

Social Scientific Antecedents of HIV/AIDS Policies in Africa

Pempelani Mufune (PhD, Sociology)

Professor and Head Department of Sociology, University of Namibia.

Introduction

Latest figures from the United Nations and UNAIDS insist that Sub Saharan Africa remains the epidemiological locus of HIV infections in the world. It is also well known that Africa has a different pattern of HIV/AIDS infections from other regions in the world. In Sub Saharan Africa just like in parts of Latin America and the Caribbean HIV was introduced around the late 1970s and heterosexuality including prostitution remain the principal mode of transmission. Overtime and due to the fact that women are inordinately affected vertical transmissions from mother to child during childbirth are of increasing importance in transmission. The male to female case ratio is tilted against women and prevalence rates have been high. This is in contrast to other areas of the globe where; the principal mode of transmission includes men who have sex with other men and intravenous drug users, the male to female heavily favours women and the overall prevalence rate is low to medium.

Social science and the explanation of AIDS patterns in Africa: there are three main explanations of HIV infections in Africa; cultural, dependency and rational choice theory.

Cultural Explanation: Caldwell and others believe that the pattern of HIV transmission between Africa and the countries of the West differ because of the "level of sexual activity and not sexual orientation". Caldwell, Caldwell and Quiggins (1989) were among the first serious researchers to set the stage for social scientific writings on AIDS in Sub Saharan Africa. They did a wide ranging review of anthropological and related literature on African sexual behaviour. Their major aim was to explain the high prevalence rates of HIV infection and the unique pattern of an equal male to female case ratio in Africa. They attributed the rapid spread of the HIV disease to sexual permissiveness in African society. They claimed to have discovered a pattern of sexual permissiveness rooted in the absence of moral and institutional constraints especially with regard to women. Africans were said to hold more permissive attitudes towards sexual relationships with multiple partners and towards extra marital sex. To explain the tilted male to female case ratio found in Sub Saharan Africa they argued that "A pragmatic attitude exists in Africa toward [female sexuality], with a fair degree of permissiveness toward premarital relations that are not too blatantly public, and a degree of acceptance that surreptitious extramarital relations are not the high point of sin and usually should not be severely punished" (Caldwell et al 1989, p.189). In addition they argued that "African society recognises as a distinct phenomena longer term girlfriends, mistresses [and] outside wives..., who partly serve in urban areas as alternatives to polygynous married wives" (Caldwell et al, 1989, p. 189). Odebiyi and Vivekananda(1991) agreed and attributed the situation to such cultural factors as polygamy which drives women to seek for sexual fulfilment outside marriage; polyandry; and the high value placed on children in African culture which drives people to indiscriminate sexual activities. "In East Africa, Masai men who were circumcised at the same time share everything including their wives. All that is required is for the visiting comrade to put his spear outside the targeted hut to announce his presence and he is entitled to the same conjugal rights as the husband " (Ateka 2001, p 1168). Caldwell et al's (1989) views were ultimately too generalised. Thus Mufune et al (1993) in a randomised study of students and youth attitudes towards risky sexual behaviour found that some groups of young people in Zambia do not favour extramarital sex or multiple partners. Gage-Brown and Meekers (1993) analysis of demographic and health surveys from seven African countries revealed that the proportions of never-married adolescents who have had sex varied enormously among countries. Premarital sexual activity was virtually absent in countries such as Burundi where about 4% of the never-married females have had sex and very prevalent in countries such as

Botswana were more than 75% of the never-married women aged 15-24 have had sexual experience. The evidence seem to support Le Blanc et al (1991) argument that:

They (Caldwell and friends) imply that sexual promiscuity, particularly among women, is the norm in Africa, and that 'lack of control' of womens' sexuality is the key to the AIDS epidemic in that region. It is our view that in fact, the sexual behaviour of women is subject to a great deal of social regulation and that norms are highly variable from one African society to another (Le Blanc et al, 1991, p 501).

