

77665

**NATIONAL RESEARCH COUNCIL
COMMISSION ON BEHAVIORAL AND SOCIAL SCIENCES AND EDUCATION
COMMITTEE ON POPULATION**

**EXPERT MEETING ON FAMILY AND DEVELOPMENT
Washington, July 16-17, 1992**

**AFRICAN FAMILIES AND AIDS
Context, Reactions and Potential Interventions**

**John Caldwell and Pat Caldwell
Health Transition Centre, The Australian National University,
Canberra**

with

**E. Maxine Ankrah, Makerere University, Kampala, Uganda
John K. Anarfi, University of Ghana, Legon, Accra, Ghana
Dominic K. Argyeman and Kofi Awusabo-Asare, University of Cape Coast, Cape Coast, Ghana
I.O. Orubuloye, Ondo State University, Ado-Ekiti, Nigeria**

AFRICAN FAMILIES AND AIDS

Context, Reactions and Potential Interventions

John Caldwell and Pat Caldwell

with

E. Maxine Ankrah, John K. Anarfi, Dominic K. Argyeman, Kofi Awusabo-Asare and I.O. Orubuloye

The African AIDS epidemic may well be regarded in retrospect as the major event of our time. Almost two-thirds of all HIV-positive persons in the world are in sub-Saharan Africa, the home of only 9 percent of the world's population. Indeed, most African AIDS sufferers are found in a range of countries from Uganda southward which contain no more than 3 percent of the world's population. Sub-Saharan Africa may well lose as many people to AIDS over the next half century as the Black Death killed in fourteenth century Europe, although without resulting in the population decline that characterized the earlier epidemic.

The African AIDS epidemic differs from that of industrialized countries in that it is very largely heterosexually transmitted. Thus there are at least as many female as male victims in Africa. It is likely that five-sixths of all seropositive females and of all seropositive children in the world are to be found south of the Sahara. The African epidemic is thus very much a family matter and has a major impact on all parts of society.

In spite of the challenge presented by African AIDS and the need for knowledge about its impact on societies and families, the work is difficult and often forbidding. The knowledge that has so far guided us originates with a small number of researchers who have examined a limited number of cases. For instance, this report relies heavily on the following studies. The Makerere University/Case Western Reserve research program has reported on one visit each to 22 urban families and 24 rural ones in Uganda where at least one person was suffering from AIDS (McGrath et al. n.d.,a,b; Ankrah et al. 1992). The first of the two projects reported from Ghana involve 30 AIDS cases (Anarfi 1992a) and the second 38 households with at least one AIDS case (Anarfi 1992b). Hunter's (1990) report on orphans was based on the Resistance Council's enumerations of orphans together with a visit to a village of approximately 60 households, although the field experience in re-enumerating a sample of the RCs undoubtedly added familiarity with the problem. The recently published book by Barnett and Blaikie (1992: 91,100) does not clearly define their field study but the reports on Rakai, Uganda, supplies data on the structure of 69 households, of which 14 were AIDS-afflicted, and on the farming production of 129 households of which eight were AIDS-afflicted and another eight affected by persons elsewhere having developed AIDS. The numbers in the Ekiti research are usually higher (Orubuloye, J. Caldwell and P. Caldwell 1991a,b; 1992 Orubuloye, P. Caldwell and J. Caldwell 1992a), but the research focus is on sexual activity rather than on

AIDS victims and the numbers fall to 49 when studying women's reactions to husbands infected with STDs (Orubuloye, P. Caldwell and J. Caldwell 1992b).

Aspects of the African family which are relevant to the epidemic

A full understanding of the conditions which allowed the spread of the disease and the nature of the society in which interventions will have to be carried out requires a statement of some of its most basic social and demographic characteristics and of their relevance. Most of these characteristics are interrelated and were determined by the nature of shifting cultivation carried out on community-owned land.

In terms of assistance and decision-making and to a large extent residence, the nuclear family has not been important. The significant units have been larger groups of relatives, often taking the form of descent lineages. Accordingly, fertility has been highly prized, and children have been readily fostered by grandparents, uncles, aunts and further with no feeling that this was not their natural location. Probably because there was no preoccupation with the inheritance of freehold land, the control of female sexuality before marriage, and to a lesser extent after marriage, did not become a central tenet of morality as it did in the Middle East, South Asia and North Africa (Caldwell, Caldwell and Quiggin 1989). The control of female sexuality was more akin to the control of property, and might be accompanied with violence. As a result there was no great condemnation of transactional sex by women outside marriage. Indeed, if the AIDS epidemic puts a stop to most nonmarital sexual relations, then there will be a relative decline in the economic condition of many women and a need for alternative sources of sustenance or income.

Partly because farming and economic strength depended solely on the size of the workforce, sub-Saharan Africa was, and still is, characterized by uniquely high levels of polygyny. This in turn determines many aspects of the family and society. With regard to males, it makes it inevitable that it should be widely believed that men, irrespective of their actual marital status, cannot be satisfied by one woman. Polygyny at levels where 40-50 percent of currently married women are at any time in polygynous marriages, such as is still the situation in much of West and Middle Africa, can exist only if men marry for the first time almost ten years later than women. In much of West Africa, western Middle Africa, Southern Africa, Kenya and eastern Tanzania men do not marry until their late twenties (Lesthaeghe 1989: 272-273) which, given the present age structures, means that half of all postpubertal males have never married. Another characteristic of much of sub-Saharan Africa is a prohibition on female sexual activity not only during pregnancy but for long periods after birth. Except in parts of contemporary East Africa and in the minority matrilineal areas, post-partum sexual abstinence still exceeds one year almost everywhere and is frequently as high as two years or more.

