à la réglementation et la répression (Coffi et Ouattara 1994 :

126), peut-être dans le but d'établir une meilleure collaboration avec les milieux industriels qui participent au financement de la lutte contre le sida sous forme de dons au PNLS.

Par ailleurs on peut se demander quelles vont être les réactions à moyen terme des entreprises face aux contraintes posées par le VIH/sida, à savoir principalement l'absentéisme et le décès du personnel. L'épidémie peut-elle entraver le développement des entreprises ou simplement ramentir leurs efforts de compétitivité sur les marchés internationaux (Henry 1993 ; Barbier 1995) ? Il reste difficile de répondre à ces questions, mais on peut suggérer, comme Thébaud et Lert (1984 : 19), que l'amélioration permanente des performances d'entreprise et les exigences de la productivité ne favorisent pas l'acceptation des employés malades et l'absentéisme pour raison médicale qu'il génère. Dans la course à la performance économique, il est probable que les solutions d'entreprises face au VIH/sida s'orienteront vers une embauche sélective incluant illégalement le test VIH, comme cela a également été constaté en Zambie (Baggaley *et al.* 1995 : 567) ou au Zaïre (Musuamba 1997 : 8), et affaibliront le système de prise en charge sociomédicale en entreprise. Les politiques de flexibilisation et d'adaptation, certes nécessaires pour faire face aux perturbations provoquées par les changements environnementaux (Etzioni 1987 : 177-179), pourraient inclure une externalisation de plus en plus massive de la main-d'œuvre (Davis-Blake et Uzi 1993 : 198-199) et accentuer gravement la précarisation de l'emploi pour les salariés atteints par le VIH.

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Laurent AVENTIN, *Stratégies d'entreprises dans le dépistage et le licenciement des employés vivant avec le VIH à Abidjan (Côte-d'Ivoire)*

Résumé — Face à la prévalence élevée du VIH/sida dans la ville d'Abidjan en Côte-d'Ivoire, les employeurs du secteur privé sont confrontés aux problèmes de santé du personnel d'entreprise et aux conséquences que l'absentéisme médical et les décès provoquent, à savoir une baisse probable de la productivité et des performances. Certains employeurs choisissent donc de limiter le nombre de salariés infectés par le VIH dans leur établissement, d'une part en licenciant les agents vivant avec le VIH, d'autre part en dissimulant les tests VIH à l'embauche. Ces situations impliquent donc la participation du personnel médical et paramédical : les médecins d'entreprise ou certains responsables de laboratoire pharmaceutique et de structures hospitalières collaborent de plein gré ou à leur insu au dépistage du personnel d'entreprise sans le consentement de celui-ci. Les médecins d'entreprise sont parfois confrontés à un choix difficile : communiquer les informations médicales à la demande de l'employeur ou respecter le secret médical et risquer de perdre leur emploi s'ils n'exécutent pas la volonté du chef d'entreprise. Dans l'entreprise, les licenciements déguisés sous un autre motif que celui de l'infection à VIH ou le refus à l'embauche d'un postulant à l'emploi ne posent aucune difficulté tant il est difficile pour les victimes de prouver une pratique discriminatoire.

Mots-clés : VIH/sida • discrimination • dépistage • licenciement • entreprise • Côte-d'Ivoire

Laurent AVENTIN, *Company strategies pertaining to HIV antibody testing and the dismissal of employees living with HIV in Abidjan (Côte-d'Ivoire)*

Summary — In light of the high rate of HIV/AIDS prevalence in the city of Abidjan in Côte-d'Ivoire, private-sector employers must address serious issues relating to the health of company personnel and the consequences arising from medical absenteism and deaths, namely a probable drop in productivity and performance. Some employers opt to limit the number of salaried staff members living with HIV in their companies, either by dismissing employees living with HIV or by carrying out secret HIV antibody tests at the moment of hiring. Such situations entail the participation of the medical and paramedical staff, company doctors or certain authorities in pharmaceutical laboratories and hospital structures collaborating in open agreement or unwittingly in the non-consensual testing of company personnel. Sometimes, company doctors are confronted with a difficult choice : pass on medical information at the request of the employer, or respect medical secrecy and run the risk of losing their jobs due to failure to execute the will of the company boss. Dismissal carried out for fraudulently concocted reasons other than HIV infection or the refusal to employ a given applicant do not pose any difficulties to the company, as it is extremely difficult for the victims to prove that they have been subjected to discrimination.

Keywords: HIV/AIDS • discrimination • HIV antibody testing • dismissal • company • Côte-d'Ivoire.

36. Les spécialistes non médicaux congolais et le problème de la connaissance scientifique du sida

Joseph Tonda

Une caractéristique fondamentale du sida a été de manifester une certaine impuissance des solutions biomédicales et d'en appeler aux solutions sociales. Or, les spécialistes non biomédicaux de la guérison ont la particularité d'occuper une position intermédiaire entre spécialistes des premières et acteurs des secondes : certains d'entre eux prodiguent des soins réputés efficaces contre des infections opportunistes et tous sont pressentis comme des agents susceptibles de jouer un rôle social décisif dans les politiques sociales de limitation de l'expansion du mal.

Cependant, le succès de l'investissement de ces spécialistes dans ces solutions sociales paraît dépendre au moins en partie de la manière dont ils se positionnent par rapport à la connaissance scientifique du sida. En effet, si selon le Dictionnaire, "connaître", c'est "avoir la pratique, l'expérience de quelque chose", autrement dit s'approprier intellectuellement ou pratiquement un objet social, il ne fait aucun doute que les spécialistes non médicaux sont, chacun dans son domaine, des gens de connaissance, et que leurs connaissances fondent leurs pouvoirs [1]. Or, de manière générale, toute appropriation, intellectuelle ou pratique, d'un objet social caractérisant l'acte de connaître se réalise toujours dans le cadre d'un champ de rapports de pouvoir légitimant ou non les acteurs, énoncés, pratiques et profits qui en résultent. C'est la raison pour laquelle, face à la connaissance scientifique qui fonde le pouvoir des médecins, se pose la question de la légitimité des spécialistes non médicaux, de leurs connaissances, de leurs pratiques et des profits matériels qui s'y attachent. Comme David Lebreton l'a écrit pour un autre contexte, « le conflit entre médecins et guérisseurs est d'abord un conflit de légitimité, il oppose le savoir élaboré par la "culture savante", incarnée par les instances universitaires et académiques, aux connaissances mises à jour par les guérisseurs traditionnels qui sont moins formalisables » (Lebreton 1990). Ainsi les rapports de pouvoir entre médecins et non médicaux ayant pour enjeu la légitimité sont, en un certain sens, des rapports de connaissance.

Or, en Afrique subsaharienne, et particulièrement au Congo, les rapports de connaissance posent les questions de légitimité et d'identité dans un champ beaucoup plus vaste que le champ des spécialistes de la

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[1] Selon Didier Fassin (1992 : 263) : « la mise en jeu des pouvoirs dans les sociétés africaines... fait intervenir un champ beaucoup plus vaste que celui auquel on a l'habitude de penser sous le terme de pouvoir (au singulier, et parfois avec une majuscule), considéré de manière restrictive dans le champ politique ».

guérison. En effet, dans le "champ du pouvoir", c'est-à-dire « l'espace des rapports de forces entre des agents ou des institutions ayant en commun de posséder le capital nécessaire pour occuper des positions dominantes dans les différents champs » (Bourdieu 1991 : 5), on peut difficilement nier le fait que ce "capital nécessaire" est, dans plusieurs champs, la connaissance écrite. Toutes les dichotomies qui sont au cœur des dynamiques sociales évoquent spontanément l'opposition entre connaissance lettrée ou écrite et connaissance orale : l'élite et la masse, la modernité et la tradition, la civilisation et la sauvagerie, le citadin et le villageois, etc., y compris celle qui en constitue le schème structurant de "base" : le Blanc et le Noir [1]. Ainsi les luttes de connaissance dans le champ des spécialistes de la guérison que sont les médecins, les "travailleurs de Dieu" [2], les *nganga* [3] et/ou tradipraticiens [4], et tous les personnages intermédiaires [5] (dont la caractéristique commune est d'être des lettrés) constituent une expression des rapports de connaissance structurant le champ du pouvoir.

Cette opposition explique tous les phénomènes de traditionalisation, de délégitimation et donc de dépossession et de destitution des *nganga* (spécialistes de la guérison) malgré leur "revalorisation". C'est donc sous sa forme de connaissance scientifique, reconnue et protégée par l'Etat dont la puissance est elle-même fondée sur la "raison graphique" (Goody 1979) que le savoir écrit, en tant que "capital", fonde le pouvoir des médecins aussi bien dans le champ du pouvoir que dans le champ des spécialistes de la guérison (ou champs des pouvoirs). Mais l'impuissance de cette connaissance face à son propre objet — le sida — fait de celle-ci un véritable problème. Cette impuissance conduit en effet les pouvoirs publics et les médecins à appeler à leur secours, pour le maintien de leurs

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[1] Comme le souligne Marc Augé (1995 : 283), il est impossible pour les Africains de penser leur modernité « sans référence au passé d'une part, à l'Occident de l'autre » et le discours prophétique, dans sa crudité (en Côte-d'Ivoire) présente toujours le "Blanc" comme "l'avenir du Noir". C'est dire le caractère structurant de l'opposition Blanc/Noir dans la modernité africaine.

[2] Dans les langues congolaises, le mot religion est méconnu et a été traduit par la notion de *zambe* ou *zambi*. Or *zambe* signifie "Dieu", et ceux qui s'adonnent à cette nouvelle activité sont réputés "faire le travail de Dieu" (*mosala ya zambe*). Ainsi nous les avons qualifiés de "travailleurs de Dieu".

[3] *Nganga* est un terme générique très usité dans les langues bantu pour désigner toute sorte de spécialistes de la maladie (guérisseur, devin, chef de culte, etc.). Il désigne ici le spécialiste de la "médecine traditionnelle".

[4] Dans le contexte congolais, le tradipraticien est le spécialiste de la "médecine traditionnelle" qui, à l'époque du Parti unique marxiste-léniniste, était membre d'une de ses organisations de masse, l'Union nationale des tradipraticiens du Congo. C'était donc une notion idéologiquement connotée, comme le montrent d'ailleurs Marc-Eric Gruénais et Dominique Mayala (1988).

