academicJournals

**Journal of AIDS and HIV Research**

*Review*

# Improving United Nations Development Programme's (UNDP's) research on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) in Africa

**Ejikeme Nonso Alo**

Department of Political Science Eastern Illinois University, Charleston, Illinois, United States.

This paper poses methodological and ethical questions on the measures adopted by the human development index (HDI) data in assessing development in Africa, with particular emphasis on human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS). It is a well-known fact that these measures are great indicators of development or otherwise. The central position of the paper is that given the difficulty in collecting data reports on Africa, how accurate and reliable are the HDI standards in measuring the spread of HIV and AIDS in Africa? The crux of the argument is giving the cultural deficit of most African societies as well as the HDI measures and standards it deserves thorough assessment.

**Key words:** HIV/AIDS, human, development, culture.

## INTRODUCTION

The measures adopted by the human development index over the years have been studied by scholars. Most scholars, like Chowdhury (1991) and Noorbakhsh (1998), emphasized on the limitations of the arbitrariness of the qualitative and quantitative measures such as ranking and the assignment of weights which are used as the indices for assessment. In this paper, the emphasis is on the social, political, technological and cultural limitations of the human development index, regarding the assessment of HIV and AIDS in Africa. In particular, the study stresses the limitations and the backdrops of data collection in Africa. Divided into four different categories,

it states the problem and briefly examines the growing trend of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) over the years in Africa as reported by the human development index, as well as the means of data collection which is used as the basis of assessment; secondly, it offers a constructive criticism of these assessment measures with specific reference to their political, social and technological limitations and finally, the study offers suggestions on what the HDI can do to improve the quality of data collection and assessment of HIV and AIDS in Africa using Badach's proposed model.

**Statement of the problem**

This research is motivated by certain underlining problems in the area of research on HIV and AIDS in Africa. Briefly, the following common problems will be highlighted:

1) Generally in Africa there is a lack of an adequate demographic and socioeconomic data.
2) This has led to an obvious problem of access and use of valid data in policy making.
3) There is insufficient data or insufficient demand and use of data, its application by policy makers and key stake holders both at National and international level.
4) The general notion that a wrong data would ultimately lead to the application of the wrong policy.
5) Finally, the United Nations Development Programme (UNDP) since its inception has spent billions of dollars on HIV and AIDS, yet, we still have a lot of unreported cases of HIV and AIDS as well as increasing number of yearly infections. This is the case because inaccurate data hinders effective policy making. The UNDP spends more on research in vain with limited and often criticized results. Based on this aforementioned problem, the aim of this study would be to use Badachs guide for policy analysis to proffer solutions on how an effective method of data gathering on HIV and AIDS can be adequately implemented by the UNDP. There are eight rules when using Eugene Badachs model of policy analysis and this includes:

1) Define the problem: As already stated earlier.
2) Assemble some evidence.
3) Construct alternatives.
4) Select criteria.
5) Project outcomes.
6) Confront tradeoffs.
7) Decision on best alternative.
8) Telling the story.

To a large extent, Badachs model provides a bench mark for our analysis in this paper and the first three rules such as defining the problem, assembling evidence and constructing alternatives was judiciously followed in this paper. This is followed by projecting outcomes and confronting the possible tradeoffs or challenges. Having stated the problems, the next phase examines some evidences based on scholarly reviews on data management and collection in Africa and its constraints.

**THE HUMAN DEVELOPMENT INDEX AND HIV/AIDS IN AFRICA**

The human development index has provided a benchmark for the assessment of sustainable development in Africa. One of its measures for assessing life expectancy among countries is the degree and spread of HIV and AIDS in a country at any particular point in time (de la Escosura, 2011). In Africa, particularly Sub-Saharan Africa, the report of the HDI indicates a rapid and escalating growth of HIV infections; this in effect determines life expectancy and the level of development in the African region. According to the records, between 1990 and 2011, there was a continuous growth in the number of the carriers of HIV and AIDS infections in Africa, totaling about 39 million. By 2011, it reported that there were 34.0 million people in the world infected with this epidemic with Sub-Saharan Africa having a total of 23.5 million; and this in HDI report as indicated was due to the increasing death occurrences of 1.2 million annually, coupled with a rapid decline due to safety and enlightenment campaigns. Meanwhile, North America and Western and Central Europe had a total of 2.0 and 1.0 million people infected at rather low annual death rates of 28 000 and 7500, respectively, according to the HDI record (UNAIDS Global Fact Sheet, 2012). These reports when considered with other variables such as gross domestic product (GDP), level of poverty and income, and others, depict the life expectancy of a particular country at a given time.

