

Governance and AIDS in West Africa: an Overview

Background

The African Civil Society Governance and AIDS Initiative (GAIN) was founded in South Africa in October 2003, and is the centre of a global coalition to address the effect of HIV/AIDS on human rights, democracy and governance in African countries. GAIN's purpose is to raise public understanding of HIV/AIDS as a challenge to democratic governance in Africa. One reason for the threat is the nature of the societal challenge posed by HIV/AIDS. The second is the considerable difficulties that are faced in ensuring that the response to the HIV/AIDS epidemic in Africa is consistent with both the technical requirements of effective public health policy, and also supportive of democratic governance.

The focus of GAIN has remained on Eastern and Southern Africa, reflecting the backgrounds and research interests of the GAIN members. It is also where a large amount of the work on HIV/AIDS published in English is centred. GAIN's founding principle is that it should have a pan-African scope, and be concerned with how HIV/AIDS impacts on all Africans lives': from Cairo to Cape Town, and from Dakar to Dar-es-Salaam.

This paper provides an overview of the AIDS and governance situation in West Africa, in order to provide a template by which GAIN members can expand their interests away from the countries with which they are already familiar. As elsewhere in Africa, the West Africa 'region' is not rigidly defined, and overlaps considerably with the North and Central African regions. For the purposes of GAIN's work, however, 'West Africa' could be usefully defined as those countries identified by Journalists Against AIDS at www.nigeria-aids.org.^{*} This report will concentrate on six of these- Cameroon, Côte d'Ivoire, Ghana, Mali, Nigeria and Senegal- as case-studies, due to the availability of good evidence, their geographical spread, size of populations and linguistic division (Anglophone and Francophone).

HIV/AIDS remains the number one cause of excess-mortality on the African continent, and its effects are only just beginning to be assessed beyond the fields of medicine and biology. The United Nations has undertaken two important acts in this regard. First, it has defined HIV/AIDS to be a threat to international security- alongside terrorism and the proliferation of weapons of mass destruction- based upon the extraordinary social pressures that HIV/AIDS can add to nations, including mass migration, competition for resources, declining tax revenues, loss of skilled workers and erosion of governmental authority. Second, it established the Commission on HIV/AIDS and Governance in Africa in February 2003 to start addressing these governance concerns in Africa.

^{*}These are: Benin, Republic of Burkina, Cameroon, Cape Verde, Chad, Côte d'Ivoire, Gabon, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.

A myth that persists is that West Africa has successfully mitigated the worst effects of the HIV/AIDS epidemic in Africa through a combination of geography, greater development, luck and cultural immunity. None of these factors are capable, in themselves, of explaining why West Africa has so far avoided an HIV/AIDS epidemic on the scale of that which has been seen in Eastern and Southern Africa; but they all, doubtlessly, contribute. One obvious area of interest for GAIN members would be to understand why HIV/AIDS, if it is indeed less prevalent in West Africa, has spread so rapidly through Anglophone nations, but been muted in a region with a Francophone/Anglophone mix. What is clear is that as Eastern, Central and Southern African seroprevalence rates reach saturation, West Africa remains the area of most potential for the spread of HIV/AIDS in Africa in the next decade.

The idea that HIV/AIDS has been limited in West Africa is pervasive, and mostly stems from early evidence in the 1980s that HIV-2, a less infectious form of the disease with a more gradual progression towards AIDS, was the dominant strain in the region. In comparison the strain which spread so virulently through Eastern and Southern Africa was the more infectious and faster-acting HIV-1. Barnett and Whiteside (2002), among others, have shown that the geographical divisions of HIV are no longer so pronounced, with HIV-1 now being the dominant strain in West Africa as it is in the rest of the continent. HIV is a rapidly mutating virus, which partially explains the failure of medical science to discover a universal cure; and it has even been suggested that a third strain of HIV exists in Cameroon and Congo. The existence of HIV-3 remains to be seen, but the intermixing of HIV-1 and HIV-2 is now extensive enough in West Africa for the dominance of HIV-2 to no longer be explanation enough for the lower prevalence of HIV/AIDS, if indeed this was ever the case.

Problems to be Considered

The GAIN project has been marked from its inception with a pan-African flavour, which obliges it to reach out across cultural, political, linguistic and religious divides. This isn't always easy. Only the most casual review of the HIV/AIDS literature published in English will show an overwhelming majority of studies, reports and data focused on Anglophone African nations, with odd exceptions such as Senegal which is universally praised for its efforts in combating HIV/AIDS. Presumably, a similar situation would occur if one were to repeat the exercise in French, with an unusually large volume of data on Francophone nations.