[5] Nous appelons intermédiaires tous les "néo-tradipraticiens" et tous les "néo-chercheurs" producteurs de théories et de pratiques de guérison qui ne se classent pas dans les registres traditionnels : biomédecine, "médecine traditionnelle", religion, etc., mais participent plus ou moins de tous ces registres à la fois.

positions dominantes, ceux dont les situations de dominés ont été produites par la magie de la connaissance scientifique [1].

Dans quelle mesure l'implication des spécialistes non médicaux dans les solutions sociales contre le sida est-elle liée à leurs positions respectives face au savoir écrit (en tant que capital) de manière générale, et à la connaissance scientifique du sida, de manière précise ? Autrement dit, dans quelle mesure la soumission totale ou relative des spécialistes non médicaux à la vérité de la connaissance scientifique du sida, et par conséquent au pouvoir commun de l'Etat et des médecins, dépend-elle de leurs positions, en tant que gens de connaissance, à l'endroit de la connaissance scientifique du sida ?

A titre d'hypothèse, nous postulons que les positions à l'endroit de la vérité de la connaissance scientifique sont plus ou moins informées par les positions et les trajectoires sociales des spécialistes non médicaux ; ces positions et trajectoires sociales sont liées au volume du capital de connaissance écrite possédé ou accumulé par les spécialistes, mais aussi selon les cas, par les institutions auxquelles ils appartiennent.

Pour essayer de vérifier cette hypothèse, nous nous appuyons sur des données diverses, dont, particulièrement, celles relevant d'enquêtes de terrain réalisées non seulement à Brazzaville, mais aussi à l'intérieur du pays, notamment dans le Nord-Congo [2].

Ces enquêtes ont permis de recueillir des biographies de spécialistes et d'étudier de manière assez exhaustive les caractéristiques sociologiques d'une centaine de spécialistes dans un quartier périphérique de Brazzaville appelé Mama Mbwalé. Elles nous ont amené aussi à interroger les responsables des centres de "médecine révélée" des paroisses protestantes, kimbanguistes et d'autres Eglises du réveil. Ont également été enquêtés des responsables des associations de tradipraticiens ou certains de leurs membres. Nous avons enfin enquêté chez un responsable de la "médecine naturelle", prodiguant des soins à base de produits "naturels" commandés en Europe, qui prétend guérir le sida. Cependant, malgré la quantité et la qualité d'informations recueillies, les développements suivants sont à considérer comme des pistes de recherche.

Les "travailleurs de Dieu"

Tant dans le champ religieux que dans celui du pouvoir, les Eglises chrétiennes membres du Conseil Œcuménique occupent une position

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[1] Le savoir écrit est source de fascination, tant il permet l'acquisition d'un pouvoir social important dans les champs religieux et profanes, en particulier dans le champ médical... De ce point de vue, son caractère magique s'impose.

[2] Nous avons enquêté à Brazzaville, à Etoumbi et à Mbomo dans la Cuvette-Ouest, dans le cadre du programme *Enjeux sociaux et politiques de la prise en charge du sida au Congo* financé par l'ORSTOM (Action incitative "Sciences sociales et sida") dont le coordinateur était Marc-Eric Gruénais. Une autre partie de ces enquêtes a été menée à Brazzaville, dans le cadre du projet *Se soigner à Maman Mbwalé*, financé par le CNRS (PIR-Villes) et coordonné par Marc-Eric Gruénais.

dominante [1]. Cela explique que, face à l'Etat, elles s'imposent, au moins depuis la "démocratisation", comme ses partenaires officiels dans le règlement des crises politiques. C'est aussi la raison pour laquelle elles sont des partenaires du Programme National de Lutte contre le Sida. Ces Eglises sont également celles dont les prises de position sont les plus fermes contre la vérité de la connaissance scientifique du sida et ses implications et applications sociales. Toutes récusent le préservatif comme solution sociale pour limiter l'expansion du sida et certaines affirment, par la voix de leurs membres spécialisés dans l'activité thérapeutique par les "plantes révélées", la guérison du sida dans leurs paroisses. Ces prises de position sont les plus marquées au sein de l'Eglise Evangélique du Congo (Protestante) [2]. Ainsi, dans des paroisses de Mayangui et de Ouenzé, d'obédience protestante, les responsables ou les membres des centres de "médecine révélée" affirment clairement la capacité qu'ils ont, grâce à Dieu, de guérir le sida.

Pourtant, cette position, opposée à la vérité de la connaissance scientifique, est le fait d'acteurs sociaux s'organisant et organisant leurs centres sur le modèle des structures biomédicales. L'imitation du person-nage du médecin et des cabinets ou centres médicaux est telle que, dans certaines paroisses protestantes, comme celle de Bacongo décrite par Bidzimou (1993), on trouve dans le "centre thérapeutique" un "laboratoi-re" où sont fabriqués des "produits", ainsi qu'un "magasin" où ils sont stockés dans des bocaux ayant contenu des produits pharmaceutiques. Les produits sont classés selon leurs "codes" : "M 105", "M 175", "P 4", "G 26", etc. Seuls les spécialistes recrutés sur la base d'un test réalisé par le Président "inspiré" sont en mesure d'interpréter ces codes. Dans leur travail, ces spécialistes portent des blouses blanches, qui renvoient, d'après les spécialistes, à la "pureté du serviteur de Dieu", mais ne s'inscrivent pas moins dans un ensemble de symboles qui réfèrent objectivement aux matérialisations de la connaissance scientifique.

Comment comprendre alors que la connaissance scientifique, dans ses matérialisations, soit à la fois le modèle justifiant tous les mimétismes et l'objet d'une opposition à la vérité qu'elle énonce ? Il ne fait aucun doute que les spécialistes de guérison des centres de médecine révélée jouent au médecin. Mais, comme l'observe Aristote, si le jeu est puéril, le fait de jouer est sérieux. Cependant, ce qui donne tout le sérieux à ce jeu c'est le fait que l'identité des joueurs est légitimée par une institution religieuse moderne, l'Eglise Evangélique du Congo, dont la modernité, définie en opposition aux cultes traditionalistes, repose sur la reconnaissance sociale de la magie de la connaissance écrite (la Bible) qui fonde son pouvoir. Dans l'espace social congolais en effet, aucun culte traditionaliste dont la légitimité n'est pas en rapport avec la magie de l'écriture n'est reconnu par l'Etat comme une religion. Ainsi, ceux dont la légitimité sociale est confortée par le pouvoir de l'écriture, symbole de la puissance blanche et de la modernité, peuvent jouer sérieusement aux médecins tout en

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[1] Sont membres du Conseil Œcuménique, les Eglises Catholique, Evangélique (Protestante), Salutiste, Kimbanguiste et Orthodoxe.

[2] L'Eglise Protestante est la première à avoir intégré depuis 1947 à Ngouédi (sud-Congo) les pratiques de guérison dans son ministère.

s'opposant avec fermeté à la vérité de la connaissance scientifique du sida.

Bien des Eglises dominées (les "sectes"), interrogées sur le préservatif ou sur leur capacité ou non de guérir le sida, se distinguent par la souplesse de leurs positions. Il y a certes, parmi ces Eglises, celles dont l'opposition à la vérité de la connaissance scientifique du sida est particulièrement forte, allant jusqu'à prôner le rejet de tout contact physique avec le préservatif, un objet habité par les "démons d'impudicité" [1].

Cependant, le fait intéressant est qu'on rencontre parmi les Eglises dominées des prises de position souples à l'endroit de la vérité scientifique du sida. Ainsi, un responsable de ces Eglises a déclaré avoir pris part aux journées de lutte contre le sida organisées par le Programme National et avoir demandé des préservatifs aux pouvoirs publics. Son Eglise serait prête à participer à une campagne de promotion des préservatifs. De plus, dans ces Eglises on entend des discours les plus vagues sur le caractère guérissable du sida, revendiquant parfois des capacités de guérir le sida, mais n'affirmant presque jamais l'existence d'un remède précis, désigné par un nom, et destiné à traiter exclusivement le sida.

Dans une secte ngounziste, des étudiants (Louenidio *et al*. 1995) ont recueilli le discours suivant qui montre comment le sida ne constitue pas une préoccupation spéciale du service de la guérison : « Dieu ne nomme pas les maladies, mais nous révèle seulement que telle personne est malade, voilà le traitement qui lui convient. Si les gens arrivent à nommer les maladies, cela ne vient pas de Dieu ». Le pasteur qui parle ainsi signale qu'il a déjà traité un malade qui présentait des symptômes du sida, mais Dieu ne lui a pas révélé que ce malade était un sidéen.

En toute hypothèse, leur position de dominées explique l'opposition moins affirmée de ces Eglises vis-à-vis de la vérité de la connaissance scientifique du sida. Ce n'est peut-être pas non plus un hasard si bien des Eglises de la mouvance ngounziste se retrouvent dans le groupe des Eglises ayant des positions souples à l'égard de la connaissance scientifique du sida, car leur inflexion traditionaliste limite sans doute et dans une certaine mesure des tendances au fondamentalisme, c'est-à-dire à une référence exclusive à la vérité intemporelle des Ecritures. D'ailleurs, elles se définissent plus comme des Eglises de guérison, et ont ainsi par rapport à la maladie des interprétations persécutives plus proches de celles des *nganga*, que chez les Protestants où l'on s'efforce de ne pas trop souligner les pouvoirs des sorciers.

Ainsi le volume global du capital du savoir écrit possédé et le rôle du schème structurant de la puissance blanche symbolisée dans ce capital expliquent non seulement le caractère dominant ou dominé d'une Eglise, mais informent aussi les prises de position fortes ou molles à l'endroit des vérités de la connaissance scientifique du sida, tant il est vrai que les chances de s'approprier le sida en tant qu'objet de connaissance et enjeu

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[1] C'est la position d'un mouvement particulièrement dynamique aujourd'hui à Brazzaville, la Communauté des Femmes Messagères du Christ, CFMC dont le cheval de bataille est la lutte contre Satan, omniprésent dans les objets de la vie quotidienne, et les "totems" propres aux traditions familiales indigènes. Il a pour origine les Etats-Unis.

de pouvoir sont plus grandes si le volume du capital du savoir écrit possédé est plus grand.

Cette observation est confortée par le fait que parmi ceux qui dans la société possèdent ce capital, beaucoup sont prédisposés à entrer dans le champ religieux. Surtout quand les espérances personnelles ou familiales d'ascension sociale ayant justifié des investissements financiers, psychologiques ou sociaux dans les études se soldent par des échecs et par une précarité matérielle et sociale. En effet, dans la mesure où, sans se réduire à cette fonction, le champ religieux constitue à bien des égards un champ où les insatisfactions, les désillusions, les ressentiments, les souffrances et les angoisses liées aux échecs caractéristiques de la modernité peuvent se convertir en vocations salvatrices et en un pouvoir social reconnu, sa vocation à recevoir des lettrés candidats à des positions de pouvoir (prophètes, pasteurs, chefs de groupes de prière ou d'Eglises) s'expose ici avec l'évidence des cas extrêmes.