The traditional African system meant that large numbers of men had no sexual access to a wife at any given time. In the Nigerian city of Ibadan in 1973 half of all married men and three-quarters of all men

had no such access (Caldwell and Caldwell 1977). This situation existed in societies that usually regarded postpubertal male continence as unnatural and even unhealthy. A major, but little discussed, African problem has always been the absorption of this male sexuality which is surplus to what can be accommodated within marriage. The age-old solution was the absorption of much of it within the extended family, together with sexual relations associated with meeting the needs for support of widows, deserted wives and some polygynously married women receiving little assistance from older husbands (Caldwell, Orubuloye and Caldwell 1991). The system was effective but fragile, and could not withstand the changes brought by colonization. The missionaries branded sex within the larger family as incestuous, and women were protected from coercive control by the courts. Men forcibly moved from their families for compulsory labor elsewhere or attracted by new job opportunities sought new sexual relations, and, in addition, no longer controlled the sexual activities of their daughters or wives back home. The fragility of the situation when faced by such changes is best demonstrated by the experiences of the Congo Free State and the French Congo in the late nineteenth and early twentieth centuries when STDs spread rapidly giving rise to high levels of infertility which have still not completely disappeared (Caldwell and Caldwell 1983).

The polygynous system necessarily has characteristics which must be taken into account when dealing with AIDS. In a society where 30–50 per cent of married women are currently in polygynous marriages, a higher proportion still will be polygynously married in the course of a lifetime, and nearly all wives must be emotionally and economically adjusted to the possibility of finding themselves in a polygynous marriage at any time. Spousal emotional links are often weak. Women are not supposed to concern themselves with, or know about, their husbands' sexual activities outside marriage. There is little discussion of sex between spouses – as family planning researchers discovered – and little between the generations. These are very important facts in an AIDS epidemic. Most African women know that the greatest danger presented to them comes from their husbands, and probably the majority of female AIDS victims have been infected by their husbands. Yet wives are not supposed to talk to their husbands as if they assumed that they were engaged in extramarital sexual relations, or imply this by demanding the use of condoms within marriage.

In most of West Africa and in substantial parts of the rest of the region there is considerable marital instability. Even where women are not divorced, husbands may not be around a great deal, especially as the women grow older. Particularly in urban areas, children may be largely brought up by mothers, grandmothers and aunts. In a study of part of Kampala, Southall (1961) found that about 23 percent of households were female-headed, and this situation is probably typical of most larger urban areas. In this situation, adolescent children, especially girls, seek affection elsewhere. Women do not easily refuse the advances of men, and most teenage girls do not long hold out against their boyfriends' demands for sex in order to demonstrate their affection. The situation is aggravated further when children are away from home in schools. Indeed, the social-scientific study of teenage pregnancies, and the resultant disruption of education, has become a major research agenda in Kenya and elsewhere; although it might be noted that it is far from certain that pregnancy is unusually high among school girls and it is likely that it is

merely more distressing. Probably most school girl relations are with school boys (Orubuloye, J. Caldwell and P. Caldwell 1992), but some girls acquire their fees or new clothes by relations with older men. There is evidence that some older men are turning increasingly toward younger women in the hope that they are less likely to be seropositive.

Not all these forces exert themselves with equal intensity across the continent. Levels of polygyny are now around 30 percent in much of East Africa and lower still in Southern Africa. However, this has not resulted in a lowering of male age at first marriage. The lowest ages at male first marriage are found in Eastern Zaire, Rwanda, Burundi and Angola, and are difficult to relate to polygyny, and are certainly not related to a low risk of AIDS. Nor does the scattered evidence on numbers of sexual partners or nonmarital sexual activity suggest any variations across the continent sufficient to explain the incidence of the AIDS epidemic. A more likely explanation lies in the pattern of urbanization. Larson (1989), Anderson et al. (1991) and Orubuloye et al. (1992) have identified one risk in East and Southern Africa being the high sex ratios in the urban areas. The substantial surplus of males means that many seek commercial sex with women who have large numbers of different partners and hence they and the towns serve as foci from which the disease can spread. Certainly HIV levels are higher in the towns. The two West African cities with high sex ratios are Abidjan and Dakar, which, probably not coincidentally, are the two urban areas with high HIV levels. The explanation for near-parity between the sexes in most West African urban areas is the fact that West African women are traders and find jobs in the towns as readily as men do. In Eastern and Southern Africa women are regarded as being mainly farmers and hence look after the farm while their husbands or boyfriends migrate to the town. Admittedly, some can find employment in the towns in beer selling or commercial sex, both usually illegal, often interrelated, and sexually dangerous. The same situation is found in the mining areas of Southern Africa. The unbalanced sex ratios in the urban and mining areas have been ascribed to colonial regulation, and this was once partly true, but the fact that they exist even in unregulated areas suggests more basic social causation and implies that they can only be overcome by changes in cultural attitudes and by the creation of urban jobs for women. The situation is aggravated in East and Southern Africa by a system whereby men normally control the whole of the family budget, in contrast to the situation in West Africa where women generally retain their earnings although it is true that in consequence they bear most of the responsibility for the support of themselves and their children. The East and Southern African urban and mining system has been described as the colonial labor migration system (Bassett and Mhloyi 1991; Hunt 1989), but the social forces extend beyond this, for Rakai in southwest Uganda has been no more subject to a labor migration system than has Ekiti in Nigeria, even though the former sends mostly males to Kampala while the latter sends both sexes to Lagos. The high sex ratios in Abidjan and Dakar are explained by the fact that they alone among the West African coastal cities receive most of their migrants from the West African savanna where women farm but do not travel great distances to trade. This cannot even be described as a Muslim pattern because those areas of Burkina Faso where traditional religions predominate still export only men to the distant urban areas.