If GAIN is to adopt and promote a workable agenda for HIV/AIDS and governance in Africa, it has to consider how its pan-African aspirations can incorporate a variety of cultural reactions towards HIV/AIDS. It has to be as applicable to Botswana with a 35% infection rate as it is to Senegal with a 1.4% rate. The huge variance in West African nations' infection rates clearly mark the region out as volatile and vulnerable to rapid and erratic change in HIV incidence. The differences between West Africa and Southern Africa, in terms of income, social cohesion, language, religion and ethnic heterogeneity are among the most pronounced on the continent. GAIN aims to develop an advocacy agenda that applies to all of Africa, and this demands in-depth examination and analysis of the issues involved.

1) Cultural Considerations

Recent thought on HIV/AIDS has developed the idea that social factors are the key variables in the progression of HIV/AIDS within a nation, rather than geography or biology. Just as it is imprecise to talk about an 'African epidemic', the idea of a 'West African epidemic' is nearly as vague. The epidemic needs to be discussed and evaluated on a national as well as on a local level. This is a region, after all, that contains Africa's largest nation, Nigeria, with 133 million people, and Togo with just 5.4 million. Although it has Africa's best known and most cohesive regional grouping- ECOWAS- it is characterised by extremes of population density, cultural tradition, linguistic division and religious cohabitation. It has nations, such as Mali and Senegal which have overcome disorder to institute progressive governance in the 1990s; and nations which have moved the other way, towards violence and division, most notably Sierra Leone, Liberia and Côte d'Ivoire.

The two most obvious divisions within West Africa, that are more pronounced than in other regions, are the linguistic separation between French and English speaking nations, and the roughly even split in the region between Christianity and Islam. Little research has been done, or at least encountered at this stage of the GAIN project, on the effect of language on HIV/AIDS. Anecdotal evidence would suggest that French-speaking Africa has been better insulated against HIV/AIDS than English-speaking Africa; but is this enough to suggest a causal relationship between language and the epidemic? Two countries to be analysed in this paper- Senegal and Côte d'Ivoire record the highest and lowest infection rates in the region (1.4% and 10.8% respectively): both are French-speaking.

The impact of religion on the epidemic has been better documented, and Muslim and Christian communities are roughly equally split within the region, often existing side-by-side or fully integrated. The tensions between Christians and Muslims have been well documented by the media, especially in northern Nigeria, and the region is often portrayed as hosting a slow-burning struggle between extremists on both sides. This is somewhat exaggerated, but the religious divides in west Africa are among the most pronounced on the continent, and need to be considered as at least a possible variable on the impact of HIV/AIDS on societies.

2) Economic Considerations

West Africa, again, displays great contrasts in terms of economic progress. As a region it is richer, and better materially endowed, than much of Africa; its nations tending towards the richer half of any income scale, measured either in GDP or per-capita income. Nigeria's regional economic superpower status is based as much on a huge population as it is on physical resources, and populations throughout the region, at least in coastal nations, are as large as they are productive. Within the prosperity, the region also includes Togo, Benin and Mali, three of the poorest nations in the world.

Agriculture is more industrialised and productive in the region than in Southern and Eastern Africa, mainly based on cash crops such as cotton and cocoa. The nations are the most industrialised in Sub-Saharan Africa, excluding South Africa, based on mining-gold, diamonds, phosphates and uranium- and oil. The service sector is booming in most nations. Again, Nigeria is the regional leader, and represents a

magnet for migration throughout the region- constantly impacting on the HIV/AIDS rate- as well as indirectly affecting the fortunes of its neighbour's economies.

Research into West Africa has to consider that the region contains a more mixed economy than the rest of Sub-Saharan Africa, with a lower proportion of the population engaged in subsistence agriculture (but still a greater proportion than in much of the rest of the world), which means a higher volume of economic migration, greater social mobility and a higher dependence on industrial sectors such as mining and transport that traditionally nurture high levels of HIV/AIDS.

3) Political Considerations

West African nations have largely democratised in the last twenty years, and Nigeria, as ever, remains the trend-setter from which the political discourse is led. In a crowded, and often divided, region democracy remains fragile, but is slowly becoming institutionalised. The GAIN partners have highlighted the importance of democratic, and above all plural, governance on managing the HIV/AIDS epidemic. The greatest challenge for West Africa is assessing whether a lower, but increasing, AIDS rate will have as great an impact upon democracy and good governance as it has in Eastern and Southern Africa.

Several unacknowledged factors could lead to potential political disaster in West Africa. First, a series of wars have engulfed Sierra Leone, Liberia, Côte d'Ivoire and Guinea in a domino effect since the late 1980s. Conflict has been shown to have an enormously detrimental effect on a society's ability to fight HIV/AIDS, due to the break-down in government health infrastructure, mass migration, rape used as a weapon of war, increased prostitution and the evacuation of healthcare-oriented NGO personnel. All of these factors have been exacerbated in each of these countries, and have a knock-on effect on their neighbours.