Moreover, Caldwell et al's study was based on unrepresentative documentary methods. The documents written during the period of colonialism were biased and of limited reliability since they represented stereotypical views of African sex prevailing at the time. "In the 19th century there were a number of highly ethnocentric, sensational, moralizing accounts of 'native' sexual behaviour written by explorers, adventurers, missionaries, and amateur anthropologists whose intent was to shock and perhaps to titillate the reader, or to show that Africans were 'oversexed' or lacking in moral restraints" (Green, 1994, p 95). The situation in the first part of the 20th century was not that much better. The assertion that extramarital sex in Africa was very high by world standards fitted these kinds of stereotypes.

Derivations from Dependency: The opposing studies to that of Caldwell et al (1989) emphasize that AIDS be understood in its wider context of national, regional and global economic inequalities. Earlier on Schoepf (1988) argued that the spread of the HIV virus is determined by the international political economy and social structures as well as by the actions of individuals and groups variously situated within this historically constructed system. AIDS is usefully viewed. Using Dependency and World Systems Theory Hunt (1989) showed the geographic spread of these infections. Hunt started from the premise cities are the place where manufacturing, mining and commercial agriculture are concentrated. Rural poverty has in the past and at present motivated people to seek employment in these sites. The spread of HIV has likewise followed this pattern. Migrants in towns, finding themselves without wives, turn to prostitutes thereby promoting the rapid spread of sexually transmitted diseases. Periodically, migrants return to rural areas and in so doing spread the disease. Hunt (1989) found that in line with this model HIV infections were most common and appeared first in places with concentrations of migrant labour. It is no accident that "especially in large cities and along major transportation routes, AIDS is far more prevalent than in comparable settings in Europe and North America" (Philipson and Posner, 1995 p.836). According to Hunt places of origin of migrant labour are also high in HIV infections compared to settings that do not serve as labour reserves.

Poverty also limits choice in terms of fertility and sexual activity. Poverty inordinately affects African women. Women have less access cattle and land (the two traditional sources of wealth) and to education and the labour market. Thus men have more access to the few jobs available and more access to income earning probabilities. Women must depend on their men for a living as they access land and cattle through men. For women marriage and sex may be the way to access resources. For some groups of single (young) women sex may be the only way to access resources. This is because they are in a less powerful position than their male folks. Men feel that they have a right to demand sex from wives and partners when they feel like.

The social structure of poverty relates to migration. The unemployment, poverty and underdevelopment of the populated rural districts are the "push" factors that motivate individuals and groups of people to move in search of jobs. Most of migrants however, keep an interest in their place of origins. Many of them keep wives in their villages. Historically, this has been because migrant wages have been inadequate to maintain families in places where they work. Moreover, during the colonial era, only males were allowed to move in search of jobs and to this end the types of houses built for migrants could not accommodate migrant families. Many migrants also needed (and still need) to lay claims to land and other resources in their areas of origin and wives are the people who can physically do that for them. This is important for migrants because their jobs have little social security attached to them. Apart from being paid little they can be fired at anytime. Migration however, means that wives and husbands are separated from each

other for considerable periods of time. Sexual liaisons in places of destination automatically mean multiple sexual partners. By definition migrants in low jobs (such as the military, police etc) have little education and many have ineffectual knowledge of reproductive health issues and little access to information that would enable them to make decisions on sex that can save them from HIV infection. Social structure comprises the patterns of social relationships within which behaviour is carried out. The relationships of poverty, migration and power in underdeveloped Africa exist as stable, continuing patterns of behaviour involving people with others at the interpersonal level. They may not be entirely open to reflection, criticism and decisions of acceptance or rejection

If the cultural explanation weakness is an exclusive focus on internal factors in explaining AIDs patterns that of those writing from the development/underdevelopment perspective is a neglect of internal factors. AIDs patterns are seen as determined by incorporation into the world economic system and the behaviour of people is not that much of a factor. Secondly, the assumption that AIDS is a disease of poverty is somewhat overdone. Thus for example among the countries most affected by the epidemic is Botswana, an economy which has been among the fastest growing in the world in the last two decades. Moreover, if AIDS is selective at all then it chooses those who are educated and economically well off in all the Southern African countries.

