Full Length Research Paper

HIV and AIDS in Africa: Questioning the validity and the efficacy of the HDI measures

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Accepted 4 December, 2013

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/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? Perhaps a medical research report in Nigeria has come up with a figure that over 7 million Nigerians have been medically proven to live with HIV while close to 5 million have been suspected to be positive to HIV. But these people have not come out boldly to either be tested for HIV or treated due to the myths and misconceptions surrounding the infection (Akingbade, 2013). The paper however held that there is a need for further research in determining the validity of HIV/AIDS prevalence in Africa. It concluded with adequate recommendations.

Key words: Human development index (HDI), Africa, human immunodeficiency virus/acquired immune deficiency syndrome.

INTRODUCTION

The measures adopted by the human development index (HDI) 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. The measurement of HIV and AIDS falls under the life expectancy variable of the HDI 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 for assessing sustainable development, by examining the impact of gross domestic product (GDP), education and life expectancy to ascertain the relationship among variables. The HDI basically collects its data on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome(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 assigned numerical values based on the quantity of the HIV/AIDS causalities recorded annually.

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 common problems will be highlighted:

i) Generally in Africa there is a lack of an adequate demographic and socioeconomic data.
ii) This has led to an obvious problem of access and use of valid data in policy making.
iii) There is insufficient data or insufficient demand and use of data, its application by policy makers and key stakeholders both at National and international level.
iv) The general notion that a wrong data would ultimately lead to the application of the wrong policy.
v) Finally the central position of this research as well as the most eminent problem is that given the difficulty in collecting data reports on Africa as mentioned, how certain are the HDI standards in measuring the spread of HIV and Aids in Africa? If the HDI assigns the Western countries low scores especially the United States merely because of their technological advancement in controlling this epidemic, then should the measurement be based on the number of the carriers of this disease or the amount of death that result from it or the sophistication of the control measures?

More also, given the unprecedented increase in teenage pregnancies in the west how certain are the generalizations made by the HDI on the prevalence of HIV and AIDS in Africa. Based on available evidence, according to the United States Center for Diseases Control and Prevention (CDC) 2012, result shows that out of 79% of teens that are teenage mothers, 80% of these pregnancies occurred accidentally. The teen pregnancy rate in the United States of America is twice as that of Canada, four times that of Germany and France, and eight times that of Japan. Given this evidence, the research questions the efficacy of the HDI reports on the prevalence of HIV and AIDS in Africa. More also, given the cultural inclination of most African societies contrasted with a Western Laissez-faire life style characterize by the portrayal of sex through the mass media which results in an inappropriate and rather careless approach about the concept of sex, the HDI measures deserves thorough and critical investigation.

In this paper, the emphasis is on the social, political, technological and cultural limitations of the HDI, regarding the assessment of HIV and AIDS in Africa. In particular, the study will focus on the limitations and the backdrops of data collection in Africa. It will examine the growing trend of HIV and AIDS over the years in Africa as reported by the HDI, as well as the means of data collection which is used as the basis of assessment; secondly, it will offer constructive criticism of these assessment measures with specific reference to their political, social and technological limitations; thirdly, the paper questions the low scores accorded to developed countries or high-income countries based on their GDP as well as the technological sophistication; and finally, the research offers suggestions on what the United Nations Development Programme (UNDP) can do to improve the quality of data collection and assessment of HIV and AIDS in Africa.

THE HUMAN DEVELOPMENT INDEX AND HIV/AIDS IN AFRICA

The HDI 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 (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 who had HIV/AIDS, Sub-Saharan Africa having a total of 23.5 million. Meanwhile, North America and Western and Central Europe had a total of 2.0 million and 1.0 million people infected at rather low annual death rates of 28,000 and 7,500, respectively, according to the HDI record (UNAIDS, 2012).

WHY IS THIS STUDY IMPORTANT?

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 solution and generalizations (Robert, 1994). Unfortunately, the researchers have largely deemphasized 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 (Hans, 2013). This displaces the whole idea of development to be facilitated by absence of HIV and AIDS predominance. It is on this instance that to totally displace 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. On the positive side there is a strong moral, cultural and communal discipline in most African societies. On the negative side the society is complicated by state shoddiness and adynamia which are asymmetrically opposed to modernization and development. On the negative side you have factors such as technological constraints and political corruptions 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. These various weaknesses will be considered in the next phase of this paper.