Second, democracies in the region relatively recent and very fragile, and have to contend with the legacy of departed dictators such as the Generals in Nigeria and Lt. Jerry Rawlings in Ghana. Western African democracies are as vulnerable to shocks such as HIV/AIDS as those in Southern and Eastern Africa. However, the generally lower incidence of HIV/AIDS in West Africa, coupled with a growing "fatigue" with the issue of HIV/AIDS in many African nations contributing to ever-increasing prevalence rates, could mean that the West African epidemic has still to reach maturity, and may do so well after the 'shock' value of HIV/AIDS wears off among donors. The impact of HIV/AIDS on governance in West Africa may, therefore, be something that communities are yet to fully experience.

Third, West Africa is the most densely populated region in Africa, and even small increases in infection rates may cause huge increases in deaths from AIDS, and all the attendant social disruption this brings. Nigeria, with a 5.8% adult infection rate, is still below the African average, but with a population of 133 million, it has more than three million sufferers, and has the third largest number of people living with HIV/AIDS on the continent behind South Africa and Ethiopia. Côte d'Ivoire's 10.8% infection rate in a population of just 16.5 million means it has at least one million sufferers; all demanding treatment and growing ever less economically productive.

4) Health Considerations

A casual look at available data on West Africa, such as that from the American Centers for Disease Control (CDC), shows a shocking lack of data on the region compared to Eastern and Southern African nations, and as such infection rates in the region must be treated even more as 'best guesses' than they are for most nations. Exceptions to this exist, such as Senegal, which has been well studied because of its successful AIDS campaigns, and Côte d'Ivoire, which has been extensively documented because of the international attention paid to the refugee crisis in the region (although a conflict situation makes data-collecting even harder than it is normally, so Côte d'Ivoire's data probably deserves as much caution as anywhere else.)

A 2000 report by The Policy Project upon Francophone nations in the region shows that HIV/AIDS data is sporadic across West Africa because the basic reproductive health indicators in the region are poorly collated- a legacy of colonial law that prohibited family planning, and restricted access to reproductive health information. As such reproductive health has a legacy of being under-funded, marginalized and lacking scientific rigour. This affects the HIV/AIDS rate because not only is data on HIV/AIDS badly collected, but fertility is high, as is infant and maternal mortality, ante-natal healthcare is under-funded and contraceptive use is minimal: all of which indirectly indicate populations at a heightened risk of HIV/AIDS.

Changes have been made recently, and pro-natal population policies across the region have largely been replaced by HIV/AIDS reduction strategies and family planning. The fact that these have occurred in the 1990s, rather than in the early 1980s as in Eastern and Southern African nations, suggests that low rates of HIV/AIDS in the region are probably the result of biology and geography rather than governmental and social action, and that these nations might still be at the very beginning of their AIDS epidemics.

The chances that West Africa has yet to see its most rapid growth in HIV/AIDS are very high indeed. The World Bank's 1999 report on HIV/AIDS in Africa estimated that only 10% of worldwide HIV infections had occurred by the late 1990s, and that while it has been suggested that Southern African nations are reaching 'saturation point' in their epidemics (reaching double figures of adult prevalence), West Africa would offer the most obvious potential for growth, due to its poor health infrastructure, large population and comparative poverty.

5) Considerations of Migration and Social Mobility

Social mobility has long been associated with high HIV/AIDS rates- consider the AIDS situation in a well-off nation such as South Africa upon return to civilian rule and the end of restrictions upon movement- but it is equally true to say that HIV/AIDS is also exacerbated by forced migration. A well understood and studied example- highlighted in Edward Hooper's *The River*- is the flight of Tutsi refugees from Ruanda-Burundi into the Kagera region of Tanzania, Uganda and Zaire in the late 1950s and early-1960s, which created a core of infection which has persisted for decades among the refugee community in the region.

UNAIDS characterises the West African epidemic as being constantly fed by well-established population movements in the region from Sahelian communities to coastal

regions for economic reasons. Nigeria is highly representative of this, with a highly productive coastal zone acting as an economic powerhouse for the region, supplied by cheap labour from an agricultural north and neighbouring countries. The movement has been further complicated in recent decades by the development of oil resources in the region, and the saturation of an oil-rich zone by skilled and unskilled economic migrants. Economic migrants are particularly vulnerable to HIV/AIDS due to their age (typically under 35), increased disposable income, and separation from their home communities, social norms and long-term sexual partnerships.

Migration in the region is further complicated by the series of conflicts that have engulfed Côte d'Ivoire, Sierra Leone, Liberia and Guinea. Refugees are particularly at risk from HIV/AIDS due to the lack of healthcare provision, rape used as a tool of war, prostitution and sexual exploitation, and lack of adequate monitoring of HIV/AIDS within refugee populations. Migrants also experience the effects of the breakdown in those social structures that slow the progression of HIV/AIDS and disseminate information on it, such as churches, community groups, trade unions and schools.