Rational Choice Explanation: In accordance with their book **Rational Choices and Public Health: the AIDS Epidemic in an Economic Perspective** Philipson and Posner argue that the rational choice model (RCM) offers a useful model to explain the spread of AIDS anywhere. The RCM is a simplified set of assumptions about human behaviour in which social action is a sum total of individuals acting to maximise their interests through the calculation of costs and benefits. Behaviour thus reflects a rational calculus of gains and losses. This is the key to understanding human phenomena including sex (Philipson and Posner, 1995). To explain the spread of HIV we need to look at the extent to which rational choices made by individuals influence personal decisions predicated indulgence in risky sex.

Philipson and Posner (1995) focus on three factors as central to explaining the African epidemic: The nature and size of "high risk groups" in the population ie the high prevalence of prostitution and non-monogamous sexual activity ; the high prevalence of sexually transmitted diseases (STDs); and the real costs of condoms in the African context.

With regard to the first factor they concur with Caldwell et al (1989) that female prostitution is higher in Africa than in America and Europe. Given the higher levels of poverty and unemployment African men can not afford to support wives and hence rely on prostitutes. Poverty encourages migration which in turn increases the demand for prostitution. So does polygyny and customs leading to marital abstinence. Prostitutes are a major source of infection in Africa. The AIDS epidemic has reduced the nominal price of prostitution (which in the first place is highly inelastic since African prostitutes do not have prospects for alternative incomes) consequently, "the amount of potentially infectious sexual activity by prostitutes has not fallen in response to the higher risk of infection" (Philipson and Posner, 1995, p 839). In the same manner the services of females in casual and non monogamous relations are inelastic and their levels of sexual activity has also remained the same. Moreover, since infections are rampant among African prostitutes and females in non-monogamous relations there is very little incentive towards safe sex. "The likelier one is to be infected already, the smaller the expected benefits of safe sex" (Philipson and Posner, 1995, p 842) consequently many of these females do not bother about safe sex. The demand for safe sex is further reduced by low education and misconceptions reducing the individual's perceptions of the risks of engaging in multiple sex and the efficacy of safe sex. Lower life expectancy also reduces the real benefits of safe sex because the costs of AIDS is not seen in terms of the number of years likely to be lost by the infected individual.

With regard to the second factor Philipson and Posner argue that many Africans are already infected with STDs leading to the increased infectivity of the HIV virus. STDs are related to such co-factors of AIDS as female circumcision and the absence of male circumcision. For males, lack

of circumcision increases the possibility of penile abrasions providing entry to vaginal fluids. For females, circumcision not only allows abrasions but also is performed in groups with contaminated equipment. With regard to condoms they argue that their full cost is higher in Africa than elsewhere. For one the poor distribution system in Africa makes the supply of condoms highly uncertain. More importantly, condoms are very costly in terms of the foregone expenditures on them. In most of Africa, one months supply of condoms costs more than two hours of work in a month. Therefore Africans do not have what the United Nations call "ready and easy access to condoms". For many the purchase of condoms have to be calculated against the foregone consumption of other goods and services and is therefore likely to be discounted. As a result the expected demand by individuals for condoms (and therefore safe sex) is much lower in Africa.