Or ces gens de connaissance et de pouvoirs, qui ont de surcroît une conscience pratique d'appartenir au même univers symbolique que les médecins qui les fascinent, sont logiquement enclins à s'approprier le sida, produit de la connaissance scientifique des médecins et donc enjeu de pouvoir. Cette réalité est attestée par l'étude systématique des travailleurs de Dieu et des *nganga* réalisée à Mama Mbwalé. Dans ce quartier, en effet, presque tous les travailleurs de Dieu enquêtés sont des lettrés d'un niveau moyen largement au dessus de celui des *nganga* (parmi lesquels on rencontre même des gens qui n'ont pas été scolarisés). Ce niveau moyen d'instruction assez élevé se double d'un âge moyen relativement plus bas que celui des *nganga*. Mais les travailleurs de Dieu sont aussi ceux dont la précarité matérielle et sociale est la plus marquée : aucun d'eux n'était propriétaire de son logement dans le quartier où il habitait avant de s'installer à Mama Mbwalé ; ils sont aussi les plus nombreux à passer d'une situation de dépendance absolue (logés par les parents ou par les amis) à une situation de dépendance relative (locataires).

Mais si la possession du savoir écrit, l'état de jeunesse et la précarité sociale et matérielle prédisposent objectivement les travailleurs de Dieu à entrer dans le champ religieux pour y officier dans un quartier périphérique (sans structures officielles de santé), leur identité d'acteurs modernes ayant une conscience pratique ou explicite des enjeux de pouvoir constitués comme tels par la modernité s'illustre, par exemple, dans l'appréciation de leur situation sociale. En effet, invités à dire s'ils se considéraient ou non en situation de chômage tout en exerçant le "travail de Dieu", neuf travailleurs de Dieu ont déclaré qu'ils se considéraient comme chômeurs. Cette conscience du chômage, absente chez tous les *nganga* de Mama Mbwalé, traduit la disposition des travailleurs de Dieu à revendiquer et à s'approprier les statuts et objets sociaux caractéristiques de la modernité : le statut de salarié dans les secteurs privé ou public modernes, les objets de connaissance produits par le savoir scientifique.

S'agissant plus précisément du sida comme objet de connaissance, cette conscience du chômage est un indice de la prédisposition des "travailleurs de Dieu" à se l'approprier, c'est-à-dire à en faire un objet et un enjeu de leurs délibérations souveraines, c'est-à-dire instruites par le

caractère souverain des Ecritures saintes qu'ils opposent ainsi au pouvoir instruit par la connaissance scientifique dont l'aveu d'impuissance sur son propre objet rend problématiques les prétentions hégémoniques. Ainsi, les travailleurs de Dieu de Mama Mbwalé, à l'instar des autres, malgré et à cause des différences sociales qui les caractérisent, sont voués par leur conscience pratique de l'analogie entre le pouvoir que confère la possession des Ecritures saintes dans le champ religieux (mais aussi dans le champ du pouvoir) et celui que confère la possession du savoir scientifique dans le champ médical, à délibérer de manière plus ou moins souveraine sur les vérités de la connaissance scientifique du sida. Ce pouvoir qu'ils ont de délibérer sur le sida les conduit non seulement à condamner la solution sociale instruite par la connaissance scientifique, analogiquement semblable à leurs connaissances religieuses, mais aussi à produire des élaborations symboliques à consonnance moderniste [1] plus ou moins sophistiquées sur la nature du mal.

C'est ce qui apparaît dans le discours de l'un d'eux sur les rapports entre sida et *mwandza* [2], sida et sorcellerie, ainsi que sur la transmission du mal.

Pasteur, âgé de 44 ans, instituteur, Nestor se définit comme pasteur-guérisseur. Il exprime une fine connaissance du *mwandza*, mais son discours est émaillé d'incohérences quand il se prononce sur le caractère guérissable ou non du sida, car il existe, pour lui, une complète identification du sida au *mwandza*, qui se complique par la double étiologie, en termes de sorcellerie et de punition divine qu'il attribue au sida. Tout compte fait, son discours sur les précautions et le mode de transmission ne peut se comprendre qu'à la lumière des liens établis entre le sida, le *mwandza*, Dieu et la sorcellerie.

Première affirmation péremptoire de Nestor : "le *mwandza*, c'est le sida". A l'appui de cette affirmation, Nestor raconte que, dans son village, existait un grand féticheur qui traitait des maladies identiques au sida. Les malades présentaient les symptômes suivants : "cheveux cassés, ils étaient squelettiques, et ressemblaient à un objet avalé par un boa". On disait d'eux qu'ils souffraient de la "maladie du serpent". Pour Nestor, la maladie du serpent n'est qu'une forme du *mwandza*, qui est un nom générique englobant plusieurs pathologies ; en effet, il y a plusieurs *mwandza* : "le *mwandza* proprement dit, avec brûlures sur le corps, la syphilis, la maladie du serpent (*yalendzo*), le *mwandza* de la gale, le *mwandza* des plaies, le *mwandza* qui fait maigrir, le *mwandza* qui rend aveugle, le *mwandza* de la grenouille, le *mwandza* de la tremblote, le *mwandza* qui provoque le courant dans le corps, et maintenant le *mwandza* du sida qui est populaire, parce que beaucoup de gens en souffrent". Sa culture religieuse l'amène à caractériser l'époque actuelle comme l'époque du déluge de feu et cette particularité est liée à la volonté divine. Ainsi, "même sans rapport sexuel, on peut attraper le sida si on ne respecte pas les lois du Seigneur".

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[1] Jean François Bayart (1993) et Jean-Pierre Dozon (1995) expriment, entre autres, l'idée de la religion comme champ "d'invention" de la modernité en Afrique.

[2] Le *mwandza* est généralement décrit sous la forme d'une dermatose. Sur le *mwandza*, on peut lire Franck Hagenbucher-Sacripanti (1994).

On voit que la détermination de l'époque du feu et le respect des lois divines rendent dérisoire l'observation de précautions particulières pour se protéger du sida. Nestor établit même, implicitement, un lien entre personnes âgées et sida, car, dit-il, "si vous avez des relations sexuelles avec de vieilles personnes, dites-vous que vous n'êtes pas loin de ce *mwandza*". Les vieilles personnes sont-elles marquées par le feu du *mwandza* ? Et pourtant, d'après lui, le sida s'attrape par les "contacts sexuels". En effet, à la question de savoir s'il prend quand même des "précautions" pour éviter d'être infecté, Nestor répond : "le sida ne se transmet pas comme ça ! Il vous attrape si vous rentrez en contact sexuel avec un malade du sida. Autrement, on peut discuter, manger ensemble sans être atteint. Mais il faut éviter le contact avec le sang".

Si l'époque est marquée du sceau du "feu", si le sida est une forme du feu que représente le *mwandza* et si on peut l'attraper parce qu'on n'a pas respecté les "lois divines", on peut penser que le respect de ces lois préserve du sida, et que l'interdit du "contact avec le sang" (non connu comme une loi du Seigneur), ne serait pas à craindre comme moyen de contamination du sida. Il y a donc "contradiction" entre le principe général énoncé par le prophète et l'affirmation du danger du "contact du sang".

Le principe général — l'époque du feu comme punition divine — évoqué par le pasteur-guérisseur est cohérent avec son affirmation selon laquelle "le sida est une maladie qu'on peut guérir avec la volonté de Dieu". D'ailleurs, il y a deux sortes de sida : "le sida injecté par les sorciers et le sida contracté par les moyens connus". "Le sida qui peut se guérir 'facilement', c'est le sida attrapé par les moyens connus, tandis que le sida injecté par un sorcier a trop de complications. Il faut réussir à chasser le mauvais esprit qui a envoûté cette personne en faisant un désenvoûtement, lorsque le désenvoûtement est réussi, vous pouvez réussir le cas". Il n'y a aucun doute sur le caractère guérissable du sida pour le pasteur, qui pourtant (seconde incohérence), ne croit pas qu'on peut guérir le sida : "même pendant 30 ans, il n'y aura pas de médicaments capables de tuer ce virus ! ".

Issu d'une famille de *nganga*, très informé sur le *mwandza*, Nestor est *nganga,* mais surtout pasteur et instruit. En se définissant lui-même comme pasteur-guérisseur, il marque la double détermination de sa pratique, et donc l'hétérogénéité de son dispositif intellectuel pour appréhender le réel, que révèlent les incohérences de son discours. Cependant, malgré ces incohérences, les propos de Nestor traduisent sa volonté de s'approprier l'objet de connaissance qu'est le sida et donc d'affronter et de confronter sa connaissance à celle des médecins avec lesquels il partage symboliquement le même univers culturel. Cette prétention des travailleurs de Dieu n'est semblable, dans l'ensemble du champ des spécialistes de la guérison, qu'à celle des intermédiaires.

Les "intermédiaires"

Il n'est pas rare que la presse congolaise publie des articles ou des interviews de "foudrologues", de "biocosmétologues", de médecins "hygiénistes, naturopathes" dont la qualité est d'être des "intellectuels" et

des “chercheurs”. Ces “chercheurs” dont les trajectoires sociales sont le plus souvent faites d’apprentissages de “sciences” parallèles aux sciences académiques, élaborent des théories et produisent des connaissances sur le corps ou la maladie. Convaincus de la pertinence et de l’efficacité de leurs savoirs et pratiques — qui se nourrissent de fragments de connaissances bibliques, chimiques, philosophiques, mathématiques, biologiques —, ils dénoncent souvent les “manques” de la biomédecine tout en recherchant la “collaboration” avec l’ORSTOM et l’OMS qui ratifieraient ainsi le sérieux de leurs travaux injustement méconnus.

C’est ainsi qu’ils s’approprient le sida, véritable défi à la connaissance scientifique. Ils annoncent des médicaments qu’ils ont découverts ou élaborent des théories singulières sur le mal. Ainsi, le “chercheur foudrologue” Itous-Ibara Ossoua écrit : « la règle d’or du sida : la fidélité devant son épouse. Le sida est une maladie liée au dixième degré de la Foudre ou dixième commandement de Dieu : “Tu ne convoiteras point la maison de ton prochain ; tu ne convoiteras point la femme de ton prochain, ni son serviteur, ni sa servante, ni son bœuf, ni son âne, ni aucune chose qui appartienne à ton prochain”. Le sida comme la foudre n’est qu’une parole de Dieu envoyée pour appliquer les Dix Commandements de Dieu ... ». Il s’interroge : « Faut-il nous demander si le *mwandza* est contagieux comme le sida ? Il y a plus de 90 formes de *mwandza*. Les formes regroupées dans le 10e degré échappent à l’homme aujourd’hui. Mais il y a des cas où le *mwandza* s’est révélé contagieux...» [1].

