UNISWA RESEARCH JOURNAL

Published by the University of Swaziland

VOLUME 27, March 2014
SPECIAL EDITION

Editorial Board:	**Professor N.F. Awasom**	**-**	**Chairman and Editor**
	Prof. C.W. S. Sukati	**-**	**Deputy Editor**
	Dr. B.T. Dlamini	**-**	**Member**
	Dr. L.Z. Dlamini	**-**	**Member**
	Prof. A.M. Zamberia	**-**	**Member**
	Dr. P.N. Joubert	**-**	**Member**
	Prof. M.P. Dlamini	**-**	**Secretary**

EDITORIAL NOTE

In an Editorial Note to Vol. 20 (December 2006) of the UNISWA Research Journal, the following remarks were made by the Editor.

"The Editorial Board is making a determined effort to enhance the image of the journal internationally and also improve the quantity of published papers, thereby making the Journal competitive. Thus, besides the [internal] members of the Editorial Board indicated above, efforts are being made by the Board to appoint four additional members of the Editorial Board. They shall be appointed from Universities in Africa; one each from Northern, Southern, Western and Eastern Africa. The functions of these members will, among others, be to review manuscripts, assist in identifying reviewers, and to receive and forward manuscripts from outside Swaziland to the Secretariat of the Editorial Board. They will be appointed by the Vice Chancellor on the recommendation of the Editorial Board".

Since then, three international members of the Editorial Board have been appointed as follows:

Prof. C.B. Nzioka, University of Nairobi-representing East Africa;
Prof. N. Osarenren, University of Lagos- representing West Africa; and
Prof. M. Malaba, University of Namibia- representing Southern Africa.
Prof. O. Jegede, Association of Africa Universities (AAU) Secretary General and CEO
The Editorial Board is still searching for a suitable candidate to represent the North African region.

Prof. Nico F. Awasom
Editor, Chairman Editorial Board

CONTENTS

Foreword 5

Acknowledgements 6

Editorial note: Social policies and development in Eastern and Southern Africa
J.N. Vilakati 7

Towards a national policy on collaboration between the modern and traditional health systems in Swaziland
Hebron L. Ndlovu 12

Re-envisioning regional integration: A focus on the Southern African Customs Union
A.K. Domson-Lindsay 26

Beyond parity: Gender in the context of educational leadership in Swaziland
Sonene Nyawo and Njabuliso Nsibande 45

The impact of antiretroviral therapy scale-up in Swaziland
Muhle Nimrod Dlamini 59

"In Jesus' name you are free": HIV, ARVs and healing space in selected African initiated churches
Eliot Tofa 70

The implementation of ICT educational policy in selected schools in Swaziland
Nokuthula Vilakati 86

Convergence and asymmetries in the common monetary area in Southern Africa
Dumsile F. Dlamini 100

The role of family members in HIV-positive status disclosure and antiretroviral therapy uptake in Swaziland
Agostino M. Zamberia and Lungile P. Mabundza 119

A socio-cultural narrative of male circumcision in Swaziland
Thandi F. Khumalo 134

The WTO trips agreement, domestic regulation and access to HIV/AIDS medicines in Southern Africa: The case of Botswana and Zimbabwe
Jimcall Pfumorodze, Emma Chitsove and S.T. Morolong 145

Notes for contributors (UREJ) 155

FOREWORD

The Swaziland Chapter of the Organisation for Social Science Research in Eastern and Southern Africa (OSSREA) has reached another milestone through the publication of its second special issue of the University of Swaziland Research Journal (UREJ). This special issue, which isbased on the theme of *Social Policies and Social Development in Eastern and Southern African,* is focused on the interdisciplinary investigation and critical analysis of contemporary social and wider environmental challenges. A myriad of socioeconomic difficulties which have been experienced across Africa in the past,persistently continue to the present. Such challenges have foregrounded the need for more comprehensivesocial policies which are well-planned and prudentlyimplemented.