**HDI METHOD OF DATA COLLECTION AND ASSESSMENT OF HIV/AIDS**

The measurement of HIV and AIDS falls under the life expectancy variable of the human development index which is compiled by the United Nations Development Program and published as the Human Development Report on an annual basis. The measurement thus serves as a global benchmark on assessing sustainable development, by examining the impact of GDP, education and life expectancy to ascertain the relationship among variables. The HDI basically collects its data on HIV and AIDS in African countries using primary sources such as the Joint UN Program and updates on HIV and AIDS, the Report on the Global HIV/AIDS Epidemic, and a joint publication of UNAIDS and the World Health Organization. On an annual basis, various regional centers provide update reports based on investigations, national data findings, data findings from governments, international organizations, non-governmental organizations and private sector organizations (such as employers, insurers and hospitals) (HDR, 2004). These reports are compiled, and states are assigned numerical values based on the quantity of the HIV/AIDS causalities recorded annually.

**HOW EFFECTIVE IS THE HDI DATA AND METHODS**

**The place of culture**

In an attempt to solve the problem of HIV and AIDS in

Africa, cultural solutions must be taken into cognizance (Müller and Moyo, 2011; Airhihenbuwa and Webster, 2004). While scholars have noted this stated fact, they however have not examined the nexus between the effect of African culture (bad governance and poor state of infrastructure) and the assumed predominance of HIV/AIDS in Africa. Why is culture a necessity for explaining the limited assumption of the prevalence of HIV/AIDS Africa? In extant literature, the emphasis has been on the need to place culture at the praxis of any development ideas, prescriptions or generalizations (Robert, 1994; Ali, 1992); unfortunately, the researchers have largely de-emphasized this concept, in the long run. Take for instance while there are plethora of debates on the origin of HIV and AIDS, its rather popular correlation with underdevelopment is largely questionable. The popular perception among scholars is that Africa is backward and that HIV and AIDS hinder development, or they are indicators of underdevelopment. But the case of Botswana appears to question this scholarly contention, thus underscoring the need to study development and underdevelopment in relation to cultural realities, where development and underdevelopment are predetermined by HIV/AIDS.

First, with Botswana's improving GDP praised by the international community, in 2007, the country's HIV/AIDS records were still on the high side (Rosling, 2013). This displaces the whole idea of development to be facilitated by absence of HIV and AIDS predominance (Rosling, 2013). It is on this instance that to totally displacing the peculiarity of Africa's culture when it comes to the study of HIV/AIDS predominance will be intellectually incapacitating. Indeed, there are reasons one should be skeptical about the predominance of HIV/AIDS in Africa, because of certain features inherent in African culture, complicated by state shoddiness and adynamia which are asymmetrically opposed to modernization and development. Or to succinctly put it, there are certain features limiting the propensity at development, making nonsense or complicating any effort of linking Africa's underdevelopment or otherwise to HIV/AIDS. Among the features, which will be considered next, are certainly technological constraints and political corruption which are all broadly endemic features in the African society, necessitated by weak governance which complicates the process of data collection, and limits the validity of quantitative findings used as benchmark for generalizations by most international agencies particularly the UNDP's HDI.

## Technological constraints

The effectiveness of any study both for academic and development purposes is hinged on the methodology of data collection (Rolfe, 2006). To a large extent, the validity and trustworthiness of a data totally depends on the wideness of its coverage, its all-encompassing approach, and not on narrow estimates. In Africa, getting adequate and up-to-date records in hospitals and maternal homes is an increasing challenge. How can the HDI obtain adequate result in Africa when the health care sector is in shambles, lacking adequate finance, space, electricity and modern computer to save health records of patients (Malan, 2012)? In Nigeria for instance, according to a study by Idowu et al. (2003) on the use of information technology in three government-owned health care institutions, it was found out that none of the hospitals had ever been connected to the internet. So, how can it be argued that the HDI assessment and measures are not inadequate? The study by Abdulkadir et al. (2011) indicates that the update and accuracy of medical records in Nigeria is questionable. Similarly, in their study, where medical records handling and archiving were assessed by examining the unit record books of Radiology and other departments in six regional hospitals, they accounted thus:

In all centres, there were variable non-documentation of patients' age and sex, hospital number, doctors' names and date of request. The names of patients and consultants in charge were commonly indicated. Unit record books generally suffered mutilations and in 27.2 to 33.2% of the requests, clinical information was inadequate or not provided. Radiological requests information provision and handling in our tertiary hospitals were inadequate.

Again, what implication does this have for the HDI adequacy on HIV/AIDS and underdevelopment or otherwise in Africa? It simply implies that given the weakness of most African governments in the provision of essential infrastructures for the public health care system, the idea of generating adequate data used as the basis of generalization remains highly impossible. The same situation was seen in Congo, a country that has been marred with crisis for a long time, the "Medecins d'Afrique" is currently engaged in a vast programme to combat AIDS through its documentation (Pana Press, 2013). This simply implies that Congo given the instability in the social and political sphere has no definite and proper documentation program.

## Discrimination against HIV and AIDS patients

Another important factor to be considered as a limitation to the adequacy and accuracy of the HDI data on Africa is the staggering rate of discrimination against HIV and AIDS patients in the continent. Due to the fact that most individuals with HIV and AIDS are discriminated against, the burden of health care as well as health provisions are left on the shoulders of the family members and friends

(IHAC, 2013). This to a large extent could limit hospital documentation of HIV and AIDS cases in most African societies. Given the great divide between the health care system and patients in Africa, getting adequate data from hospitals or even private clinics might be difficult, accordingly complicating the whole process of obtaining very reliable information on HIV and AIDS patients in Africa. And it is a fact that only the few rich and the well-to-do can afford hospital bills and medical care in the African continent (Mbele, 2005).

## Unregistered hospitals and clinics

In examining the validity of an adequate HDI-generated data, furthermore, an issue that must not be left out also is the existence of many health care centers that are not approved by the governments and thus will not want to affiliate with any agency of any sort in most African states. As mentioned earlier, the adequacy of any data-gathering methodology is dependent on its coverage within the involved polity (Rolfe, 2006). The issue of unregistered clinics is further aggravated by government legislations. In Kenya, while one may applaud the passage of the Health Care Record bill in 2006, which demanded that Kenyans register with government-acknowledged and approved hospitals, the national hospital insurance funds of civil servants awarded medical insurance to unregistered clinics and health care outlets in April, 2012 (Wabala, 2012). What this simply means is that there are no existing legislations governing the modus operandi of the health care sector in Kenya (Wabala, 2012). So, how can reliable data be collected and available in the health facilities?

In September, 2012, the Lagos State government in Nigeria shut down 15 clinics and hospitals which had been operating illegally for years in the urban society. With Lagos being one of the metropolitan cities in the country, how well can it be argued that the annual HDI and UNDP surveys have been able to obtain the accurate and adequate records they need to compare HIV epidemic with that in other countries (Akinsanmi, 2012)? The implication of this is that given the dormant approach of most African government towards the adequate regulation of the health care system, accuracy in data collection is highly limited.

## Corruption in the health sector

Corruption is an endemic phenomenon in Africa affecting every aspect and context of the society. Corruption goes beyond embezzlement of government funds or direct stealing of government monies in the areas of contract awards, budgetary allocations and during implementation

of policies. Corruption comes with a lot of complexities and complications which threaten the viability of the health care industry in terms of health care accessibility, equity and outcome (Vian, 2008). In a qualitative comparative study of Armania, Bulgaria, Albania, Armenia, Azerbaijan, Republic of Georgia, Mozambique and Carpe Verde, Vian (2008) found out that the Presidents Emergency Plan for AIDS Relief (PEPFAR), the Global Fund for AIDS, TB and Malaria, and other development partners, contributing hundreds of millions of dollars per year, created pressure to increasingly spend funds and increased the risk of corruption by requiring hasty decisions with limited and falsified, and sometimes unavailable data. From the foregoing, the tendency to inflate the number of carriers of HIV and AIDS in African countries due to perceived aid benefits from external donors remains a questionable issue and deserves further studies and thorough investigation, especially given the fact that virtually all the governments in Africa are corrupt.