West Africa is thus known for large population movements, and this high volume of migration within a large population evidently exposes a large pool of people to HIV. The 'slow-burning' nature of HIV/AIDS means that the full implications of the forced migrations of the late 1990s and early 2000s have been delayed by some years, but will soon become apparent within the nations involved. The implications of large numbers of HIV/AIDS victims in states in post-conflict environments may not bode well for the reinstatement of democracy and stable governance in the region; and if West Africa's wars show anything it is that one state's problems are quickly passed on to its neighbours.

6) Considerations of Conflict

Judy Benjamin of the Women's Commission for Refugee Women and Children has noted that quantifying the link between conflict and HIV/AIDS is difficult because collection of reliable statistics is often hindered by militaries and paramilitaries, who remain generally suspicious of the type of large-scale surveys needed to accurately measure disease. What is known is that the link between violence and HIV/AIDS extends far beyond the anecdotal- 66% of survivors of the Rwandan genocide are thought to be HIV positive. More than 70% of deaths in modern wars are those of civilians, and violence will often be accompanied by rape, sexual slavery, forced migration and people trafficking, all of which adversely affect the AIDS rate.

Refugees that do not cross international borders are known as internally displaced persons (IDP's), and are often even more vulnerable to HIV/AIDS than international refugees, as they receive little attention under international law, and are not protected by the UN High Commissioner for Refugees (UNHCR). The number of IDP's has increased in Africa in the last two decades relative to the number of refugees, as it has worldwide, and this can only lead to greater incidence of HIV/AIDS. In Sierra Leone, up to 99% of women have tested positive for a sexually-transmitted disease within internally-displaced persons camps.

Conflicts also increase military mobility, with soldiers and paramilitaries spread over large areas rather than confined to barrack-towns. This increases prostitution and rape

and military culture often involves the spurning of reproductive health advice and forced sexual acts as a means of 'initiation'. Promiscuity is not just confined to those committing human rights violations. One criticism made of the ECOWAS intervention in Sierra Leone has been the increase in prostitution and rape by peace-keepers; and this is ultimately detrimental to the region's capacity to sustain such peace-keeping operations.

As well as increasing exposure to HIV/AIDS, conflict also erodes the abilities of governments, NGOs and the rest of the public health infrastructure to tackle the epidemic. It is the quick erosion of these structural mechanisms that provide healthcare that is the longest lasting, and most destructive legacy of conflict. Medicins san Frontieres reports from Côte d'Ivoire that the healthcare infrastructure has virtually collapsed in the nation, with the severing of supply lines, flight of healthcare professionals, evacuation of NGO staff, and the difficulties faced by patients in travelling to decent hospitals. Under such circumstances, healthcare expenditure is often limited to emergency medicine, and programmes such as reproductive health are quickly dropped for lack of resources. This creates a 'double-whammy' of reproductive healthcare resources being unavailable, and the drying up of reproductive health monitoring, upon which strategies for fighting diseases such as HIV/AIDS are based. Healthcare, as it exists, is left to disparate groups of aid agencies often unable to provide coordinated responses to health emergencies.

UNAIDS identifies modern conflict as marked not only by the rapid unravelling of healthcare infrastructure, but also by the deliberate targeting of hospitals, clinics and healthcare professionals as tools of war. War also makes the long-term study of HIV/AIDS infections (sentinel surveillance), upon which most AIDS data is based, very difficult; and once such studies are suspended they are very difficult to restart. West Africa is not unique in this respect. Much work has been done in the Balkans studying the effect of war on HIV/AIDS. The social unravelling that accompanied the Balkan wars was similar to that experienced in West African states, but the increase in HIV/AIDS did not match some fears. The difference between West Africa and the Balkans, however, is that the Balkans started and returned to a state of relative economic prosperity, and this seems to have mitigated some of the social collapse that would have otherwise occurred; and the Balkans entered the conflict with low HIV rates and ended it with low HIV rates.

Country Profiles

In order to gauge a better understanding of HIV/AIDS and governance in West Africa, GAIN has identified six nations- Cameroon, Côte d'Ivoire, Ghana, Mali, Nigeria and Senegal- as primary focuses for initial research. These nations have been chosen for the availability of substantial evidence, geographical spread, size of populations and linguistic division (Anglophone and Francophone). The country profiles are intended to be indicative of the region as a whole, but represent the reality that public understanding of HIV/AIDS in the region is still limited, and that some nations are more instructive than others.