Cette appropriation du sida par les néo-chercheurs trouve dans la biographie, le discours et les pratiques d’un “médecin hygiéniste-naturopathe”, chef d’un centre de “médecine naturelle”, quelques éléments fondamentaux de sa logique sociale.

Né vers 1939, B. M. a une trajectoire sociale marquée par la volonté de s’arracher aux statuts et fonctions propres à la tradition pour acquérir celles qu’offraient les champs de la modernité. C’est pourquoi il ne se contente pas de son niveau d’étude primaire et se lance dans des scolarités par correspondance à l’étranger, en particulier en France et au Sénégal. Il finit par exercer la “médecine naturelle” à partir de1987, après avoir exercé plusieurs métiers. Mais cette dernière fonction est aussi celle qui le situe dans le registre des “vocations” de type religieux : “J’étais atteint chroniquement de troubles de santé de 1974 à 1976 sans guérison malgré des soins de la “grande médecine” par-ci, par là. J’avais donc choisi de me faire suivre par la médecine naturelle qui a réussi à restaurer ma santé sans rechute”. Membre de l’association nationale des tradipraticiens du Congo, B. M. lie par ailleurs sa qualité de “Bon Citoyen” à son appartenance à l’Eglise Evangélique du Congo (Protestante). Se qualifiant lui-même comme “Docteur Hygiéniste-Naturopathe”, B M. décrit ainsi l’originalité de sa médecine : “La médecine naturelle enseigne que la santé est l’expression normale de la vie et résulte toujours des conditions naturelles non perturbées et que la maladie est la conséquence du non-respect des lois naturelles”.

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[1] *La Foudre, 3* (avril - mai) 1993 : 3.

B. M. traite toutes les maladies, y compris le sida qu'il affirme guérir avec un médicament qui n'a pas de nom particulier, mais est composé de "plantes de désintoxication, de revitalisation" auxquelles il ajoute des "savons avec lesquels le patient doit se laver pendant le traitement". Pour le sida, comme pour d'autres maladies, il prescrit une alimentation obligatoire et des interdits. Tout compte fait, le "traitement contre le sida est le même pour les autres maladies, sauf qu'il va un peu plus loin en comprenant d'autres produits, car l'organisme du sidéen est complètement abîmé". Tous ses produits naturels proviennent des laboratoires de "produits médicinaux" occidentaux, sans que les laboratoires fournisseurs sachent que leurs produits servent à guérir les sidéens. En effet, déclare B. M., "J'ai mené une étude qui m'a permis d'établir une ordonnance capable de désintoxiquer, éliminer et revitaliser l'organisme dégénéré suite à une mauvaise vie menée par le patient lui-même".

A propos d'une participation éventuelle à une campagne de promotion du préservatif, il estime : "Notre profession, c'est la médecine naturelle et pour ceux qui la pratiquent, le préservatif est une erreur". Il illustre ce point de vue par le cas d'un de ses patients, "qui après chaque cure, faisait un test à Bioquick et dont la séropositivité était très faible et ne comprenait pas pourquoi ses démangeaisons au niveau du sexe ne passaient pas. A la fin, je lui ai dit : 'tu ne dois plus toucher ta femme'. Il était très déçu. Mais il se rachetait ailleurs, auprès d'une copine avec laquelle ils utilisaient des préservatifs. Je lui ai dit que c'est vrai que le préservatif arrête le microbe, mais nous ignorons quelque chose : le préservatif a des lubrifiants, quand vous introduisez votre verge, ça rentre, ça sort, ça respire et ça absorbe ce produit là qui va dans l'organisme et il dérègle tout, chez la femme comme chez l'homme". Après deux semaines de traitement dans l'abstinence, le patient est venu voir B. M. en lui montrant les résultats de son test révélant sa séronégativité.

B. M. dit avoir reçu depuis 1992 jusqu'au 1er avril 1996, date de l'entretien, 121 malades du sida, (63 hommes et 58 femmes). Il souhaite une "collaboration" avec les médecins et l'ORSTOM pour "sauver l'humanité", mais ne cache pas sa grande déception devant le mépris affiché à son égard par les médecins du PNLS [1].

Ces discours révèlent, entre autres, le fait que les jeux d'imitation des médecins sont inséparables ici des enjeux de valorisation des joueurs dans un contexte d'aliénation où le modèle est en même temps le concurrent. Si le joueur, visiblement, a besoin de "collaborer" avec le modèle-concurrent, c'est parce que de cette "collaboration" dépendrait l'affirmation de son identité et de sa légitimité, avec cependant l'espoir implicite de renverser l'ordre des choses par l'administration de la preuve de l'efficacité méconnue des pratiques qu'informent ses connaissances.

C'est cette espérance qui, perçue par le modèle concurrent comme une prétention ridicule, rend problématique toute soumission de l'imitateur-concurrent à la vérité de la connaissance scientifique du sida au nom de laquelle le modèle-concurrent le méprise et le rejette. Pourtant, cette

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[1] Un signe des temps, exprimant les ambiguïtés des rapports entre le PNLS et les "chercheurs", a été le fait que celui-ci semble intéressé par la "découverte" d'un "médicament" par une équipe de "chercheurs", comme le rapporte le journal *Le Savoir*, *2* juin 1996.

prétention ne serait pas si grande et ne provoquerait sans doute pas tant le mépris de la part des modèles si le joueur-imitateur et le modèle-concurrent ne partageaient pas des connaissances reposant sur le pouvoir de l'écriture [1] qui, ainsi, les situe dans le même univers culturel ou symbolique. C'est ce que semble attester *a contrario* la position des *nganga*.

Les *nganga*

Les travailleurs de Dieu et les intermédiaires ou "néo-chercheurs" relèvent du même univers culturel que les médecins, du moins sur le plan symbolique. Cette attitude générale trouve son contraire paradigmatique dans l'attitude de *nganga* responsables d'un culte traditionaliste appelé *ndjobi*, subissant l'agressivité des mouvements prophétiques dirigés par des jeunes lettrés à Etoumbi. Ceux-ci déclarent en effet ne rien savoir du sida et donc ne posséder aucun remède pour le guérir. L'accusation de "pratiquer la magie" qu'ils portent contre les jeunes prophètes ou pasteurs subsume toutes les considérations liées à leur exclusion du champ de la connaissance lettrée et des pouvoirs de la modernité. En effet, dans les représentations ordinaires, la magie est liée à l'écriture, à la modernité et au personnage du Blanc (Tonda 1994).

Une autre expression de la position d'extériorité des *nganga* par rapport au sida est l'opinion selon laquelle celui-ci est une "maladie d'intellectuels", une "maladie de médecin" ou de "Blancs" — position qui situe ainsi l'origine du sida dans l'espace social et culturel propre à la connaissance scientifique. A titre de comparaison, aucun travailleur de Dieu enquêté n'a dit que le sida est une maladie d'intellectuels, de Blancs ou de médecins. Ainsi, contrairement à une idée assez répandue dans les milieux médicaux, tous les "tradipraticiens" ne s'approprient pas le sida. Les tradipraticiens qui ont tendance à le faire sont davantage lettrés et jeunes qu'illetrés et vieux. Un exemple de tradipraticien affirmant avoir des connaissances sur le sida est donné par Victor Ngongo, Président de l'Association des Tradipraticiens à Etoumbi. Il affirme ainsi : "Un jour, j'ai appris qu'un homme de ma connaissance était atteint du sida. Il avait deux femmes dont l'une était enceinte. Celle qui n'était pas enceinte est morte du sida. En étudiant ce cas, je me suis dit la chose suivante : la femme enceinte provoque de la répulsion chez plusieurs hommes. Aussi il est fort possible que notre homme ait pu éviter d'avoir des rapports sexuels avec la femme enceinte. Cependant, cet homme ayant repris des rapports sexuels avec cette femme après l'accouchement, il a certainement attrapé le "microbe" de *tchenga*, une maladie qui frappe ceux qui ont des relations sexuelles avec des femmes qui viennent d'accoucher. Ainsi il a pu transmettre ce microbe à la femme qui n'était pas enceinte en couchant avec elle". Ngongo insiste bien sur le fait qu'il s'agit là d'une "réflexion"

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[1] Certes les *nganga* ou tradipraticiens sont aussi rejetés pour motif "d'escroquerie" par les médecins qui condamnent ainsi les profits financiers illégitimes que réaliseraient ceux-là en proposant aux malades des traitements inefficaces. Mais l'argent n'est un enjeu de pouvoir ici que chez ceux qui partagent le même espace de pouvoir. En cela il est analogue à l'écriture.

qu'il a faite et se demande s'il ne serait pas possible de soigner les sidéens avec les plantes qui "tuent le microbe de *tchenga*".

On constate bien que la "réflexion" de Victor Ngongo, les hypothèses qu'elle enferme, les notions comme "microbe" ou "étude" qu'elle décline (en français) situent l'intéressé dans le registre de la modernité. Elles traduisent des dispositions mentales différentes de celles des *nganga ndjobi* qui se refusent à discourir sur ce qu'ils ne "savent pas", à savoir le sida.

C'est cette disposition inséparablement intellectuelle et affective qui fonde les opinions des *nganga* de Mama Mbwalé sur le préservatif, les rapports entre sida et sorcellerie, sida et pathologies locales, etc. Ceux-ci évoquent en effet le préservatif, produit de la science et de la technique occidentales, comme quelque chose qu'ils ne "connaissent pas" et se refusent par conséquent à le conseiller.

Ainsi aucun *nganga* enquêté n'établit de lien d'identité entre sida et *mwandza*. D'ailleurs, disent certains, plus particulièrement les spécialistes de *mwandza*, ce sont des médecins ou des personnels biomédicaux qui leur ont dit que le sida ressemblait au *mwandza*, mais eux savent que le *mwandza*, non seulement se guérit, mais ne se transmet pas par voie sexuelle, ni par le sang. Pour cette raison ils pensent que le sida est une maladie des médecins — comme le *mwandza* est la leur — au sens d'une maladie construite par le savoir médical.