Finally, it might be noted that most of traditional sub-Saharan Africa regards sexual activity as pleasurable and good for the health. It gives strength in contrast to the Indian belief that it weakens. Respondents in Ekiti had to be reassured that the research program was not part of a deliberate church and government attempt to attack sexuality. It is difficult to see how anti-AIDS programs can be regarded in any other light.

The epidemic and society

The battle against AIDS is rendered difficult because of the long latency period of AIDS and because its symptoms are really a mixture of other complaints. Those who know little about the disease believe that the apparent healthiness of themselves and their partners shows that there is no danger. Those who have been taught about the latency period often decide that they may well already have the disease and that there is no point in either being tested or changing their sexual behavior. Families and even hospitals may discuss the sickness merely in terms of the opportunistic diseases rather than as manifestations of AIDS.

Indeed, unlike STDs with their public symptoms, AIDS can in no way be related by the general public to sexual behavior. The shame at having been attacked by this most terrible of sexual diseases, which is found throughout the interviews with AIDS patients and their families, is a taught relationship, proof that the campaigns against AIDS are getting their message across. The shame and silence surrounding AIDS is probably largely, but not wholly, attributable to this message. Traditional society believed that nonmarital sex should be surreptitious and that public revelation or being caught out often resulted in punishing illnesses and other disasters. Nevertheless, most shame and guilt now appears to be associated with Christian and Islamic teachings.

It is likely that the vulnerability of Africa to the AIDS epidemic will be shown to rest upon high levels of STD infection among the population. Africans probably have no more sexual partners than some sections of industrialized societies but the latter are protected because higher levels of health services mean that STDs are continually being cleared up and that there are not long periods of ulcerating disease. Because STDs persist in Africa they serve not only as carriers for HIV infection but as foci of infection for maintaining the high levels of STDs themselves. Admittedly, in one sense, the message was the same, namely that fewer sexual partners will reduce the risk of STDs as well as AIDS. But it also allows a direct attack on STDs through massive investment in health services with a major component for detecting and curing STDs. This will have to be accompanied by a direct educational program on STDs as well as AIDS. In Nigeria, and elsewhere, males often regard gonorrhoea as a sign of maturity or of a full sexual life, while females frequently regard it as just another vaginal infection or discharge. Because husbands and wives do not normally sleep together or dress and undress together, because marital sex almost always occurs in the dark and often at least partly clad, and because spouses are little aware of each others' urination, married partners usually do not know that the other is infected. In Nigeria, the most frequent method of learning of the partner's infection is that one partner tells the other as a result of

a doctor insisting that treatment will not be worthwhile unless both partners are cured at the same time (Orubuloye et al. 1992b). The AIDS epidemic is unusual in that its chief targets are not the old and the weak. Instead, it attacks the most sexually active or the spouses of the most sexually active. This means a disproportionate number of deaths among those of prime age who were largely responsible for caring for both the very young and the very old. So far, most attention has been focussed on young orphans and the load imposed on grandparents in caring for them. Nevertheless, there will undoubtedly be problems also as to who cares for the very old. Admittedly, if the disease begins to stabilize, then, after a number of years, so will the ratio of those in prime years to the old. But, at present, that stabilization has not yet occurred, and, there will continue to be many families in trouble no matter what the ratios are for the total population.

One of the saddest aspects of the African AIDS epidemic is that it has occurred just as structural adjustment and cost recovery programs are being implemented. These programs have actually blunted the ability of the medical system to give help with AIDS let alone to extend their services further into the STD field. They make it more imperative for school girls to secure the money for school fees or for their mothers to earn this money. There are widespread reports that transactional sex has increased during the structural adjustment period rather than declined in the face of AIDS.

One of the other ironies of AIDS is that families are often proudest of, or at least most grateful to, their members who practice dangerous professions. There is no doubt that truck drivers often pose an STD and AIDS threat to their wives, but most wives are pleased with the substantial income that they bring into the household. Much the same can doubtless be said of many entertainers.

The family and the epidemic

AIDS attacks families in a variety of ways. In both Uganda and Zambia only about two-thirds of the victims are married and the remainder look primarily to their parents for care (Ankrah et al. 1992; Peltzer et al. 1989: 164), while in Ghana the predominance of female commercial sex workers returning from the Ivory Coast means a particular selectivity for the young and unmarried.

Families are more often than not ignorant about their AIDS situation. The vast majority of nonsymptomatic seropositive individuals in Africa do not know of their condition and hence their families do not know. Even among married symptomatic persons, it was found in Kampala that 29 percent told no one of the diagnosis and only a minority told their spouses. More frequently, they informed an older blood relative (McGrath et al. n.d.a). In Nairobi only 37 percent of seropositive women who had been counselled in a maternity hospital and advised to tell their partners claimed to have informed the partners and only two demonstrated that they had done so by returning with their partners for further counseling (Temmerman et al. 1990: 249). In Kinshasa, the research team believed that hardly any of the women counselled in hospital following a birth told their partners and fewer than three percent brought partners in for testing (Ryder et al. 1991).

An important issue, for which there appear to be practically no data at present, is what happens to a marriage when one spouse is told that the other has AIDS. In hypothetical discussions in Kinshasa with healthy factory workers and their wives a majority of men said that they would not tell their wives if they were seropositive but would take precautions (Irwin et al. 1991). Most wives said that, if told, they would refuse sex but stay with their husbands. The latter, however, argued that most wives would leave if only because of their families pressing them to do so. The majority of wives claimed that, if they were HIV-positive, they would have to tell their husbands partly because husbands have predominant rights in the sexual and reproductive arenas and partly because they would have to explain why they needed money for treatment. They were well aware that they might be accused of infidelity and told to leave. A Zambian study found that the relationship of unmarried persons almost always ended when one found that the other was seropositive (Peltzer et al., 1989). It did not report on the fate of marriages, implying that most stayed intact, but this may have been because three-quarters of the wives of seropositive men were also seropositive. A leprosy program decided that it was better not to tell seropositive women of their condition when it was likely that they had been infected by their husbands (Ponnighaus and Oxborrow 1991: 105).