Cameroon

Cameroon demonstrates the problems of studying HIV/AIDS in West Africa very well. A predominantly Francophone nation, but with a sizable Anglophone minority and membership of the Commonwealth, it has a medium-sized but dispersed population. A lack of reliable HIV/AIDS data, and other poor health indicators, suggest that the official (2000) 7.7% adult infection rate is an educated guess (alternative figures from 2001 show this to be 11.8%.) UNAIDS reports that national HIV/AIDS planning has only been implemented by the Ministry of Health, and does not extend to other government departments, indicating low governmental engagement with HIV/AIDS.

US Centers for Disease Control (CDC) reports that epidemiological evidence from Cameroon is generally limited, but urban surveillance of pregnant women and blood donors (two indicative groups) throughout the 1990s showed ranges of 6-19% prevalence, suggesting that the adult infection rate may be an underestimate. Data on sex workers, another core group, is limited, but a study in the capital Yaounde returned a result of 33% prevalence.

Cameroon's major industries of oil, mining and logging increase the nation's vulnerability to HIV/AIDS due the large volume of people moving into the country and via it's neighbours; and the port city of Douala is the nexus of established road and rail links through the region and into Congo Brazzaville and Congo Kinshasha, increasing population mobility. Like much of French West Africa, Cameroon's attitudes towards family planning did not shift until the 1980s, and the potential for contraception to control HIV/AIDS may be limited for this reason. Cameroon did not adopt a National Population Policy until 1992, and a Women's Plan until 1997. The cultural legacy of pro-natalism and the suppression of family planning, if socially ingrained, may not bode well for instituting rapid and comprehensive AIDS control programmes.

Cameroon has avoided political violence since 1990, but recent elections won by the ruling CPDM party in 2002 attracted numerous accusations of irregularity. President Biya has been in power since 1982 and has survived two coup attempts, winning re-election in 1997 with a 92.5% share of the vote, a result that has been heavily criticised. Cameroon's politics can therefore be judged as fairly undemocratic one-party rule, but with other parties permitted and with substantial followings.

This indicates a nation at moderate risk of political violence and instability, and therefore of heightened vulnerability to HIV/AIDS. Coupled with a substantial and mobile population, and poor HIV/AIDS surveillance, Cameroon could reasonably expect to see its adult prevalence rate continue to increase, creating future potential political crises in a nation without a long tradition of stable and legitimate government.

Côte d'Ivoire

Côte d'Ivoire has recorded the highest adult prevalence rate for HIV in West Africa- 10.8%- which is closer to the rates recorded in many Southern and Eastern African nations than it is to many of its neighbours in West Africa. Since the latest violence started in Côte d'Ivoire in September 2002, involving a partially successful army coup in the north of the country, good estimates of the adult prevalence rate have been impossible, but it has been suggested that it might stand at over 12%.

It is alarming that Côte d'Ivoire, although beset by political instability throughout the 1990s, recorded such a high HIV-rate before the latest political instability. Although political violence is well known to encourage HIV/AIDS, such high levels of infectivity in Côte d'Ivoire stand in marked contrast to the rest of West Africa. A worrying possibility for AIDS activists is that as Côte d'Ivoire and its neighbours- Liberia, Sierra Leone and Guinea- are so sensitive to each other's political troubles, this pattern could be replicated throughout the sub-region, and is under-reported due to political instability in all four nations.

The most recent violence masks any potential progress that may have been made in the years of relative stability during the mid and late 1990s. Ante-natal sentinel surveillance in urban areas (an indicator of the overall epidemic pattern) recorded significant decreases during this period, and the monitoring of blood donors and blood products seemed to be controlling, if not slowing, this method of transmission. Projects such as these require long surveillance periods, and are very fragile successes, but have been largely discontinued since 2001.

Another outbreak of violence means that healthcare monitoring in Côte d'Ivoire will be much reduced. As the HIV infected population increases, as it often does in conflict zones, donors, health agencies and governments will not only have a harder time in delivering services to communities, but will lose control of the accurate monitoring of the population's healthcare needs, severely limiting the response to healthcare emergencies. Conflict situations also demand greater resources to be devoted to treating combatants and refugees and strengthening emergency provision. Secondary healthcare concerns such as preventing or monitoring HIV/AIDS will be de-prioritised, and consequently any control of the epidemic is lost. The NGO Centre for Solidarity and Social Action worked with 900 families affected by AIDS in Bouake, the second-largest city, throughout the late 1990s, but now only treats 268 since the violence prompted mass migration and the break-up of families; presumably this is repeated throughout the country.

Côte d'Ivoire's political instability has resulted in the country having no national HIV/AIDS strategy, no specific AIDS-discrimination legislation, and no strategic plan assigning governmental and donor funds to HIV/AIDS programmes. HIV/AIDS

control is therefore weak and uncoordinated. Côte d'Ivoire's current occupation by a French/ECOWAS peacekeeping force in the centre and east of the country, and Liberian-backed guerrilla control of the west is not conducive to the return of IDPs in either area, and their numbers continue to grow. As noted already, IDPs are especially vulnerable to HIV/AIDS, and do not receive international legal protection.