Conclusion

La question initiale était de savoir si le volume du capital de connaissance écrite possédé par des spécialistes non médicaux ou accumulé par les institutions auxquelles certains d'entre eux appartiennent ne commande pas les chances de voir ceux-ci se soumettre ou non à la vérité de la connaissance scientifique du sida et ainsi de s'investir ou non dans les solutions sociales qu'elle fonde.

On constate donc des difficultés objectives de mobilisation, pour trouver des solutions sociales contre le sida fondées par la connaissance scientifique :

1° des spécialistes appartenant à des institutions dont la forte légitimité sociale ou la position dominante dans les champs du pouvoir et des spécialistes de la guérison est fondée par la magie de l'écriture ;

2° des spécialistes instruits et des jeunes que les trajectoires et les situations sociales précaires vouent à entrer dans le champ religieux pour régler des questions d'identité en occupant des positions de pouvoir ;

3° des spécialistes imitateurs-concurrents des médecins que leur qualité "d'intellectuels" en quête de reconnaissance et d'identité situe dans un rapport conflictuel avec les modèles-concurrents ;

4° des spécialistes dominés et marginalisés dont la fonction de thérapeutes n'est pas légitimée par la possession du capital de connaisance écrite et dont l'extériorité ainsi définie par rapport à la vérité de la connaissance scientifique du sida, et aux solutions sociales qu'elle instruit et justifie des attitudes plus ou moins avouées de défi aux médecins et aux pouvoirs publics.

Ainsi, les uns, pour s'être approprié le sida en tant qu'enjeu de pouvoir, et les autres, par leur rapport d'extériorité à cet enjeu ou ressource de pouvoir, rendent problématique leur mobilisation dans les solutions sociales tant que les problèmes de pouvoir, d'identité, de légitimité ou de dignité que posent, de manière générale, leur rapport à l'écrit, et de manière précise, leur rapport à la connaissance scientifique du sida ne seront pas intégrés dans l'ensemble des problèmes à résoudre par les pouvoirs publics et les médecins.

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Joseph TONDA, *Les spécialistes non médicaux congolais et le problème de la connaissance scientifique du sida*

Résumé — Le volume du capital de connaissance écrite possédé par des spécialistes non médicaux ne commande-t-il pas les chances de voir ceux-ci se soumettre à la vérité de la connaissance scientifique du sida et ainsi de s'investir ou non dans les solutions sociales qu'elle fonde pour prévenir la maladie ? Une étude menée au Congo a permis de montrer la très grande diversité de l'appropriation de la maladie par les différents types de spécialistes non médicaux de la maladie, selon leur âge, mais surtout selon que leurs pratiques relèvent du religieux d'inspiration chrétienne ou de celles des devins guérisseurs, et selon le type de légitimité plus ou moins traditionnel dont ils se réclament.

Mots-clés : tradipraticiens • religieux • écriture • Congo.

Joseph TONDA, *Congolese non-medical specialists and the problem of scientific knowledge of AIDS*

Summary — Is it not true that there is a direct link between the amount of written knowledge in the hands of non-medical specialists and the probability that such people submit themselves to the truth about AIDS-related scientific knowledge and also whether or not they contribute to the derived social solutions to prevent the illness? A study carried out in Congo shows that there is great diversity in the level of appropriation of the illness by the different types of non-medical specialists in the illness. This variation depends on their age, but above all on the extent to which their practices are the product of Christian religious figures or of traditional healers/soothsayers, as well as on the type of legitimacy —more or less traditional— to which they lay claim.

Keywords: traditional practitioners • religious figures • scripture • Congo.

37. Livelihood mobility and AIDS prevention in West Africa. Challenges and opportunities for social scientists

Thomas M. Painter [1, 2]

Introduction

The relationship between population mobility and the spread of diseases has been noted numerous times by social scientists, historians and medical epidemiologists (Gellert 1993). Since the 1980s increased attention has been given to the links between various forms of population mobility and the spread of HIV/AIDS in sub-Saharan Africa and other world areas (Quinn 1994). To date however, the contribution of the social sciences to clarifying the dynamics of the relationship between forms of livelihood mobility and the spread of HIV/AIDS in sub-Saharan Africa has been limited (Amat-Roze 1993; Amat-Roze *et al.* 1990; Hunt 1989). More important, the contribution of the social sciences to HIV/AIDS prevention interventions for persons engaged in mobile livelihoods has been even more limited. This paper argues for change in this situation and suggests possible approaches for increasing the engagement by the social sciences with HIV/AIDS prevention initiatives among people on the move and their sexual partners.

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[1] The views expressed in this paper are the author's views alone and do not necessarily reflect the views of the Centers for Disease Control and Prevention, the U.S. Public Health Service or the U.S. Department of Health and Human Services.

[2] These notes are from an ongoing project to examine aspects of uneven development in sub-saharan Africa and their impacts on the livelihood strategies used by members of African households to gain access to, exercise a degree of control over, and benefit from the utilization of resources which they define as critical for their well-being. Earlier elaborations of the concepts used herein have been presented elsewhere (Painter 1985, 1987, 1994b, 1994c, Painter *et al.* 1992, Painter *et al.* 1994). To a significant degree, this conceptual development builds on perspectives earlier developed by Berry (1989, 1993), but also by others who have addressed issues of opportunity structures, uneven development and regional dynamics.

Uneven socioeconomic development and livelihood mobility in West Africa

Uneven development, human actions, mobility and the creation of action spaces

Markedly uneven development is a defining characteristic of societies and economies in West Africa. This is the result of several factors, two of which we will consider here.

First, natural resource endowments vary considerably in West Africa. Soil quality and fertility vary although it is fair to poor overall. The region is subject to pronounced variations and seasonality of rainfall alternating with long dry periods, sometimes combined with longer-term processes of desertification. Proximity to ground water tables and access to other sources of water varies. Historically, diseases such as onchocerciasis have infested large river valley areas, thereby limiting human access to more desirable habitats. Deposits of valuable minerals such as gold, diamonds, bauxite, are distributed unevenly within the region, etc. This uneven natural resource endowment affects the possibilities throughout West Africa for agricultural and non-agricultural production for domestic consumption and/or sale and profit. It shapes opportunities and constraints associated with livelihoods in important ways.

The second factor is the cumulative impact over time and across geographic space in West Africa of uneven development. This results from choices made by individuals, groups, communities, by private capital, governments, international development assistance organizations, and finally, the impact of market forces within a global economy, on features of social reproduction, production, investment and profitability (Painter *et al.* 1994). We find examples of this in the uneven distribution of investment in on-farm and off-farm production and marketing and the uneven development of transport and communications infrastructure education, health and other social services throughout sub-saharan Africa.

Uneven and inequitable socioeconomic development affects the *livelihood opportunities and constraints* of millions of people in West Africa —an estimated 197 million people in 1993 (World Bank 1995), both urban and rural dwellers, across an immense region of the continent. The opportunities and constraints that result from uneven development influence in turn, the kinds of *livelihood strategies* that are possible for individuals as they pursue the resources they need for their well-being (Painter 1985, 1987; Painter *et al.* 1994; Berry 1989).

By virtue of the multiple linkages that humans have produced and reproduced through their enterprises over time and across geographic space, they have created a coherent regional entity that may be accurately described as a *regional economy* or a *regional action space* (Painter 1985; 1987; Painter *et al.* 1994). This regional economy includes the societies and economies of a dozen countries [1] in relation

[1] These countries include Senegal, The Gambia, Guinea Bissau, Guinea, Côte-d'Ivoire, Ghana, Togo, Benin, Nigeria, Mali, Burkina Faso, Niger, and to a lesser extent,

to which rural and urban household members organize their livelihoods year in and year out, elaborating distinctive livelihood strategies.

Patterns of livelihood mobility in West Africa

Historically, rural and urban dwellers in West Africa have exploited this dynamic regional action space through mobility. Livelihood mobility of West African populations has been remarkable and has been given considerable attention by social scientists, historians, economists and planners. Forms of livelihood mobility among people on the move in West Africa often involve trans-national or trans-border travel, affecting individuals many times over the course of their lifetimes and affecting households, families and communities over the course of several generations of lives and livelihoods. Another feature of this widespread mobility is its cyclical or 'seasonal' character. As seasons change during the year, so do the livelihood constraints and opportunities within the West Africa region. Seasonality thus promotes and helps sustain intra-regional mobility ... massive intra-regional mobility.

What produces such remarkable movement? Individual and collective decisions repeated many thousands of times over by West Africans to:

— seek extra-local opportunities for obtaining needed income;
— flee or mitigate constraints, be they permanent or related to seasonality, on local income-generating opportunities;
— 'manage,' that is, *spread* recurrent risks to individual / family well-being by looking for opportunities for securing multiple sources of real income, often at multiple locations and during different times of the year.

Coerced population movements have also contributed importantly to mobility in West Africa and other areas of sub-saharan Africa and deserve more attention, particularly in relation to the current and changing geography of HIV/AIDS in Africa. Notable examples of coerced displacement prior to the advent of HIV/AIDS include the

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Mauritania. While Sierra Leone and Liberia are very much a part of West Africa, their economic linkages with other countries in the region, in the form of major highway systems and flows of people and commodities, are less developed. Within this large region, several subclusters of countries can be identified in terms of significant socioeconomic linkages, as reflected in large cyclical population movements or migrations and commodity flows. Thus Senegal draws large numbers of temporary workers from nearby Guinea Bissau, The Gambia and Mali. In addition, Senegal also has important transcontinental linkages. The northern areas of Senegal are an important source of male migrants who travel for extended periods of time to cities in European countries (particularly in France, where they work as laborers in industry, but also to other cities where they are often engaged in trade) and in North America (particularly New York, where they have been actively engaged in urban petty trade and export to West Africa). Côte-d'Ivoire and Ghana historically have drawn large numbers of migrants from Mali, Burkina Faso, Niger, Benin, Togo and Guinea. Nigeria draws migrants from Togo, Benin and Niger as well as from countries such as Chad and Cameroon.

Atlantic slave trade during the pre-colonial period and the widespread practice of forced labor recruitment and displacement during the colonial period, particularly in French territories and colonies (Cordell and Gregory 1994; Cordell *et al*. 1996). Civil war and strife are major factors contributing to current forms of coerced population mobility that are associated with increased risk of infection by HIV.