EXPECTED BENEFITS TO THE DEVELOPING AND DEVELOPED STATES

This paper is expected to contribute to the broader discourse on the challenges and solutions to Africa’s development. As it relates to the issue of HIV and AIDS, it is expected that if the United Nations Development Program 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. The aim is not solely to criticize the findings of the UNDP but also to proffer adequate solution on what can be done to achieve proper documentation which will not only have positive implication on the society in terms of transparency and goal oriented policy application, but will also be beneficial to the developed societies such as the United States, Canada, France, Great Britain who contribute a substantial amount of their wealth to the actualization of the goals of UNDP. As the global economic domain becomes more challenging, it will be wise on the part of the developed countries that run these institutions to device a more strategic approach towards the actualization of its goals.

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 made 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, 2007). In a qualitative comparative study of Armenia, Bulgaria, Albania, Armenia, Azerbaijan, Republic of Georgia, Mozambique and Cape Verde, Vian 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 (Vian, 2007). 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 HIV/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 prevalence 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.

**LOCATION OF TESTING AND GLOBAL PERCEPTION OF AFRICA**

The location of testing when it comes to HIV and AIDS largely can influence the outcomes. Given the prevalent deteriorated health care systems, biological evidences have contradicted most study results in Africa. According to research, there are 70 diseases or conditions that can possibly cause false-positive reactions on HIV results in Western and non-western blocs by Johnson (2001). Many of these conditions are quite prevalent in Africa, including tuberculosis, malaria, leprosy, Q-fever, tape-worms or other parasites, and leishmaniasis. In order for tests for the conditions to work properly, it must be true that a protein (also called an antigen) will react only with the antibody that matches it. Antigen-antibody reactions are non-specific. Antibodies cross-react with antigens other than the ones that originally elicit them (Johnson, 2001). Scientists routinely ignore this well-known factor when it comes to HIV antibody tests. This questions the reason how in most cases individuals in Africa test positive and at some point test negative (Johnson, 2001). From the fore-going the argument is made that given the already destabilized health status in Africa, the HIV status of individuals may further be complicated resulting to false or wrong judgment of HIV status. This uncertainty is further worsened with the low testing ratio of some African countries. For instance, Zimbabwe government emphasized the importance of voluntary counseling and testing for HIV (VCT) in its National AIDS Policy in 1999. Between 2005 and 2010, the total number of health facilities offering HIV testing and counseling increased from 3,951,218 but still only 20% of the population knew their status in 2009 (IHAC Report, 2013).

**DISCRIMINATION AGAINST HIV/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).

**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 depends on the wideness of its coverage, its all-encompassing approach, and not on narrow estimates. In Africa, getting accurate 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? 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”.

To further illustrate the weakness of HIV/AIDS reports in Africa particularly in Nigeria, according to a new revelation made known to the media:

"A medical research report in Nigeria has come up with a figure that over 7 million Nigerians have been medically proven to live with HIV while close to 5 million have been suspected to be positive to HIV. But these people have not come out boldly to either be tested for HIV or treated due to the myths and misconceptions surrounding the infection (Akingbade, 2013)"

Having identified these weaknesses based on available evidence it is in the position of this paper to go beyond mere criticisms. The next phase identifies what can be done to ensure an adequate data gathering process as it concerns HIV/AIDS in Africa.

**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 collaboration with the various bureaus of statistics. 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 care 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, than HIV/AIDS.

Without an adequate health care system, diseases are further complicated by giving the wrong medications for the wrong diseases. 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 educational institutions**

There is a need for adequate partnership between research institutions in Africa and the UNDP in generating adequate data for its policy purposes. This will not only ensure for accuracy in terms of numbers but transparency in the end product of the research conducted. More also, datas generated and compiled by these institutions will not only improve the validity of adequate methodology in the research conducted on HIV/AIDS across the continent but will also contribute immensely in institutionalization of adequate research culture in the continent of Africa. This is important because one discouraging fact in conducting research on HIV/AIDS and other related health and social issues is the lack of adequate and reliable data. More also government policies across the continent is highly skewed due to this stated fact. In other to improve an adequate research culture, transparency in data collection which contributes immensely to policy making, there is a need to partner with educational institutions in the continent.

**REFERENCES**