As Philipson and Posner seem to realise the RCM is a heuristic device - a simplifying mechanism aimed at enhancing understanding and explanation. However, when all human behaviour is taken as rational or maximising interest there is a problem. As Arrow (1987) pointed out people may act out of habit. Many of our actions are not only non rational but may even be irrational. We act out of impulse or emotions. Individuals may be less of rational actors and more of Schutz's (1973) phenomenological actors proceeding on the basis of the here and now reasoning (Hughes and Malila, 1996). AIDS is mostly a sexually transmitted disease in Africa and no behaviour is more open to emotions and habit than sex. Its quite unlikely that any body takes into account the issue of life expectancy when seeking sexual encounters. "The optimization of benefits that is implicit in the calculative model of rationality is flawed by virtue of lacking meaningful consideration of the temporal dimension that characterises every day action. Risk of infection may be less important than the immediate and pressing relevances of sexual gratification because the apprehended risks (eg rejection, loss of income, distrust) are more consequential than the more abstract risk of death in the future" (Hughes and Malila, 1996, P 9). Sexual practices are imbued with symbolic meaning and these rather than rationality may structure and frame individuals lived experiences of sex. By simply neglecting to integrate emotional and traditional action (ala Max Weber) in their explanation of AIDS in Africa, Philipson and Posner have dealt the quality of their argument a severe blow. The RCM also comes with a price. Culture is reduced to whether it promotes knowledge or not (e.g. paying for sex as a way appropriating some lesser god in Uganda) and collective action is simply a sum total of individual rational actions. As a result the RCM can not really explain why in Zambia, Zimbabwe, Botswana, Malawi, Namibia and South Africa the HIV prevalence rates are around 20% while they are considerably less in other countries despite the fact that the same conditions (i.e. prostitution, non-monogamous relations, costs of condoms, prevalence of STDs) obtain. Lastly the RCM fails to explain why HIV rates in Africa are high in the first place. Proponents agree with the cultural explanation that prostitution is the norm in Africa but why this is the case is left unanswered. Phillipson and Posner's analysis is incomplete since it is based on the view that sexual activity and therefore infections are voluntary. Clearly some groups in society (e.g. rape victims, minors, newborns and accident victims) cannot control their risk of infection voluntarily (Kremer, 2000).

Policy reactions to AIDS as Antecedents of Social Science

Inevitably, many of these sociological ideas have found their way in AIDS policies of the region albeit in an unsystematic way. Helen Jackson (1996) has pointed out that there are several reasons why AIDS policies are necessary in the region. Firstly, the scale of the epidemic is such that it needs organized responses promoting effective ways to combat it. Clearcut policy is necessary in that it may assist behavioural change that could make a difference to the ultimate scale of the epidemic. Secondly, HIV/AIDS comes with a stigma and therefore discrimination against the infected and those perceived to be at high risk. Such discrimination undermines basic human rights (eg access to health care) of certain groups of people in society. Policy is necessary to safeguard rights as a matter of ethics and as part of the strategy to combat HIV. Lastly, policy is also necessary to deal with the escalating costs of the disease on individuals, families and society especially with regard to education and employment.

Usually policies towards AIDS are worked along two axis: pragmatism/ moralism and coercion/ compassion. These reflect the different interests and positions to be found within society (Pollak, 1992). The coercion - compassion continuum reflects a behavioural disposition which emphasises compulsion or force in dealing with AIDS victims and in the controlling of the HIV disease as against that which lays emphasis on understanding the social needs and the plight of the afflicted and the fact that every human being is a potential victim of the HIV disease. The pragmatism - moralism continuum reflects a behavioural disposition emphasizing the unethical nature of certain types of sexual conduct (for example that outside marriage) and therefore which are wrong and should not be condoned as against that emphasizing what is practicable rather than ideal.

We can identify four policy options emanating from these two axis:

A - The option that lies between coercion and pragmatism. Policy here advocates for external but not necessarily punitive action targeting those afflicted with the HIV virus who together with those defined as belonging to risk groups are seen as dangerous to society. The policy emphasises **containment combined with pragmatic education and prevention.**

B- The option that lies between coercion and moralism. Policy here is punitive against those who are afflicted and those seen as belonging to risk groups. There is a clear bias towards institutions of punitive controls on those infected as a precaution against the spread of HIV/AIDS. The infected and those defined as at risk are seen as "them" out there who underly what is wrong with society (Vass, 1989). To this end quarantines are advocated and distribution of condoms is opposed as unethical. Policy emphasises **punishment so that others may learn.** Born again groups of the pentecostal persuasion have been a vocal minority promoting this policy alternative. Some groups eg religious ones consider discussing risk factors as premature or preventative measures as unacceptable (Osei-Hwedie and Osei-Hwedie, 1996).