A question that is central to both the nature of the family and the battle against AIDS is the extent to which wives have any control over marital sexuality. As AIDS informational campaigns have intensified, women have increasingly concluded that their husbands present a major danger to their own health and survival. Ankrah (1991: 971) concluded that in Uganda, and more generally in East Africa, wives had practically no power to negotiate that their husbands should practice safer sex outside the home, or to refuse sex or demand the use of condoms within the home. Bassett and Mhloyi (1991: 146) came to a similar conclusion with regard to Zimbabwe in Southern Africa. Orubuloye et al. (1992b) examined the situation in southern Nigeria, West Africa. They found that most wives with STD-infected husbands do not realize the situation (as is also the case with HIV infection). When they do know, most refuse sex until treatment. Relatively few believe that condoms would protect them from the disease. The right of coastal West African women to refuse sex to diseased or even drunken husbands derives from the ease with which they can break up marriages and return to their families of origin and from the traditional expectation that they have prime responsibility for ensuring that sexual relations do not take place during pregnancy or the post-partum period. AIDS, however, differs from other STDs in that it cannot be successfully treated and would be more likely to result in marriage breakup. It is probably no coincidence that Anarfi (1992b) found that nearly all the AIDS victims he studied in Ghana were being looked after by blood relatives.

Temmerman et al. (1990: 249-250) reported that, among women released from a maternity hospital in Nairobi, the divorce rate was only slightly higher among the seropositive than the seronegative. Part of the explanation is that at least half the women did not inform their husbands but it is also possible that fewer marriages would break up under the impact of AIDS in East Africa than in West Africa. However, Barnett and Blaikie (1992: 61-62) report, but provide no quantitative data, that many young wives in

Rakai, Uganda, leave symptomatic husbands, and have little problem in remarrying if they appear to be healthy and robust. One reason for most older women staying on with AIDS-afflicted husbands is that they thereby stake a claim for their sons (and, hence, also themselves) to remain after his death in the house and to maintain rights to the land (Barnett and Blaikie, 1992: 113). They also imply that there is a growing reluctance to marry for the first time because so many young single women are seropositive, but again one would like to see some numbers. It might be noted that there is a growing reluctance to marry in southern Nigeria which is quite unrelated to AIDS (Caldwell, Orubuloye and Caldwell 1992a).

There is no clear evidence as yet as to the impact of AIDS on fertility. There is very little Ugandan evidence that seropositive women attempt to prevent further births and considerable hearsay information that they attempt to have more children so that the healthy ones will survive them. Ankrah (1991: 974) reports that many Kampala women are keen to give birth in the belief that the production of healthy children will establish that they are seronegative. If AIDS does lead to a fertility decline it is likely to come about through any of four causes: a delay in first marriage; the erosion of the numbers of women in the prime childbearing ages; a reduction in sexual activity during the symptomatic phase; and widespread use of condoms to prevent infection.

There is some evidence that at least one of the family life cycle ceremonies is being affected by the epidemic. Barnett and Blaikie (1992: 107) report that in Uganda the sheer number of deaths has led to funerals being shorter and cheaper. In Ghana, Anarfi (1992b) reported that funerals were also likely to be accompanied by some shame, guilt and embarrassment.

Coping with the AIDS-afflicted

Studies in Uganda (McGrath et al. n.d. a,b; Ankrah et al. 1992) and Ghana (Anarfi 1992a,b; Argyeman, Anarfi and Awusabo-Asare 1992) come to very similar conclusions. AIDS patients are cared for by their families with the great majority of the burden borne by women, wives, mothers, sisters, daughters, aunts and grandmothers. AIDS weakens relationships with non-relatives. The sufferers rarely leave the house and give up collecting water from communal wells or attending church. Neighbors reduce their contacts with households afflicted by AIDS. The family turns in on itself, and even desires to do so because of its shame and embarrassment. Anarfi found that researchers were sometimes treated like neighbors and families refused access to the patients. In the affected households women are less capable of caring for others, and there is a parallel here with the impact of AIDS on the public health care system (Berkley 1992: 340). Anarfi also found that some of the female carers had to give up or reduce their income-earning activities, and thus became more dependent on the family themselves.

The families stood up to the strain in the sense that blood relatives did not drive sufferers from their households. Nevertheless, there was often suspicion of contamination and fear of using the same eating vessels. In Ghana there were cases of AIDS sufferers being shut away in a room. In Northern Ghana, more part of the savanna culture with its greater control of women, shame was a commoner reaction, and

the AIDS victims were more likely to be scorned and set apart. More frequently they had to go to the treatment center without any accompanying relatives. In this area 5 percent of patients in hospital, mostly women, have been abandoned by their families. Both the Ugandan and Ghanaian research shows that most families anticipate little help from the state or their neighbors, and that most of the sick turn immediately to their families, especially their blood relatives.

Anarfi (1992a) investigated the reaction to this kind of family care and to the predicament of Ghanaians with symptomatic AIDS. One-fifth of those with symptomatic AIDS said that they were primarily looking after themselves even though in the household. In terms of their main reaction to the situation in which they found themselves, one-third said that it was the pain and sickness which dominated their life, one-third reported that it was their shame and regret, and one-third referred mostly to their boredom at being largely confined to the house with few contacts with others. However, when asked about their greatest problem, the majority pointed to the lack or insufficiency of medicines to cure them, to reduce their symptoms, or to make life more comfortable.