Côte d'Ivoire seems to indicate that economic development is no barrier to HIV/AIDS, as between political crises the country has had sustained periods of prosperity. The social mobility of the population, and the constant movement of people fleeing violence appear to have created ideal conditions in which HIV can flourish. A high adult infection rate hinders governance as it depletes national resources, inspires fear, and de-legitimises leaders' attempts to unite the nation. HIV/AIDS born out of violence is often the result of rape and sexual exploitation, the legacy of which creates sizable obstacles to peace by fostering mistrust and a tradition of vengeance between groups. Overcoming such problems, and re-instituting democracy and good governance is difficult as HIV/AIDS acts as a persistent reminder of violence and social enmity.

Ghana

Nations such as Ghana seem to prove that HIV/AIDS is taking longer to become established in West Africa than it is elsewhere on the continent. The current adult infection rate of 3% in a population of twenty million is among the lowest in Africa, and significant infected populations were not recorded in the country before 1989. Reports on current interventions project an adult infection rate of 4% by 2014 for successful strategies, and up to 9% if such interventions fail. Failure of current strategies would mean that AIDS would account for a quarter of deaths in Ghana by 2014, a situation many African nations have already surpassed. Ghana is potentially well insulated against HIV/AIDS, but is certainly still experiencing its growth phase.

Ghana's economy is one of the least industrialised in the region, and 61% of the labour force is engaged in agriculture- subsistence mainly, but with significant numbers growing coffee and cocoa for export. A nation in a region with a relatively low AIDS-burden, with political stability and little forced population changes has reason to be optimistic about its capacity to deal with the HIV/AIDS epidemic, and should be well placed to mitigate any political shocks that could develop. Comparative poverty, however, and a reliance on subsistence agriculture means that governmental revenues are low, and any spare capacity for healthcare crises will have to be met from non-governmental sources, or by cutting budgets elsewhere. HIV/AIDS is well noted to cause shocks in the agricultural labour supply, forcing farmers to swap cash for food crops. This creates a decline in foreign earnings, and further reductions in government spending. Ghana would be particularly vulnerable in the region to such labour shocks due to its heavy dependence on the agricultural sector.

One significant industry, however, is gold mining. This too could pose potential problems for Ghana, as mining tends to be a magnet-industry for HIV. Miners, typically young men, are sexually active and have high disposable incomes, and the industry becomes associated with prostitution and homosexuality in the absence of conventional social mores. Mining also requires good communication links- typically

road and rail. Improvement in physical infrastructure creates greater social mobility and can increase HIV/AIDS, so if mining increases its share of economic output, the HIV/AIDS rate is likely to increase.

Two problems remain. The inter-relationship between tuberculosis and HIV/AIDS is well established, and it seems to be well entrenched in Ghana. Once tuberculosis and AIDS become linked in a population the two diseases often become co-dependent; and tuberculosis is the largest cause of death for people living with HIV/AIDS in Africa. The Ghanaian Ministry of Health estimates that cases of tuberculosis have increased three-fold since HIV/AIDS was first identified in Ghana in 1984. The Ghanaian epidemic is thus complexly bound up with tuberculosis and with other diseases- as it is in all African nations- but the problem seems to be growing ever more acute.

Secondly, while the intermixing of the various strains of HIV has occurred in all nations in the region, HIV-1 (the more infectious and fast-acting strain) is rapidly increasing in Ghana, perhaps due to the low incidence of HIV/AIDS in the country until now. As such, 90% of new infections are now of HIV-1, creating a population that is more infectious, and dying more quickly from AIDS.

Ghana has been a political success story, and been relatively stable since 1981, and even the coup that brought Fl. Lt. Jerry Rawlings to power was relatively bloodless. Ghana has experienced three free elections since 1990, and Rawlings remains one of the few leaders in Africa to leave office constitutionally after seizing power by force. This legacy should help Ghana to provide the governance response necessary to fight HIV/AIDS, and should provide institutional strength within the government to absorb the shocks of HIV/AIDS without restricting democratic freedoms and human rights. Ghana remains a good example for HIV/AIDS activists and the policy community to monitor, as it will continue to demonstrate the effects of an expanding HIV/AIDS epidemic in a nation with good governance institutions and a democratic tradition. Ghana's epidemic, whether destined to explode or remain muted, offers a benchmark by which HIV/AIDS effects' on governance can be measured in West Africa.