C- The option between moralism and compassion. Here policy rejects mechanisms such as quarantine as inhuman and lacking compassion for the afflicted and those at risk but equally rejected are safe sex mechanisms such as condoms, sterile needles and sex education on the grounds that they are immoral and would lead to promiscuity. Policy emphasises **increased awareness through preaching what is wrong or right to everyone.** Mainstream churches and traditionalist circles have argued for this policy alternative.

D- The option that lies between compassion and pragmatism. HIV is seen as a danger to society but the rationality of external controls is questioned. Society is seen as having the same responsibility with the sufferer which is how to prevent the spread of HIV/AIDS in the most humane way. What is envisioned is a positive interaction between society and HIV/AIDS sufferers (Vass, 1989; Osei-Hwedie and Osei-Hwedie, 1996). Here policy endorses the distribution of condoms, promotion of sterile needles and sex education and resolutely opposes quarantines and compulsory testing of individuals. Policy emphasises **actions which are humane and practical given that people are not going to stop indulging in sex.** The idea is that HIV is a problem that subjectively and hypothetically exist in everyone.

Most AIDS policies in the region shun moralism on the grounds that it is not of immediate relevance to solving the problem. Even if it is true that people are infected with the HIV virus because they engage in "wrong" sex the fact is that people will continue whatever they are doing and something must be done about the situation. Mere moralism is like a cope out and is not helpful. To this end AIDS policies in the region have not been aimed at exacting punishment (policy option B) or preaching right from wrong (policy option C). AIDS policies in the region have straddled options A and D.

There have been important advocates of HIV disease containment combined with prevention through education and other means on one hand and advocates of doing whatever works without infringing on the rights of the afflicted. Social science has been instrumental in promoting these two policy options. It is my contention that writings such as that of Caldwell, et al may justify

policies combining containment of the HIV disease with education measures to change culture and therefore behaviour. There is an agenda in their message aiming at rolling back the tide of permissiveness. The blame for AIDS is on sexual lifestyles characterised by "sexual over activity". African society is ultimately to blame in that it has promoted a laxity resulting in promiscuity. The implication is that if African society is to be rescued from the AIDS menace resolute measures must be promoted. Their discourse implies that those with AIDS are responsible for their situation. Although they do not say it I believe Caldwell et al would not be that opposed to measures which promote partner and national notification of the infected; removal of confidentiality clauses; and mandatory testing as a way of preventing HIV infection in Africa but mixed with education and other means of prevention. Zambia and Zimbabwe have in part pursued policies in line with this. Women have been seen as transmitting AIDS to men. They have been elevated to the role of "disease vectors". The single urban woman is seen as a prostitute or a potential prostitute who must be contained in Zimbabwe.

As Rob Pateman (1996) put it "The perception of single urban women as prostitutes pertains in contemporary Zimbabwe with the enforcement of periodic 'cleanup' campaigns in Harare in which women unaccompanied by men at night may be arrested unless they can produce marriage certificates" (Pateman, 1996, p 32). Zimbabweans may have copied these "cleanup" campaigns from Zambia where they were, from the 1970s, a regular strategy for controlling single women who showed some independence from direct control of their sexuality. Unaccompanied women were also locked up in Zambian police cells. In Kenya only women are forcibly tested and then criminally charged under the Public Health Act, section 17 if they have any sexually transmitted disease (Gould, 1993). For Zimbabwe Jackson and Pitts (1991) found that AIDS screening was being practiced by a significant number of firms. Thus 22% of the firms in their sample had some form of HIV screening in place while 40% thought pre employment screening was justified despite the fact that it was not provided for in the law. Similarly, in South Africa 1987 Health regulations introduced compulsory testing for foreign labour recruits and the repatriation of all HIV positive foreign workers (Jochelson et al, 1991).