## Does aid increase occurrences of HIV and AIDS?

Studies have queried the prevalence of HIV/AIDs in Africa in donor-dependent countries. Particularly in the case of Uganda, the rationale behind the acceptance of the prevalence of HIV and AIDS in Uganda by the incumbent president has been linked to the government's total dependence on aids (Tumushabe, 2006). To a large extent, Museveni's government has been totally dependent on aid from non-governmental organizations, international donors and others. With a constant huge yearly pay by late 1999 and early 2000 to 2005, Uganda was heavily externally financed to the tune of 600 million dollars per year (Tumushabe, 2006). In reality, the early assistance was vital for the government's delivery of basic social services and amenities, reduce the prevalent high costs of basic services, goods and remuneration of its public servants, which owed to the harsh economic situation suffered in the country after the long years of despotic military leadership under the Idi Amin and Obote regimes (Tumushabe, 2006).

Accordingly, considering the economic devastation and financial apocalypse of the Museveni-led Ugandan government, as well as its corrupt tendencies, how justifiable is that the government did not embrace the pre-valence of HIV and AIDS as a premise to attract financial largess? Tumushabe (2006) has argued that the Museveni government in its attempt to claim the success of HIV/AIDS eradication monopolized the press and has given the international community a positive impression; meanwhile, HIV and AIDS in Uganda remain a threatening epidemic issue till date (Tumushabe, 2006).

## CONSTRUCTING THE ALTERNATIVES: HOW CAN HDI IMPROVE DATA COLLECTION ON HIV AND AIDS IN AFRICA?

### Solution 1: Adequate and comprehensive researches

If the HDI will tackle the perceived and unclear prevalence of HIV/AIDS in Africa, it must be certain about the number of the carriers of this disease in the continent. It is the position of this paper that the HDI under the umbrella of the UNDP must spend more on research. Adequate data-gathering techniques in Africa will not take merely a year to build but decades. UNDP must invest and develop a more adequate and sophisticated data-gathering mechanism. In doing this, if the HDI is sincere, it must work with the government agencies, adequately financing and mobilizing its activities during this period. This is because any project left in the hands of African governments is due to be "compromised", given the kakistocratic system that has ravaged the political and social spheres in Africa.

### Solution 2: Integrated electronic health record systems

The HDI must invest wisely together with the collaboration of the various national governments at the development of an adequate health data base system, which will connect various government-registered clinics and hospitals together in a database at the national level and at the continental level. The integrated electronic health record system is operational in most developed societies like the United States, Canada and United Kingdom. The information contained in this database is organized primarily to support enduring, efficient and quality health care. And the database will help in sharing information about patients within the nation or across the continent. The implication this will have on the African states is not only a radical change in the health care delivery system, but also a radical improvement in recognizing the prevalent diseases that mostly result in mortality in the continent. Malaria, tuberculosis and typhoid are even more deadly diseases that kill sporadically, more than HIV/AIDS.

Without an adequate health care system, sicknesses are further complicated by giving the wrong medications for the wrong diseases. Millions of Africans have died due to this inadequacy in health records. Thus, there must be an adequate, interconnected data system managed by the HDI; otherwise, the true position of HIV/AIDS prevalence in Africa will remain elusive. It is only when the accurate number of HIV/AIDS infection is known that the adequate approach towards prevention can be devised.

### Solution 3: Partner with existing educational institutions in the area of research

Given the institutional collapse in most developing countries particularly Africa, the UNDP cannot rely on the collaborative effort of the bureau of statistics in most of these countries, rather a collaboration with the educational sector which essentially lacks funding will be necessary not only to improve data access but as well as the culture of research in these countries. A collaboration with colleges of sciences as well as departments of public health and medicine in various educational institutions would help to eliminate such forms of biases in data collection which will be strictly projected for academic and research purposes. It is appalling that majority of ongoing research on HIV and AIDS in Africa is undertaking in developed countries. This will also enhance a joint involvement of African institutions and scholars in the search for effective preventive measures and possibly a cure for the disease.