The persistence of livelihood mobility on West Africa

Widespread livelihood mobility has been sustained as households throughout the West Africa region construct their livelihoods in relation to changing structures of opportunity and constraint that affect their access to resources they need for their well-being. Mobility has been a hallmark of livelihood strategies among members of West African societies for nearly a century. Some students of society and economy in West Africa have gone so far as to describe this mobility as an 'immemorial' or 'natural' feature of West African societies. While we strongly disagree with the 'timeless' image of African mobility, this is not the place to critique these interpretations (*cf* Amin 1974; Cordell *et al*. 1994; Painter 1985; 1987; 1990; 1994a). Suffice it to say that if opportunities and constraints vary significantly through space and time and if livelihood mobility is useful as a means of coping with these situational features, many members of many West African households *can and do move*.

Patterns of population movement in West Africa often consist of cyclical mobility —recurrent travel— between areas having limited and greater opportunities respectively for obtaining needed income. The most noteworthy patterns of cyclical or two-way migrations in West Africa occur *between* the land-locked Sahelian countries of Mali, Niger, Burkina Faso after the rainy season and harvests, and the coastal countries of Côte-d'Ivoire, Ghana, Togo, Benin and Nigeria (Amin 1974; Gervais 1994; Painter 1985; 1994a; Painter *et al*. 1992; Rouch 1956; 1957). Cyclical migrations also occur over shorter distances between less advantaged northern areas and more developed southern areas *within* coastal West African countries. In all cases these movements are oriented toward areas where livelihood opportunities are greater. Figure 1 [1] shows the directions and relative importance of major, largely cyclical migration flows in West Africa.

HIV/AIDS in West Africa

The first cases of AIDS were reported in West Africa in 1985. Shortly thereafter small numbers of AIDS cases were reported in other countries scattered throughout the West Africa region (Painter, forthcoming). Coastal urban and periurban areas have had higher HIV

[1] I wish to thank Jean Smith of the Visual Information Unit, Division of HIV/AIDS Prevention, CDC, for preparing the maps for the original presentation on which this paper is based. I accept full responsibility for any inaccuracies depicted therein.

seroprevalence levels and more reported cases of AIDS than the sahelian area in West Africa's interior (De Cock *et al*. 1990). While indicators point to higher HIV risk and and greater impact of AIDS in coastal urban areas, the number of AIDS cases has continued to increase in rural areas of Côte-d'Ivoire and nearby countries —Ghana, Burkina Faso and Togo (De Cock *et al*. 1989; 1990).

Figure 2 depicts the uneven impact of HIV/AIDS in West Africa. The data presented are based on the numbers of AIDS cases reported by National AIDS programs in West Africa to the Global Programme on AIDS of the World Health Organization, now UNAIDS, through the end of 1995 (WHO 1995; 1996a; 1996b). The figure shows the total number of reported AIDS cases for each country and the AIDS case rate calculated by UNAIDS as the number of known cases per 100,000 population. The UNAIDS data may be subject to some criticism and debate. For example, the number of actual AIDS cases is probably several times greater than the reported number of cases in each country; national AIDS rates do not reflect differences in seroprevalence or the impacts of AIDS related to the geographical distribution of populations that face higher risk of HIV infection.

Despite their limitations, these data are useful in showing the relative magnitude of intraregional differences in the impacts of AIDS in West Africa. These include increased morbidity and mortality, reduced life expectancy and changes in the structure of affected households, families and communities. More specifically, these translate into increasing numbers of AIDS orphans (Preble and Foumbi 1991), potential losses of generations of productive person-power and declining agricultural and off-farm production and economic productivity. Additional socioeconomic impacts of AIDS include negative effects on health services and community coping capacities and on the ability of African governments to respond to HIV/AIDS during a time when external development and investment resources are increasingly scarce.

Studies to date of the localized impacts of AIDS are very few in number and have been done in Eastern Africa (Barnett and Blaikie 1992; FAO 1995). No social science research has been done on the socio-economic impacts of AIDS in West Africa or on the coping strategies of individuals, households and communities that are affected by HIV/AIDS.

Livelihood mobility and the spread of HIV/AIDS in West Africa

A mortal threat to health is juxtaposed on a longstanding and widespread pattern of livelihood strategy

Mobility has assumed a new and problematic significance due to the juxtaposition of increasing risks of HIV/AIDS since the mid-1980s on well-established and fairly effective livelihood strategies in West Africa. Population mobility continues between areas having lower and higher opportunities within the region, but with the advent of AIDS,

destination areas having greater earning opportunities have become areas of high risk of HIV infection.

A comparison of figures 1 and 2 provides a better idea of the relationship between patterns of livelihood mobility and the geography of HIV/AIDS in West Africa (*cf* Amat-Roze *et al*. 1990; Amat-Roze 1993). The impact of AIDS, hence the risk of HIV infection, is much greater in destination areas than in the countries of origin of persons engaged in migrations and other forms of livelihood mobility in West Africa. Data on the number of reported AIDS cases and AIDS rates per 100,000 population (Figure 2), strongly suggest that the impact of AIDS in destination areas of people on the move is three to fifteen times greater than in areas of origin. Currently Côte-d'Ivoire has the highest seroprevalence levels and the largest number of declared AIDS cases in West Africa (U.S. Bureau of the Census 1995; WHO 1995). It is important to appreciate, therefore, that we are dealing not only with a national-level problem but also with multiple national-level problems as well as a larger regional problem of spreading HIV/AIDS.

While this pattern of disease spread, linked as it is to livelihood mobility, is relatively new to West Africa, it has been recorded earlier in central and eastern Africa (Hunt 1989) and in southern Africa (Jochelson *et al*. 1991) and in other parts of the world. This is particularly true of areas having markedly different levels of socio-economic development and linked through human mobility.

Social mechanisms of HIV transmission

What are the social mechanisms of HIV risk and infection? Studies indicate that high-risk sexual networking is common in the urban and periurban areas of coastal West Africa (Caldwell *et al*. 1993; Orubuloye *et al*. 1994; Painter *et al*. 1992). Studies also indicate that HIV seroprevalence and the frequency of reported AIDS cases are greater among persons in a variety of social categories that are frequently labeled 'high risk' by epidemiologists and AIDS-prevention specialists. Individuals and groups in these categories are known to frequently engage in sexual networking that places themselves and their partners at risk of HIV infection.

The issue is not simply one of identifying and targeting 'high risk' groups or categories, although we do need to know what kinds of livelihood patterns are most conducive to high risk sexual networking (Painter 1995b; Seidel 1996; Taverne 1995). In addition, we need to focus on high-risk behavior *and* the contexts (settings) in which risky sexual networking typically occurs. We also need to recognize that this risky sexual networking is directly linked to the processes and contexts of mobility that have become necessary for livelihoods in West Africa.

Examples of livelihood patterns that are often combined with mobility and high-risk sexual networking include prostitution (commercial sex work) and also a multitude of more casual encounters where women, particularly younger women and girls, engage in sexual contacts in exchange for some form of material or monetary gesture

Livelihood mobility and AIDS prevention in West Africa 651

Figure 1 : Major Migration Flows in West Africa

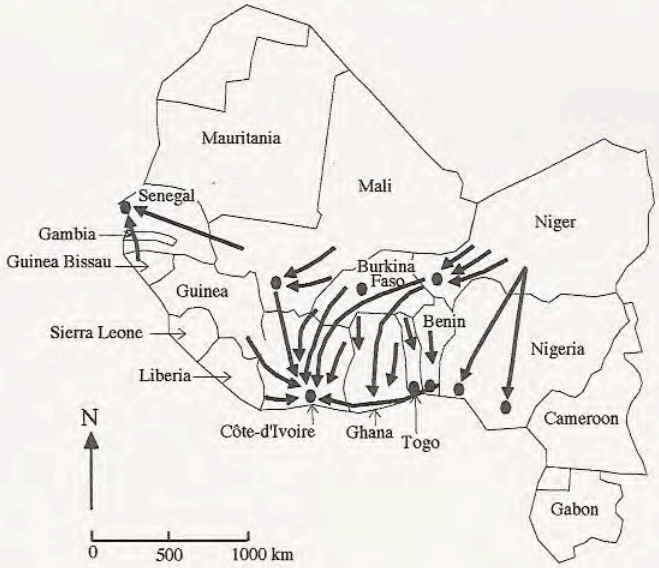
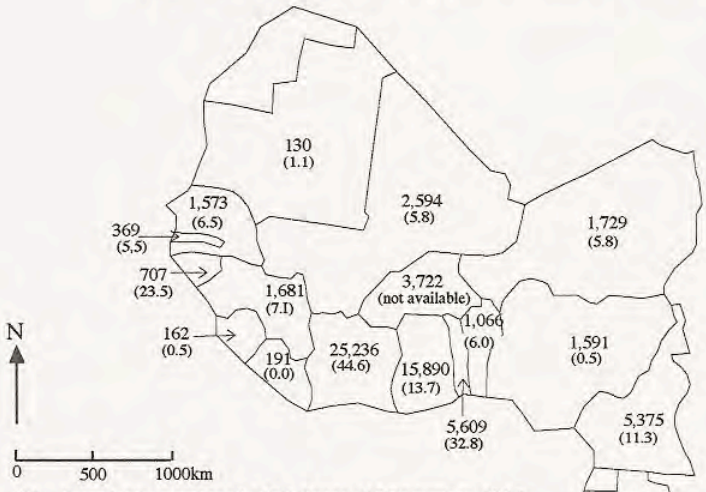


Figure 2 : AIDS Cases in West African Countries



130 = Cumulative number of AIDS Cases (15 December, 1995)
(1.1) = Rate of Number of AIDS Cases for 100,000 population (1994)

Source : WHO / GPA. AIDS Cases Reported to WHO by Country / Area through 15 December, 1995
The Current Global Situation of the HIV / AIDS Pandemic, Geneva. 15 December, 1995

from their sexual partners. Other examples include working as waiters, barmaids and waitresses; driving trucks and buses over long-distances, often internationally; and ambulant petty trading, involving sales of everything from drinking water in plastic bags to fruit, cola nuts and cooked food to clothing and electrical gadgets. Finally, migrating is included here insofar as it is linked to income-generating activities and social conditions that are conducive to high-risk sexual networking.

The changing geography of HIV/AIDS in West Africa

A review of data from annual reports by WHO/GPA and UNAIDS for the years prior to and including 1995 (WHO 1995, 1996a, 1996b) suggests that:

— The marked differences between lower seroprevalence levels in Sahelian countries and higher seroprevalence levels in coastal/urban areas of West Africa are gradually decreasing as time passes. For example, AIDS rates in Mali and Niger continue to increase, albeit slowly, when compared with higher rates in Ghana or Côte-d'Ivoire. In other words, differential seroprevalence levels, unlike the diverging trends we observe in socio-economic development in West Africa, seem gradually to be converging. This is due to intra-regional spread of HIV and the dynamics of HIV transmission within individual countries and communities.