On the other hand those working from the development/ underdevelopment perspective can not be happy with such a policy on the grounds that it blames the victim. Such policy is perceived as simplistic because those who are infected with the HIV virus are seen as having chosen to conduct their lives irresponsibly and are therefore responsible for their situation. This deflects attention from the social economic context that make it very difficult for people to escape infection. It also deflects attention from the relationship between poverty, illness, powerlessness and the colonial induced inequalities that characterise Africa.

Those working with the development/ underdevelopment perspective point to psychological and social pressures which come into play where HIV infection is concerned. For them an effective policy is one which addresses power and economic relations in African society. As a short term measure it may be prudent to promote condoms, sterile needles and safe sex education. Mandatory testing, quarantines, partner notification, wilful transmission of HIV laws and other containment measures are to be avoided. In the medium term, policy has to focus on female empowerment in limited situations. For instance those working with prostitutes must teach them bargaining skills so that they can negotiate for safe sex in their operating situations. In the longer term women's empowerment has to involve increasing their education and economic and political voice in the societal realm.

Policy measures from the RCM straddle those of the others. Philipson and Posner (1995) spell these as in the short term, public intervention is more likely to work in Africa than elsewhere. For instance in the USA where the majority can afford condoms and where knowledge of HIV is high, condom subsidies and public education do not help much. The case is different in Africa where condom subsidy and AIDS education are likely to be effective tools. Secondly, and in the longer-term inequalities between men and women have to be reduced. This would lessen prostitution and enhance the capacity of women to negotiate for safer sex thereby reducing HIV infectivity. Among policies, which will not work in Africa, say Philipson and Posner, are unionisation or minimum wage laws for prostitutes. This would raise the price of prostitution thereby driving prostitutes to non-monogamous relationships in order to get male support. This would be low paying prostitution but in name which is at the heart of the spread of HIV in Africa. Also unlikely to work is notification of partners of people living with HIV/AIDS. This is because such partners are

very transient and given the prevalent co-factors chances are high that such partners already have the disease.

Conclusion

Social science research and debate has ensured that moralism has played a minimal part in the formulation of AIDS policies in the region. This has been through research showing that all individuals are at risk and that the situation is going to get worse unless serious effort is committed towards the fight against AIDS. To its credit social science debate has ensured that the afflicted are seen as victims more than as vectors. AIDS policies in Southern Africa have seesawed between containment of victims and potential victims and their sympathetic treatment. I personally prefer policies which do not emphasise containment. However for these to seriously work the conditions which make Africa the most seriously AIDS hit region in the world must be addressed. Poverty, inequality and underdevelopment must be seriously tackled if any dent is to be made in the AIDS fight. In the case of South Africa Jochelson et al (1991) have argued that HIV transmission cannot be reduced unless the social conditions promoting it - migrant labour system, vulnerable family situations, low wages for women- are transformed. It is difficult to disagree with them. All the three major explanations of the AIDS epidemic from the social science perspective have major problems. The cultural explanation is not adequate for there is no one African culture but many and consequently it fails to explain the wide variations in the sexual activity of Africans in different countries. It is also gender biased in its belief that sexual promiscuity among women is the key to understanding AIDS in Africa. The RCM approach fails to take seriously Schutz's (1973) contention that human beings are phenomenological actors who proceed on the basis of the here and now. This may be more important to understanding AIDS than the calculative model of rationality since few human behaviours are as open to habit and emotion as sex. Derivations from dependency model are too concerned with the workings of the world system forgetting internal dynamics of the various countries. Consequently they can also not explain the various differences in the sexual activity of people in different countries and indeed in the infection rates. More over their claim that AIDS is a disease of poverty seem to be overdone.

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