Mali

Mali is the largest of the states in this survey, but has the smallest of populations- just 10.5 million. Unlike its peers it is landlocked, and much of the north of the country is Sahel and Sahara desert. Its adult prevalence rate of 2.0% is very low, but this is based upon very poor data- perhaps the worst set for any of the six nations reviewed here. Anecdotal evidence from sex workers in Bamako, the capital, reported by the Centers for Disease Control suggests that, with 30% rates in urban prostitutes, the national general rate must be greater than that reported. A 1992 report of 6% prevalence in blood donors is more indicative, but is twelve years old.

Like many of its neighbours, one easily identifiable trend has been the rapid replacement of HIV-2 with highly infectious HIV-1 in Mali, and this suggests that HIV/AIDS will become worse within the next few years. Mali is the fourth poorest nation in the world, GDP averaging little more than \$80 per head. More than 80% of the population is engaged in subsistence or industrial farming, making the population very vulnerable to health shocks such as HIV/AIDS. With the exception of cotton,

there is little cultivation of cash crops. Substitution of cash for food crops in times of hardship is one method of survival in agrarian societies; heavy reliance on subsistence farming means there is little scope for absorbing the labour shocks inflicted by HIV/AIDS, and so Mali could find itself vulnerable to HIV/AIDS should the infection rate increase.

The Policy Project identifies two major difficulties for Mali. First, it is landlocked, this means that it is reliant on good road and rail connections to coastal ports, is dependent upon the goodwill of neighbours to transport goods, and is thus less able to control population flows than nations with sea-ports. Good transport links aid population mobility, and allow for increased human interactions and more chances for HIV transmission.

Second, mining is expanding as Mali's vast mineral resources are opened up for exploitation, and the government seeks ways to earn foreign currency. As shown, mining increases HIV incidence due to an increase in social mobility and the establishment of attendant sex industries. Mining labour remains highly nomadic in this vast country, and so HIV/AIDS becomes rapidly diffused through the general population.

Mali has been free of political violence for ten years, and the riots of 1993 were largely a legacy of the transition from dictatorship to democracy. Elections in 1997 were marked by wide spread irregularities and were not recognised by the political opposition, but were largely free and fair in 2002. Mali's ability to co-ordinate and adopt effective HIV/AIDS control programmes will, therefore, be restricted more by a lack of resources, and distribution of these over such a large nation, than they will by political instability or violence.

Nigeria

Nigeria is probably the most important country in this survey because even though its adult infection rate is low (5.1%), with such a large population (133 million) its number of HIV-positive citizens is among the highest on the continent, and by some way the largest contingent of sufferers in the West Africa region. The monitoring of HIV/AIDS in Nigeria remains inadequate for a nation of its size and wealth. Poor monitoring in a nation with such high social mobility and large population flows allows an unchecked epidemic of understandable concern.

Nigeria is also important due to the influence it has in the region, socially and economically, as well as politically. The success of ECOWAS interventions in Liberia and Côte d'Ivoire was largely based upon Nigerian manpower and money, and it remains the economic hub for the region. Since return to civilian rule in 1999, Nigeria has been welcomed back into international life, and its regional power status is now recognised and fed by international approval.

The fact that Nigeria, along with the rest of West Africa, has now developed a generalised epidemic (rather than one restricted to certain core groups), means that the entire population of the country is at possible risk of HIV/AIDS. The epidemiology is complex on a local level, however. Rates vary dramatically between Nigeria's federalised states, from a low of 3% adult infection in regions of the South East to

17% in the North. The fact that HIV/AIDS is higher in Muslim Nigeria could be a potential source of tension, as this population already outweighs the Christian community, which largely resides in the south and traditionally controls the state. Potential flashpoints between a politically dispossessed but highly infected majority, and a politically connected but uninfected minority, are easy to imagine, and within Nigeria's teeming millions could create enough opportunities for enmity to spill over into violence.

As in the rest of West Africa, HIV-1 has now displaced HIV-2, and so Nigeria has real potential to expand its infected adult population to Southern African levels. Double-digit inflation of Nigeria's AIDS burden could create tens of millions of AIDS victims, and a potential political crisis for a nation of any size. The epidemic seems to be more rampant in rural populations than in urban in Nigeria; this is fortunate as Nigeria contains at least one 'supercity'- Lagos- of 15 million and a dozen other cities of more than one million. Nigeria has rapidly urbanized, and so any increase in the urban share of HIV/AIDS would lead to a large increase in HIV/AIDS.

Nigeria is newly democratized, but its most pressing governance concern is mediating between the competing claims of a largely Christian South and a newly vociferous Muslim North. Although the introduction of Sharia law in Northern states in 2000 was well publicized, this is just the most visible expression of a deep-seated and ingrained cleavage within Nigeria that has spilled over into communal violence on more than one occasion. The religious tension is bound-up in a series of complex inter-relationships with ethnic tensions that have been crudely expressed as a struggle between Muslim Hausa and Christian Igbo and Yoruba. (The complexity of Nigerian society means, of course, that the reality is not this simple.)