— The overall HIV/AIDS 'numbers' are increasing throughout the region. The West Africa region as a whole is increasingly affected by HIV/AIDS.

What more can be said about the social categories that are associated with high risk sexual networking, particularly in higher HIV seroprevalence areas of West Africa? Certainly there is considerable diversity, but these categories include:

• Individuals who are more or less long-term residents (its all quite relative, in fact) of coastal destination areas of West Africa (Togo, Ghana and Côte-d'Ivoire) where the risks of HIV infection are considerably greater.

• Individuals who are not longer-term residents and who travel periodically between lower opportunity/lower HIV risk hinterland areas of West Africa and coastal urban and periurban areas where the opportunities for earning needed income *and* for becoming infected with HIV are greater. Typically, these persons are from:

* less advantaged Sahelian countries to the north of the West African coastal zone (as we see in the instances of long-distance truckers, commercial sex workers and migrant laborers and traders from Mali, Niger and Burkina Faso) or

* less advantaged northern areas of the coastal countries themselves, *eg* northern Côte-d'Ivoire, Ghana, Togo.

Typically these individuals are men, often married, who spend 3-9 months each year in coastal areas having higher risks of HIV infection (CERPOD 1991; Painter 1987). They spend this time unaccompanied by female partners from their home communities and frequently engage in unprotected sexual networking in their destination areas. As

a result, increasing numbers of these men are returning home with HIV infections. Once home, some men infect their spouses and other sexual partners, contributing thereby both to heterosexual HIV transmission and to eventual mother-to-child HIV transmission.

• Individuals who are not necessarily permanent residents of higher HIV/AIDS risk coastal destination areas, who originate from nearby countries. Examples include women from southeastern Ghana who have long accounted for most of the commercial sex workers in Abidjan, and have thus played an important role in sexual networking, in being infected with HIV and in infecting their sexual partners with HIV in turn (Anarfi 1990; 1993). What is perhaps less well-known about these women from Ghana, who have been blamed in the past as a major source of HIV infection in southern Côte-d'Ivoire, is the extent to which they have been affected by HIV/AIDS themselves. Increasing numbers of these women have been returning to their home communities in Ghana, sick and dying of AIDS (Anarfi 1990). Of particular interest and concern in this regard are recent observations that younger women from Côte-d'Ivoire are moving in to fill the gap left by departing and dying women from Ghana.

A new and deadly dimension has been added to the widespread practice of intra-regional livelihood mobility in West Africa

• Cyclical ('seasonal') migrations involving hundreds of thousands of men (and, therefore, hundreds of thousands of household members in their home communities) and increasing numbers of women (David 1995) occur every year in West Africa.

• This widespread mobility occurs between lower opportunity/lower HIV-risk areas and greater opportunity/higher HIV-risk coastal urban and periurban areas of West Africa.

• Combined with high levels of sexual networking in high HIV risk destination areas, widespread livelihood mobility has become a significant contributing factor to the spread of HIV/AIDS between coastal and interior areas of West Africa (Amat-Roze 1993; Amat-Roze *et al*. 1990; Lalou and Piché 1994; Painter 1995a; Painter *et al*. 1992; Pison *et al*. 1993; Kim Vanden Hengel, SIM Projet SIDA/AIDS Project, Niger, personal communication; World Bank 1994a; 1994b; Yéo-Ouattara and Sawadogo 1994; Hunt 1989).

For social scientists who are concerned with the spread of HIV/AIDS, the challenges and opportunities created by this situation are multiple and significant.

Challenges and opportunities for social scientists in relation to livelihood mobility and the spread of HIV/AIDS in West Africa

Ensuring that the right messages are delivered effectively to appropriate persons, groups and communities

A great deal of HIV/AIDS prevention communication has been generated in West Africa following the creation of national AIDS

programs in the mid-1980s. These HIV/AIDS prevention communications have been disseminated in three major ways: electronic media, printed media, and direct and interactive approaches.

Electronic media (radio and to a lesser degree, TV) are widely used. While fairly affective in terms of increasing public awareness about AIDS, this approach suffers from several limitations:

— Access to the electronic media, particularly TV, is limited outside urban and periurban areas.

— The impact of national-level programs using post-colonial 'administrative' languages such as English or French is limited due to poor understanding among persons who never mastered these languages. Worse still, persons coming from a different post-colonial background (e.g., Anglophone Ghanaians in Francophone Côte-d'Ivoire) may be largely excluded from access to media-based information of this kind.

— The impact can be even more limited when 'maternal' or national ethnic languages are used for these communications in a particular country, excluding foreigners from the benefits of HIV/AIDS prevention mesages (Painter *et al.* 1992; Painter 1994b).

— The one-way flow of information provided by the electronic media limits their impact by precluding the possibility of dialogue and clarification, both of which are needed and desired by recipients of HIV/AIDS communications. The persistence of widespread erroneous understandings about how HIV infection occurs and can be prevented is particularly striking, given the considerable investments that have been made to date in HIV/AIDS communications in Western and sub-Saharan Africa (Cohen and Trussel 1996; Painter *et al.* 1992; Rosensvard and Campbell 1996).

Printed media such as newspapers, magazines, brochures, posters, billboards, are also used for HIV/AIDS prevention communications. The effectiveness of printed media is constrained due to widespread illiteracy, particularly among poorer segments of mobile populations, effectively excluding large numbers of people from printed information (Painter *et al.* 1992; World Bank 1994b). Low literacy levels affect persons in urban as well as rural areas.

Some HIV/AIDS communications strategies involve *direct and interactive approaches* for disseminating information. We find examples in some social marketing campaigns. In many cases messages are undifferentiated in terms of the life situations or the particular concerns of would-be target populations.

Messages may be tailored to particular audiences, however, and disseminated by individuals ('peer educators') recruited from the target audience population who are specially trained to deliver HIV/AIDS prevention messages to their peers.[1] The following target

[1] In West Africa, Population Services International (PSI) has been particularly innovative in its approach to communications strategies for social marketing campaigns. In Burkina Faso, PSI has initiated several interventions that work through long-established community-based organizational forms. In Côte-d'Ivoire PSI has produced a televised film series *Sida dans la cité* which has become extremely popular in Côte-

groups in sub-saharan Africa have benefited from HIV/AIDS prevention messages delivered by peer educators: taxi, truck and bus drivers; migrants (of various kinds); commercial sex workers; bar and hotel staff; sorghum beer brewers; religious leaders; traditional medical practitioners; soccer players; military personnel.

Despite the accomplishments of HIV/AIDS communications in increasing AIDS awareness, there is a pressing need to improve AIDS prevention messages in terms of form, content and targeting. A large part of the challenge consists of ensuring prevention messages are adapted to the socioeconomic and cultural contexts, the concerns and priorities of message recipients. Typically, however, insufficient attention is given to these issues in the preparation and dissemination of HIV/AIDS prevention messages (Cohen and Trussel 1996).

Better communications strategies are needed to effectively reach persons and groups that engage in and provide collective (normative) support for high-risk sexual networking among people on the move in Africa. HIV/AIDS prevention messages must also create opportunities for dialogue and questions involving deliverers and recipients of messages.

In summary, social science has an important opportunity to help ensure that the content and form of HIV/AIDS prevention communications fit with the everyday realities, concerns and contexts of target groups, particularly those involved in mobile livelihood strategies and who are also prone to participation in high-risk sexual networking. Finally, it is important to realize that target groups have their own stories to tell. Once again, social scientists have an important role to play in ensuring that these voices are heard and integrated as appropriate within HIV/AIDS communications.

Building stronger linkages between research and action

General considerations

The link between social science research and HIV/AIDS prevention actions in sub-saharan Africa needs to be strengthened. This is particularly true for interventions designed for persons and groups that practice mobile livelihoods. The linkage between social science research and HIV/AIDS prevention actions must ensure a two-way, not simply a one-way flow of information. While prevention actions need to be informed by pertinent social science perspectives and knowledge, research needs to be informed by action and action-based learning. In other words, HIV/AIDS prevention actions must generate as well as apply relevant social science knowledge and concepts.

Occasionally we hear terms such as 'action research' being used in connection with the elaboration and implementation of AIDS-prevention programs in West Africa but not often enough (CCIP 1995; World Bank 1994a; 1994b; Schoepf 1993; 1995; Painter 1994b;

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d'Ivoire and in nearby francophone countries. The film series captures very nicely the dynamics of sexual networking and everyday life within couples that lead to opportunities for high-risk or safe sex contacts.

Painter *et al*. 1992). Approaches are urgently needed where selected information is obtained on specific issues and problems and where there is a strong and rapid *feedback link* to prevention interventions. A stronger link between information gathering and action in the form of *pilot initiatives* is also needed.

The complex and changing socio-economic contexts where people carry out their mobile livelihood strategies including sexual networking require approaches to data collection and analysis that are more flexible and process-oriented than the cross-sectional survey approaches that have been widely used for social-behavioral issues related to HIV risk and spread (Painter 1994b; Painter *et al*. 1992).

Innovative HIV/AIDS prevention initiatives with people on the move

Despite the importance of livelihood mobility to life throughout West Africa and an increasing recognition of a linkage between livelihood mobility and the spread of HIV/AIDS, the number and scope of HIV/AIDS prevention interventions for people on the move have been limited. National and regional-level responses to these challenges and opportunities for HIV/AIDS prevention have developed very slowly.

In the meantime, non-governmental organizations (NGOs) have stepped in to help fill the gap. Of interest are several projects undertaken by CARE-International in conjunction with national AIDS programs in West Africa. This NGO was among the first to develop approaches for working with mobile populations. The AIDS and migration project, implemented by CARE in Niger, is the only intervention to date that targets people on the move (male migrants) in more than one country. It includes prevention activities in the migrant's home communities in Niger, at points of departure and border areas, and in the migrant's destination areas in Abidjan, Côte-d'Ivoire (CARE International/Niger 1995; Painter 1994b; Painter *et al*. 1992; Purves 1994).

The CARE International project offers valuable lessons concerning the strengths and weaknesses of 'trans-border' AIDS prevention interventions. Strengths include a range of innovative approaches to contacting and working with migrants, including peer education and audio and video techniques. Weaknesses include a lack of follow-up of migrants in their destination areas where the men are commonly involved in high-risk sexual networking. Ensuring high quality follow-up at multiple sites, particularly in distant destination areas, is a major challenge to all HIV/AIDS interventions with people on the move in sub-Saharan Africa.