The family's care system is tested not only by the demands of relatives they have long known but also by new infected babies born into the households. The major focus of child research so far has been less on infected infants than on all children where one or both parents have died, a focus that has largely been confined to Uganda. Preble (1990: 677) has produced a median projection of the number of orphans in the ten most AIDS-affected African countries estimating 600 thousand in 1992 and 4.5 million in 1999, but orphans are not defined. Hunter (1990: 664) estimated that in Rakai, Uganda, in 1989, 12.8 percent of children under 18 years of age were orphans. Certain qualifications should be made. This is a high age given the fact that most African children largely look after themselves well before this. Not all these orphans resulted from the AIDS epidemic as many African children have always lost their fathers at an early age, partly because of high mortality levels and partly because husbands may be decades older than the younger wives in polygynous or later marriages. Only one-quarter of these orphans, or three percent of all children, had lost both their parents, and most had lost their fathers in a social situation where care largely derives from mothers. Muller and Abbas (1990: 78) report of orphans in central Kampala, 13 percent are double orphans, 13 percent are single orphans with no mother, and 74 percent are single orphans with no father. Nevertheless, there is a problem of orphans, especially double orphans. Barnett and Blaikie (1992: 114 ff) report that the destination of double orphans is often discussed at Rakai funerals and that such children have four destinations: (1) staying on in their parents' house to look after themselves (often with relatives living a short distance away) with the partial aim of protecting their rights to the house and land; (2) going to grandparents or uncles and aunts; (3) going to more distant relatives or to non-relatives; (4) going into some kind of institutional care; although there are more plans than institutions at present. The situation is made easier by the long-standing tradition of child fosterage, and may prove easier still in West Africa where that tradition is more pronounced. The evidence seems to be that the family structure, although under great pressure, can provide the care, but may need some economic support to do so. The problem about institutional care in poor societies, with a

tradition of fosterage, is that any institutions established would probably soon be filled with children said to be AIDS double orphans. There are, indeed, problems about providing help only to those specifically affected by AIDS in a poor society subject to a range of disasters.

There is evidence that fostered AIDS orphans are likely to be removed from school on the grounds that they must help with their own support (Barnett and Blaikie, 1992: 102). Muller and Abbas (1990: 77) reported from their study of central Kampala that 47 percent of the households with orphans could not send the children to school compared with only 10 percent of households without orphans. Fostered AIDS orphans are not unlike other fostered children. They are subject to higher mortality than children living with both biological parents (Bledsoe, Ewbank and Isiugo-Abanihe 1983), partly because there is some dispute about who should meet medical costs (Orubuloye et al. 1991b). Non-relatives and more distant relatives certainly see fosterage in terms of assistance and a net material return.

The need to care for both young and old in a situation where the ranks of the middle aged are being depleted will certainly have an impact on the family and on household structure. Barnett and Blaikie (1992: 90-91) reported in Rakai villages an increase in the proportion of households which were either three-generational or composed of a single person. They also reported that households with AIDS victims were not only burdened by longer hours devoted to care but also longer hours devoted to religious activities (p. 58).

Rural-urban migrants who develop AIDS in town have special problems. Ankrah et al. (1992) Reported that rural families inevitably accept them back. Nevertheless, the same research team reported from their Kampala study that most of those afflicted in town stay there, partly because travelling costs money and is usually justified only if it promises greater earning opportunities (McGrath et al. n.d.: 28-29).

The family economy and AIDS

It is frequently said that AIDS has a major effect on the farming household economy and more generally on household incomes. There is, as yet, little available evidence. Anarfi (1992b) reports that when AIDS-affected households were directly asked about the economic impact of the disease upon them, 40 percent reported a loss of labor and another 5 percent loss of income, often remittance income. Nearly all households said that they were poorer, but only 5 percent reported that they had been forced to restrict the area of land they cultivated. Nevertheless, when asked about the major impact of the disease upon the household, these considerations ranked fairly low. Barnett and Blaikie (1992: 89-90) reported that AIDS depletes the household labor force, but their quantitative comparison of household producer-consumer ratios showed these ratios to have improved over five years (p. 100), possibly because these were existing households where the children were getting older. They concluded that, with crops like bananas and others with no inescapable peak labor demands, Ugandan farming systems are fairly resilient to labor shortages but that AIDS mortality might have a more damaging effect in semiarid areas

with marked seasonality of rainfall (pp. 127-151). Higher AIDS levels in urban areas almost certainly affect the volume of remittances available to rural families.

Anarfi's (1992b) study of AIDS households in Ghana showed that the major economic impact on the household earning was the additional expenditure that had to be made on medicines and treatment, whether in the modern or traditional healing sector. The median monthly expenditure during the symptomatic period is around US\$25 (equalling per capita income). About three-quarters of this expenditure is solely for modern treatment, while the remaining households either employ only traditional healers or a mixture of both. In almost two-thirds of all cases the burden was borne solely by the household, mostly from current income although in about one-quarter of these households it has been necessary to borrow or to sell property. One-third of AIDS-afflicted households had received assistance from the extended family beyond the house of residence.

Possible Interventions

One problem in discussing interventions is that most of them are desirable in poor societies even without an AIDS epidemic and most of them are also desirable in AIDS-afflicted areas for nonafflicted households as well as those with AIDS patients.

There is surprising agreement among afflicted persons and their families that the victims need more medical care. Part of this may merely be a dream of cure, but part is also a demand for the treatment of the opportunistic disorders. An important health intervention would be an effective attack on STDs, but there is some controversy about the level of resources that would be needed.