Political violence in Nigeria could lead to sectarian rape and sexual exploitation, with large communities being denied healthcare coverage, and being left out of HIV/AIDS monitoring. Dictatorship has given way to democratic nepotism, and while Nigeria is more stable and pluralistic than it has ever been, huge social cleavages make the democracy a fragile one. Given the large number of people in Nigeria that political instability would effect- and the knock-on effect that this would have throughout the West African region- the ability to effectively and peacefully govern in the presence of HIV/AIDS must be taken as a cause for concern.

Senegal

Senegal has been described as the West African success story in combating HIV/AIDS. Its adult rate of 1.8% is the lowest recorded for any African nation, and it is one of the few Sub-Saharan nations to have avoided a generalised epidemic, largely containing its HIV/AIDS cases to certain groups such as prostitutes who record levels of up to 40% infection. Senegal's success has rested upon resisting the spread of HIV-1, and subsequently the percentage levels of the less infectious HIV-2 are the highest in any African population. Senegal's relative epidemiological purity may account for its persistent success in combating HIV/AIDS.

Whilst success in combating HIV/AIDS is always welcome, the difficulty in assessing Senegal is knowing whether this success is due to deliberate intervention or the effect of biology and society. Trying to prove the success of an intervention against

HIV/AIDS that started at the very beginning of the epidemic, and never had to tackle an epidemic of more than a few percentage points, is somewhat like trying to prove a negative. UNAIDS compares Senegal's success against two other successful interventions in Uganda and Thailand. The Ugandan and Thai interventions can be shown to be causally effective because rampant epidemics diminished in the face of assertive government policy. Senegal, however, launched a National AIDS Programme in 1986 when AIDS cases literally numbered in the dozens.

All doubts aside, given the relatively good monitoring of the epidemic, and Senegal's consistent commitment to tackling HIV/AIDS, Senegal probably does represent the best example of an African nation that intervened early to prevent a massive HIV/AIDS epidemic. This rigorous observation includes household surveys, targeted behavioural surveys of children, students, professionals and sex workers, as well as ante-natal and reproductive health clinic sentinel surveillance.

Coupled with this are committed spending regimes for reproductive health and paediatrics within the government health budget. Anecdotal health indicators, such as infant and maternal mortality levels are good. Much has been made of the widespread tradition of household savings for healthcare, and this does seem to be an effective and ingrained part of the social culture. Total spending on healthcare in Senegal is well above the average for a Sub-Saharan nation, and is belied by the size of the government health budget. NGOs and other civil society groups are well established in the health sector, some having been engaged for over forty years.

Senegal has adopted some radical and enlightened policies in preventing the spread of HIV/AIDS. Firstly, it legalised prostitution in 1969, and since this time comprehensive services (including healthcare) have been opened up to sex workers. Although prostitutes are still the most infected group in Senegal, the rates are nowhere near the levels found among sex workers in some parts of the continent. Secondly, tax on the sale of condoms and other contraceptive devices has been eliminated, and they have 67% coverage. This in a nation 95% Muslim.

Religion has been used to great benefit in Senegal. A vibrant civil society, with massive interaction between non-governmental organisations and religious groups, has been used to great effect in sustaining the anti-AIDS message, and the media is often recruited to help in this regard. A successful consensus on condom use has been adopted and stuck to, insisting that fidelity was the best defence against disease, but condoms, whilst frowned upon, were preferable to no protection at all. One indirect way of measuring public information success against HIV/AIDS in Senegal is that the message preached concurrently with AIDS awareness- that sex should be restricted to marriage- has led to a raising of the age of first sexual experience (65% over 19). The success of this campaign indicates that public health campaigns do work in Senegal.

Senegal has a peaceful political tradition, influenced by the largely benign one-party rule of the Parti Socialiste (PS) that ruled from independence until 2000, when it was replaced by the PDS party. An armed independence campaign has been fought in the southern Casamance region since 1982 by the Mouvement des forces démocratiques de Casamance (MFDC), but recent splits have reduced this to rival criminal operations rather than coordinated guerrilla action. Casamance has seen under-development due to sporadic violence, rather than full-blown social collapse in the

face of civil war. This remains the one region of the nation highly vulnerable to HIV/AIDS as a result of social disruption, and the sustained violence reduces the ability for authorities to accurately measure and plan HIV/AIDS control strategies. Rebel activity is limited enough for the wide-scale abuses of human-rights that promote the spread of infection, such as rape, sexual exploitation and forced combat, to have only a minimal effect on the infection rate in Senegal. In the absence of a dramatic increase in political violence, the only effect of rebel activity on HIV/AIDS will be an increased difficulty in providing extensive epidemiological monitoring of the Casamance region.

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