In addition to the project in Niger and Côte-d'Ivoire, CARE International is implementing AIDS prevention projects with people on the move in Cameroon (initially youth; now long-distance truckers), Ghana (commercial sex workers and laborers in gold mines) and Togo (taxi drivers, truckers and commercial sex workers) (Purves 1994).

Burkina Faso provides a final example of an NGO country-level intervention in West Africa. The 'Union des Routiers Burkinabè de

Lutte contre le SIDA' (URBLS) and the 'Association Française des Volontaires du Progrès' (AFVP) have supported peer education activities for several years among long-distance truckers who ply the international highway between Burkina Faso and Côte-d'Ivoire (AFVP 1995; Naigeon and Pourrat 1994; URBLS 1995). Following an interruption of activities during 1995/96, the project has started again, this time as part of a trans-border component of a regional health project for Western and Central Africa funded by USAID.

It is critical that lessons be learned from experiences and evaluations of HIV/AIDS initiatives such as these. Social scientists have a potentially important role to play in facilitating the assessment and analysis of these experiences and ensuring that lessons learned are disseminated in a form that is easily accessible to program staff and donor agencies.

Adding a new dimension? Recent efforts to introduce a regional approach to HIV/AIDS interventions in West Africa

A recent UNAIDS/World Bank sponsored initiative, the 'West Africa HIV/AIDS Initiative,' is another promising approach to HIV/AIDS prevention. This regional initiative endeavors to work with individuals and groups that practice mobile livelihoods (migrants and commercial sex workers). The approach focuses on social settings near major commercial and crossroads areas along international highways where people on the move carry out their livelihoods and engage in high-risk sexual networking. The initiative also aims to strengthen the links between problem-focused social science research and HIV/AIDS prevention actions.

Country-based teams trained in action research will implement HIV/AIDS prevention activities at selected crossroads sites along highways that link Senegal, Mali, Guinea, Niger and Burkina Faso with Abidjan, Côte-d'Ivoire. Recall that Abidjan is *(a)* a major West African terminus for people on the move, *(b)* the area of highest HIV infection risk in the West Africa region and *(c)* provides numerous settings for sexual networking that places people on the move and their sexual partners at risk of HIV infection (CCIP 1995; Painter and Bagassa 1995; Schoepf 1995; World Bank 1994b; 1996).

The innovative feature of this initiative consists of its aim to introduce a regional dimension to HIV/AIDS organizational and action capacity in West Africa by linking and coordinating several country-based activities in relation to the same target groups and similar settings of sexual networking and HIV risk. Despite the real need for a regional intervention, implementation of the West Africa HIV/AIDS initiative has been slow. Delays appear to be the result of the slow pace at which existing organizational structures can adapt or new structures be developed to implement a novel intervention strategy.

This is an important initiative worthy of support and careful assessment as it implements prevention activities. It deserves particular attention to ensure that, perhaps for the first time in the West Africa region, the potential for developing pertinent social science input is integrated from the very beginning of prevention interventions. Of

additional interest is the initiative's potential for maintaining a strong link between research and action throughout the life of the program.

In summary, social scientists have an important opportunity to assist with:

• generating pertinent knowledge relative to HIV-risk and risk management among persons and groups involved in mobile livelihood strategies in West Africa;
• ensuring that this knowledge is accessible to non-social scientists who work in HIV/AIDS prevention and, insofar as feasible, is translated into action either in the form of policy or concrete interventions;
• encouraging, cajoling or doing whatever else is needed to ensure that commitments by NGOs, national, bilateral and multilateral organizations for support of innovative AIDS prevention interventions are maintained and that important actions such as those we have described here move ahead, learn from their own practice (and the practice of others), and are able to improve the quality of interventions on the basis of practice.

Identifying existing community-based organizations for mutual assistance among groups involved in livelihood mobility for their potential contribution to HIV/AIDS prevention

Local organizational forms that embody a concern for the well-being of community members are as ubiquitous in Western and other areas of sub-saharan Africa as they are poorly understood. These community-based organizations among persons with mobile livelihoods may lend themselves as locally accepted, legitimized local structures for the incorporation of AIDS-related actions. These could range from dissemination of prevention information to follow-up and support of prevention efforts, to assistance with community-based care and social reintegration of persons living with HIV/AIDS within their home communities.

Examples of these local organizations were identified by a 1992 study of migrants from Mali and Niger in Abidjan, Côte-d'Ivoire (Painter *et al*. 1992). The description of these community-based organizations echoed earlier reports by observers of social organization among communities of migrants living and working far from their home communities in West Africa (Painter 1985; Rouch 1956; 1957; Schildkrout 1978). To date, however, national and international organizations involved in HIV/AIDS prevention efforts in West Africa appear not to have explored the potential for incorporating these local social structures in HIV/AIDS actions among migrants and their sexual partners.

In summary, social scientists have an opportunity to contribute to the elaboration of sustainable HIV/AIDS prevention and support actions by:

— identifying existing community-based (sometimes termed 'traditional') forms of organization for mutual assistance among persons on the move;

— assessing and initiating pilot activities for incorporating these organizations in AIDS-prevention actions (information dissemination, support and follow-up; even training);

— playing a more proactive role in calling the attention of HIV/AIDS prevention initiatives with people on the move to opportunities of this kind, and badgering them if need be to ensure that appropriate actions are taken.

Considering possibilities for modifying contexts of high-risk sexual networking by persons engaged in livelihood mobility

The final challenge and opportunity for social scientists appears to be so formidable that it is rarely mentioned within the context of HIV/AIDS prevention initiatives among people on the move. This entails the engagement of social scientists in efforts to modify the structures of opportunity and constraint that contribute in important ways to widespread livelihood mobility in West Africa, to high-HIV risk sexual networking in destination areas, and to the spread of HIV/AIDS. Greater attention needs to be given to the possibilities for modifying socioeconomic factors which reinforce high-risk sexual comportment. These factors shape the situations within which large numbers of people in West Africa organize their livelihoods and deal with risks of HIV infection (Lurie *et al*. 1995; Tawil *et al*. 1995; *cf*. Painter 1994b; Painter *et al*. 1992).

What should be done?

Social scientists need to give attention to issues having salience of a broader structural nature in addition to issues that are relevant for specific situations or levels such as individual/small group/community-level structures, contexts and processes. It is necessary to deal with multiple 'levels' in description, analysis, translation of research into action and finally, in prevention efforts. Focusing attention on the possibilities for changing individual behavior without an equally serious effort to focus on, and possibly modify the socio-economic settings of choices and decision-making, including decisions relative to HIV risk management in everyday life, is a luxury that we cannot afford.

If we are to believe the results of the many knowledge, attitudes, beliefs and practice (KABP) surveys that are published and presented at international AIDS conferences, there are too many people in sub-Saharan Africa who are aware of AIDS but who continue to engage in high risk sexual networking. This persistent and dangerous gap between awareness, attitudes, knowledge and human action is very probably sustained by contextual factors that influence individual actions. We need to address these issues. This will require greater commitment by the international community to identifying opportunities for modifying contextual or structural features that are linked —often causally— to high risk sexual networking and the spread of HIV/AIDS.

What is to be done if we cannot change these socioeconomic structures? The challenge here is for social scientists to identify and propose options that will potentially assist individuals and groups in identifying and practicing livelihood strategies that are less vulnerable to the deadly risks of infection by HIV.

In summary, social scientists have an opportunity to critically examine and explicate the relationships between mobile livelihood strategies, high-risk sexual networking and the socio-economic contexts in which these occur in West Africa. Furthermore, social scientists need to engage themselves at the level of structural modification and transformation of these contexts and processes on the basis of their analysis, their critical reflections and through contributions to policy development. If, finally, structural transformation does not appear to be a feasible option, social scientists then need to assist with the identification of strategies for better equipping people on the move and their sexual partners to pursue their livelihoods without placing their lives at risk due to HIV infection.

From analysis to action

The aim of this paper has been to identify areas where challenges and opportunities exist for social scientists to become more engaged with efforts to slow the spread of HIV/AIDS in relation to livelihood mobility in West Africa and sub-Saharan Africa more generally. For each challenge and opportunity presented, there is a need for social scientists to produce sound scientific knowledge but also to move beyond the production of social science knowledge. Stronger linkages are needed between social science research and HIV/AIDS prevention actions. Finally, social scientists need to examine the possibilities for modifying or transforming existing conditions that are conducive to high-risk sexual networking and the spread of HIV/AIDS, linked as these are to widespread livelihood mobility in sub-saharan Africa.

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Thomas M. PAINTER, *Livelihood mobility and AIDS prevention in West Africa. Challenges and opportunities for social scientists*

Summary — This paper reviews patterns and causes of widespread livelihood mobility in West Africa, describes the relationship between livelihood mobility and the spread of HIV/AIDS, and identifies several areas where social scientists can —and should— play an active role in current efforts to slow the spread of HIV/AIDS in relation to livelihood mobility. While social scientists have been involved in HIV/AIDS prevention in West Africa and other areas of sub-saharan Africa, the challenges and opportunities are such that social scientists must increase their levels of engagement and contribution. We make several recommendations concerning opportunities for social scientists to contribute to HIV/AIDS prevention in relation to widespread livelihood mobility in sub-saharan Africa.

Keywords: HIV/AIDS prevention • livelihood mobility • migrations • socio-economic development • West Africa.

Thomas M. PAINTER, *Déplacement des populations et prévention du sida en Afrique de l'ouest. Défis et opportunités pour les sciences sociales*

Résumé — Cette étude examine les modèles et les causes des intenses mobilités migratoires développées partout en Afrique de l'ouest et décrit la relation entre cette mobilité et la propagation du VIH/sida. Elle identifie différents domaines où les sciences sociales peuvent et doivent jouer un rôle actif dans les efforts actuels en vue de ralentir la propagation du VIH/sida liée aux mobilités migratoires. Pendant que les sciences sociales s'impliquent dans la prévention du VIH/sida en Afrique de l'ouest et dans d'autres zones de l'Afrique subsaharienne, les défis et les opportunités sont tels que les chercheurs en sciences sociales doivent augmenter leur niveau d'engagement et de contribution. En conclusion, plusieurs recommandations sont faites à propos des opportunités offertes aux sciences sociales pour contribuer à la prévention du VIH/sida en liaison avec les fortes mobilités migratoires en Afrique subsaharienne.

Mots-clés : prévention du VIH/sida • déplacement des populations • migrations • développement socio-économique • Afrique de l'ouest.