There is certainly a need for social counseling and psychic support. Community education is needed to reduce the level of blame and shame and to prevent families having to turn in on themselves in defense against the suspicion of neighbors. It is also necessary to protect AIDS patients from being isolated within households and to provide family members with confidence that they can live with AIDS victims, and share with them, without being infected. Pre-release hospital counseling is necessary, although one should note Anarfi's (1992a) finding in Ghana that a significant proportion of all AIDS hospital patients believe that the counseling is irrelevant because the disease has been caused by evil spirits. Some of the most effective efforts have been carried out by NGOs such as the Salvation Army Hospital at Chikankata, Zambia and the TASO program in Kampala and Masaka, Uganda, although such programs need external support.

It is probable that African families are in a better position to provide care, even for double orphans, than hospices or orphanages. At Chikankata, foreign offers of funds for a hospice have been refused on the grounds that the demand for places in the hospice would be overwhelming. There is evidence from efforts to establish similar institutions in Uganda that there are real difficulties in distinguishing between those children with a right to places in the institution and those with no right (Barnett and Blaikie, 1992:

155 ff.). The most promising direction is to follow the Chikankata lead in sending out nurses and mobile teams to villages and households and to bring patients into a central hospital for limited periods. The evidence is also that households need some financial assistance especially when fostering distant relatives. There is also a demand for free schooling and increased vocational training in areas badly hit by AIDS.

It has been clear since the beginning of the epidemic that there have to be simple and convincing messages on the danger of sexual networking and on the safety of monogamous relations, or what the Ugandans call "zero grazing". The educational programs will be more convincing if they are based on adequate research and hence can produce firm facts and figures. They are also likely to be most effective if they can be adequately addressed not only to captive school children but to the section of the community which is at greatest risk and is most dangerous to the rest of the community, namely 16-44 year old males. Governments find it hard to deal with young adult males and they experience difficulties in developing programs that will really reach them.

In major AIDS epidemic areas ultimate protection can probably be achieved only by moving toward more monogamous relationships. If sex is to be kept within the home or within the partnership, then this is probably also possible only if a massive change occurs in the nature of spousal relationships. It is probably also possible only if continuing sexual relationships can take place within that partnership, and hence the family planning movement has a role to play in substituting contraception for postpartum sexual abstinence. Ultimately, the target for attack must be the belief that men need more than one woman, and inevitably such campaigns will run counter to polygyny. Polygyny presents no greater danger of STDs or AIDS to polygynists, and in fact it probably gives some protection. However, at the level of the whole society, it undoubtedly is a major factor in placing that society at greater risk of coitally-related disease because of the necessity for males to marry later and because of the message that they sexually need many women.

Central to the battle against AIDS is the need to empower women. This again means attacking traditional spousal relations. AIDS is likely to diminish only when it is understood that wives have a major concern with their husbands' other sexual relationships and when husbands are sufficiently apprehensive of that concern to change their behavioral patterns. Mothers who feel they have a right to take an interest in their sons' sexual activity and to give them advice are more likely to have an effective impact than are school teachers. Women's movements have a role. They are likely to be most successful if they work through the existing women's groups.

Campaigns for the use of condoms must continue, with a significant component aimed at assuring people of their safety in terms of their health and in terms of the condoms acting as a prophylactic against STDs and AIDS.

There is now some evidence that condoms will prove acceptable for many premarital and extramarital relations provided that they are easily and discretely available through the general retailing system (Caldwell et al. 1992a).

In most AIDS-stricken countries there is far too little factual knowledge and far too little informed discussion - often far too little discussion (Caldwell et al. 1992b). There is an undeniable need for much more social-scientific research and for very conscious attempts to create a new social-science field and to set and raise standards within it.

Problems, anomalies, contradictions and difficulties

(1) The campaigns under way against AIDS, notably governmental policies in Uganda, are clearly an assault on the traditional African family. Without actually saying so, the campaigns aim at producing a more Western-type companionate marriage and probably nuclear family. This was also the aim of most Christian missionaries, and the new goals can be described as Christianizing ones as well as Westernizing ones. There can be no doubt that this is a cultural assault and will be supported by many who are just as interested in producing cultural and social change as in providing a defense against AIDS.

(2) The campaign against AIDS will necessarily involve both the promotion of fear and the reduction of fear. There is no other way of preventing AIDS than by making people fearful of unsafe sex and of the risk of multiple sexual partnerships. Yet the campaign has at the same time to reduce the fear that family members and others have of being infected by AIDS victims and to demonstrate that there is a multiplicity of ways by which they cannot contract AIDS. It is a fearful disease but it is necessary to convince the sufferers that it is just another form of sickness.

(3) There is conflict between optimal campaigns against AIDS and structural adjustment programs. There is a need for free medical treatment and for a vast expansion in health services, particularly against STDs. There is a need for inexpensive schooling and an expansion of vocational education. There is a need for some financial support and possibly food for those looking after orphans bereft of parents and old people bereft of children.

(4) We have taught the world that AIDS is a sexually transmitted disease. There has been a temptation to increase guilt about nonmarital sex and even all sex. This has fitted in with older traditions about discrete nonmarital sex and new Christian and Islamic condemnation of nonmarital sexual relations. Much of the emotional misery of African AIDS sufferers is derived from the belief of the community, neighbors and families that they have been caught in sexual transgression and sin. This has received the enthusiastic support of many religious leaders. There is a need for sophisticated programs to attempt to reverse this situation. The antisex message of many of the educational programs is

destructive of human relationships and of the traditional emphasis on the essential healthiness of sexual relationships.

(5) There is need for a strong women's movement to empower women, but to empower them in such a way that spousal relationships are strengthened rather than weakened. This movement is most likely to succeed if it works through the women's groups long-existing in many parts of Africa, which ironically are themselves a product of the distance between the sexes and the weakness of spousal relations.