## PROJECTING OUTCOME: POSSIBLE EFFECTS OF THE AFOREMENTIONED SOLUTIONS

There are two possible outcomes if this policy is adequately implemented. First it will not only transform the status of health care delivery on the continent but will enhance other sectors of the society such as security, transparency and public scrutiny. If an adequate interconnected health care data base system is installed this will encourage other sectors of the society to emulate same features. Secondly, and as mentioned before, partnering with educational institutions in data accumulation will make it easier for researchers to develop sound and quality findings on what the government can do to curtail the spread of HIV and AIDS in the country. What target population or area needs much more focus in terms of intense enlightenment programs and public awareness? Instead of spending unnecessarily and outrageously without a defined target population that needs such enlightenment, a quality data will define the population that needs such enlightenment.

## TRADEOFFS: CONSTRAINTS

### Finance

For the UNDP to adequately implement this policy there are tradeoffs, one which is funding. First its present spending on HIV and AIDS in the continent will have to be directed to the area of adequate and measurable/reliable data. Though much of the funding on HIV and AIDS have been directed towards finding a cure for the epidemic, the

organization will have to re-direct its focus on solving the number of problems by adequately ensuring that there is available and reliable data. This will be highly difficult as the funds necessary to implement the already stated policies can be demanding, given the technological backwardness of the continent as well as the general state of education and research.

## BEST ALTERNATIVE

However, there must be a major step taken. Before partnering with educational institutions in the area of research, there is a need to partner with major stake holders in the health care industry in the continent before a major step is taken at integrating public universities.

## Conflict of Interests

The author(s) have not declared any conflict of interest.

### REFERENCES

Abdulkadir AY, Yunusa GH, Tabari AM, Anas I, Ojo JA, Akinlade B, Suleman BM, Uyobong I (2011). Medical record system in Nigeria: Observations from metacentric auditing of radiographic requests and multicentered auditing of radiographic requests and patients information documentation process. J. Med. 2(5).

Airhihenbuwa CO, Webster JD (2004). Culture and African contexts of HIV/AIDS prevention, care and support. J. Soc. Asp. HIV/AIDS Res. Alliance 1(1):4-13.

Akinsanmi G (2012). Nigeria: Lagos shuts 15 clinics, hospitals. Thisday Newspaper, September 17, 2012.

Ali MA (1992) "Development in a Multi-Cultural Context: Trends and Tensions in Culture and Development in Africa." Serageldin, Ismail and Taboroff, June (eds). Proceedings of an International Conference held at The World Bank. Washington D.C.

Chowdhury OH (1991). Human development index: a critique. Bangladesh Dev. Stud. 19(3):125-7.

de la Escosura LP (2011). Human development in Africa: A long run perspective. Explorations Econ. Hist. 50(2):179-204.

Human Development Report (2004). Notes on statistics in the human development report.

Human Development Report (2006). Human development indicators.

Idowu OI (2003). Information and communication technology in Nigeria: The health sector. J. Inf. Technol. Impact 3(2):69-76.

IHAC Report (2013). HIV and AIDS in Zimbabwe.

Mbele J (2005). Africans and Americans: Embracing cultural differences. Fridley, MN: Africonexion.

Müller J, Moyo N (2011). The influence of cultural practices on the HIV and AIDS pandemic in Zambia. Theological Studies 67:3.

Noorbakhsh F (1998). The human development index: Some technical issues and alternative indices. J. Int. Dev. 10(5):589-605.

Pana Press (2013). Congo conducts census of orphans under 18.

Robert K (1994). 'Taking Culture into Account: From 'Let's' to 'How''. In: Serageldin I, Tabaroff J (Eds.), Culture and Development in Africa. Washington: D.C.: The World Bank.

Rolfe G (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. J. Adv. Nurs. 53(3):304-10.

Rosling H (2013). HIV – New facts and stunning data visuals.

http://www.ted.com/talks/hans_rosling_the_truth_about_hiv

Tumushabe J (2006). The Politics of HIV/AIDS in Uganda. Social Policy and Development Program. pp. 1-39.

Vian T (2008). Review of corruption in the health sector: Theory, methods and interventions. Health Policy Plann. 23(2):83-94.

Wabala D (2012). Kenya: NHIF faulted unregistered clinics. The Star.