(6) The campaign against AIDS has inevitably cast as villains female commercial sex workers and to a lesser extent all women who engage in transactional sexual relations and even all women. This is clearly a process which has to be reversed.

(7) In East and Southern Africa there is a major need for the massive creation of female urban employment, so that the towns can house as many women as men and wives as well as husbands. This runs counter to structural adjustment programs and policies in favor of smaller government. There is a need for attitudinal as well as occupational change. There is also a need to modify farming so that it is not predominantly a female occupation as far as labor inputs are concerned.

(8) Many Africans feel that there is a fundamental conflict between the campaigns promoting monogamous sexual relations and premarital sexual abstinence and those promoting the use of condoms. They also feel that wives who encourage husbands to use condoms are sanctioning sexual relations with multiple partners.

(9) To many Africans there is a seeming conflict between the continuing family planning programs and the threats to the survival of the family posed by AIDS. It is pointless to emphasize that on a national basis the AIDS campaign is unlikely to prove Malthusian. Quite apart from the reduction in fertility, family planning programs have roles to play in encouraging the substitution of contraception for postpartum sexual abstinence and in encouraging the use of condoms.

(10) There are losses and benefits accruing to extending the present very low level of HIV testing. More testing would certainly bring home the message about the dangers of the epidemic and might protect some spouses and other sexual partners from danger. Nevertheless, unless the health authorities change their policies and directly inform partners, the evidence suggests that few partners will be told. The losses are that many people would live a longer span of years with fear and guilt. Even if wives were told, the evidence suggests that in many societies they would still have to persist with unsafe sex with their husbands.

The African family under the threat of AIDS

The structure of the African family and African society long preserved it from the inequities of a class society and the seclusion of women. However, once its society was shaken and partly transformed by colonialism and modernization it proved to be particularly susceptible to coitally-related disease. The invading culture believed that African family life should conform to its own model. Naturally, there was resistance, but that resistance may crumble under the threat of AIDS.

The African family, as a mechanism for providing comprehensive care, has performed well under the onslaught of AIDS. The vast majority of care provided for AIDS victims in Africa is provided by the family. The strongest link in this care giving is probably that provided by blood relationships. In East Africa most marriages appear to have remained intact, except possibly when the wives are young and easily remarriageable. In these circumstances, spouses have also been major providers of care. It is less certain that West African marriages will prove equally durable. It should be noted that, although the family has provided the care and coping structure, the provision of care has been almost wholly an undertaking of females.

What is startling is that, given the magnitude of the sub-Saharan African crisis, it has been necessary to base these generalizations on such a tenuous fabric of proven social science findings. A great deal is being written but much of it is based on the continuous recirculation of a small number of research findings. There is an urgent need for the creation of a social science field of a caliber to meet the challenge posed by the African AIDS crisis.

BIBLIOGRAPHY

- Allen, J. and Preston-Whyte, E. (1989), Sowing the Seeds of Despair: Structural and Cultural Factors Accounting for Extramarital Pregnancies Among Young Women in Two Durban Communities, paper presented to the Annual Conference of South African Anthropologists, University of the Western Cape, 1989.
- Anarfi, J. K. (1992a), *Structured Conversations with AIDS Counsellors/ Coordinators*, Institute for Statistical, Social and Economic Research, University of Ghana, Legon, Accra.
- Anarfi, J.K. (1992b), *Report on a Pilot Study on the Coping Strategies of Households with AIDS Sufferers - June 1992*, Institute for Statistical, Social and Economic Research, University of Ghana, Legon, Accra.
- Anderson, R.M. *et al.* (1991), The spread of HIV-1 in Africa: Sexual contact patterns and the predicted demographic impact of AIDS, *Nature*, 352:581-589.
- Ankrah, E.M. (1991), AIDS and the social side of health, *Social Science and Medicine*, 32,9:967-980.
- Ankrah, E.M., Lubega, M. and Nkumbi, S. (1992a), The Family and Care-Giving in Uganda, V International Conference on AIDS, Montreal, 1989.
- Ankrah, E.M. *et al.* (1992b), Stress and Coping Among Rural Families in Uganda, VIII International Conference on AIDS/III STD World Congress, Amsterdam, 19-24 July 1992.
- Argyeman, D.K., Anarfi, J.K. and Awusabo-Asare, K. (1992), *Coping Mechanisms Among Families with AIDS Patients*, University of Cape Coast, Cape Coast, and University of Ghana, Legon, Accra.
- Barnett, T. and Blaikie, P. *AIDS in Africa: Its Present and Future Impact*, Bellhaven Press, London.
- Bassett, M.J. and Mhloyi, M. (1991), Women and AIDS in Zimbabwe: The making of an epidemic, *International Journal of Health Services*, 21,1:143-156.
- Berkley, S. (1992), HIV in Africa: What is the future?, *Annals of Internal Medicine*, 116,4:339-341.
- Caldwell, J.C. and Caldwell, P. (1977), The role of marital sexual abstinence in determining fertility: A study of the Yoruba in Nigeria, *Population Studies*, 31,2:193-217.
- Caldwell, J.C. and Caldwell, P. (1983), The demographic evidence for the incidence and cause of abnormally low fertility in tropical Africa, *World Health Quarterly, WHO*, 36,1:2-34.
- Caldwell, J.C., Caldwell, P. and Quiggin, P. (1989), The social context of AIDS in sub-Saharan Africa, *Population and Development Review*, 15,2:185-234.
- Caldwell, J.C., Orubuloye, I.O. and Caldwell, P. (1991), The destabilization of the traditional Yoruba sexual system, *Population and Development Review*, 17,2:229-262.
- Caldwell, J.C., Orubuloye, I.O. and Caldwell, P. (1992a), Africa's new type of fertility transition, *Population and Development Review*, 18,2 (in press).
- Caldwell, J.C., Orubuloye, I.O. and Caldwell, P. (1992b), Underreaction to AIDS in sub-Saharan Africa, *Social Science and Medicine*,
- Foster, G. (1990), Raising AIDS awareness through community mobilization, *Tropical Doctor*, 20:68-70.
- Hunt, C.W. (1989), Migrant labor and sexually transmitted disease: AIDS in Africa, *Journal of Health and Social Behavior*, 30:353-373.
- Hunter, S. (1990), Orphans as a window on the AIDS epidemic in sub-Saharan Africa: Initial results and implications of a study in Uganda, *Social Science and Medicine*, 31,6:681-690.
- Irwin, K., J. Bertrand, N. Mibandumba, K. Mbuyi *et al.* (1991), Knowledge, attitudes and beliefs about HIV infection and AIDS among health factory workers and their wives, Kinshasa, Zaire, *Social Science and Medicine*, 32,8:917-930.
- Jochelson, K., M. Mothibeli and J.-P. Leger (1991), Human Immunodeficiency Virus and migrant labour in South Africa, *International Journal of Health Services*, 21,1:157-173.
- Karim, Q.A., S.S.A. Karim and J. Nkomokazi (1991), Sexual behaviour and knowledge of AIDS among urban black mothers: Implications for AIDS intervention programmes, *South African Medical Journal*, 80:340-343.
- Larson, A. (1989), The social context of HIV transmission in Africa: Review of the historical and cultural bases of East and Central African sexual relations, *Reviews of Infectious Diseases*, 1989.

Lesthaeghe, R. (1989), *Reproduction and Social Organization in sub-Saharan Africa*, University of California Press, Berkeley.

Lesthaeghe, R.J., G. Kauffman and D. Meekers. 1989. *et al.* The nuptiality regimes in sub-Saharan Africa. pp. 238-337 in Lesthaeghe.

McGrath, J.W., E.M. Ankrah, D.A. Schumann, M. Lubega and S. Nkumbi. n.d.a. The Psychological Impact of AIDS in Urban Ugandan Families, Case Western Reserve University Cleveland, Cleveland, and Makerere University, Kampala. (mimeo)

McGrath, J.W., E.M. Ankrah, D.A. Schumann, S. Nkumbi and M. Lubega. n.d.b. AIDS and the Urban Family: Its Impact in Kampala, Uganda, Case Western Reserve University, Cleveland, and Makerere University, Kampala.

Müller, O. and Abbas, N. (1990), The impact of AIDS mortality on children's education in Kampala (Uganda), *AIDS Care*, 2,1:77-80.

Orubuloye, I.O., Caldwell, J.C. and Caldwell, P. (1991a), Experimental research on sexual networking in the Ekiti district of Nigeria, *Studies in Family Planning*, 22,2:61-73.

Orubuloye, I.O., Caldwell, J.C. and Caldwell, P. (1991b), *The Impact of Family and Budget Structure on Health Treatment in Nigeria*, Health Transition Working Paper No. 8, Health Transition Centre, National Centre for Epidemiology and Population Health, Australian National University, Canberra.

Orubuloye, I.O., Caldwell, J.C. and Caldwell, P. (1992), *Diffusion and Forms in Sexual Networking: Identifying Partners and Partners' Partners*, Health Transition Working Paper No. 11, Health Transition Centre, National Centre for Epidemiology and Population Health, Australian National University, Canberra.

Orubuloye, I.O., Caldwell, P. and Caldwell, J.C. (1992a), *The Role of High-Risk Occupations in the Spread of AIDS: Truck Drivers and Itinerant Market Women in Nigeria*, Health Transition Working Paper No. 10, Health Transition Centre, National Centre for Epidemiology and Population Health, Australian National University, Canberra.

Orubuloye, I.O., Caldwell, P. and Caldwell, J.C. (1992b), *African Women's Control over their Sexuality in an Era of AIDS*, Health Transition Working Paper No. 12, Health Transition Centre, National Centre for Epidemiology and Population Health, Australian National University, Canberra.

Page, H. (1989), Childrearing versus childbearing: Coresidence of mother and child in sub-Saharan Africa, in R. Lesthaeghe (1989) pp.401-441.

Peltzer, K. *et al.* (1989), Psychological counselling of patients infected with Human Immunodeficiency Virus (HIV) in Lusaka, Zambia, *Tropical Doctor*, October 1989:164-168.

Ponnighaus, J.M. and Oxborrow, S.M. (1991), Counselling HIV-positive leprosy patients, *Leprosy review*, 612:105.

Preble, E.A. (1990), Impact of HIV/AIDS on African Children, *Social Science and Medicine*, 31,6:671-680.

Ryder, R.W., V.L. Batter, M. Nsuami, N. Badi, L. Mundele, B. Matela, M. Utshudi and W.L. Heyward. (1991), Fertility rates in 238 HIV-1-seropositive women in Zaire followed for 3-years postpartum, *AIDS*, 5:1521-1527.

Schoenmaeckers, R., I.H. Shah, R.J. Lesthaeghe and O. Tambashe. (1981), The child-spacing tradition and post-partum taboo in tropical Africa: Anthropological evidence, in H.J. Page and R. Lesthaeghe (eds.) *Child-Spacing in Tropical Africa: Traditions and Change*, Academic Press, London, pp.25-71.

Southall, A.W. (1961), Kinship, friendship and the network of religions in Kisenyi, Kampala, in A.W. Southall (ed.) *Social Change in Modern Africa*, Oxford University Press, London, pp.217-229.

Temmerman *et al.* (1990), Impact of a single session post-partum counselling on HIV infected women on their subsequent reproductive behaviour, *AIDS Care*, 2,3:247-252.