The rationale behind the theme is that development relies much on the implementation of social policies, hence attention to the twin issues of policy formulation and implementation.The research articles in this special issue intersected with studies that attempt to determine the status of policy formulation and implementation as well as research that revisits some of the policies in line with their intended outcomes, in order to re-evaluate their relevance and establish any intervening factors. Therefore, the main objective of the publication is toestablishthe state of social policy practice and research in Eastern and SouthernAfrica, and the extent to which these are responsive to the problems and needs ofthe population. Some of the papers have made a contribution through among other objectives, at identifying gaps and prioritiesfor research so as to make research more accessible to policy; and to establishlinks across social and related policies. **(Outgoing Swaziland Chapter of OSSREA, 2013).**

ACKNOWLEDGEMENTS

This publication has been made possible by the UNISWA Research Journal. The national chapter of OSSREA is indebted to OSSREA for providing necessary funding and support towards this publication. This special issue has been funded through a grant which the Swaziland Chapter of OSSREA was able to secure after submitting a winning proposal in 2012. The Chapter also acknowledges the invaluable input made by the Editorial Team consisting of the following members: Ms JN Vilakati, Prof M Kongolo and Prof VN Muzvidziwa. At another level of iteration, extensive editorial input was made by the UNISWA Research Journal Editorial Board members. We have learned many valuable lessons and look forward to more similar learning opportunities. We also subscribe to the value attached to the critical role that UNISWAplays in the viability of growing knowledge economies,which is fundamentally the result of the creation, application and transfer of knowledge.

The Chapter also acknowledges the support extended by the Vice Chancellor, Prof CM Magagula, the Pro-Vice Chancellor, Prof VSB Mtetwa and the UNISWA Research Board for granting publication space and quality assurance mechanisms. The Chapter also sincerely expresses appreciation to the authors of the ten papers in this publication, as well as others for providing their expertise through various functions.

EDITORIAL NOTE
SOCIAL POLICIES AND DEVELOPMENT IN EASTERN AND SOUTHERN AFRICA

J.N. Vilakati[1]

Like strangers in the night, dimly aware of each other's presence, health service researchers and managed mental health organizations have been exchanging glances but not much more.

Feldman S. (1999)

Strange as it may seem at a glance to begin an editorial note for an academic journal with the above quotation; on a closer look it is not. This Special Issue of the UNISWA Research Journal (UREJ) contains research papers written under the theme: Social Policies and Social Development in Eastern and Southern Africa. Such a theme was chosen by the Swaziland Chapter of OSSREA from 5 of the official research cluster themes that are contained in the 2011-2015 OSSREA Research Programmes. Listed as number 2, this theme fits into one of the long standing objectives of OSSREA, namely, "to facilitate the incorporation of the findings of social science research into the policy-making process in Eastern and Southern African countries".

When the Swaziland Chapter generated a proposal for funding of this research project to OSSREA headquarters, the team that drafted the proposal distinctly noted that the choice for the research theme resonates with both the global and the African continents' research and development discourse. It was noted in the proposal that the Millennium Declaration which gave birth to the Millennium Development Goals (MDGs) partly articulate a collective pledge by United Nations member states to working towards the realisation of the human right to development and "freeing the human race from want". Noted also was that the Millennium Declaration had included a provision for "meeting the special needs of Africa under Section VII. One of these special needs was identified as "poverty eradication and sustainable development".

It is common cause in development discourse that decision making regarding the what, why, when, who and how of development efforts rests squarely on information, evidence and data all of which are made available through research activity. To effectively address development needs therefore every country ideally ought to base creation of its programmes and interventions on contents of research outputs. For efficient delivery, programmes and interventions further need to be guided by relevant policy frameworks. Further, it is commonly agreed that policy planning and implementation ideally need to be based on evidence from research.

Yet as commonly accepted as it is in theory that policy makers and researchers need to work cooperatively towards the common goal of human development, this is an ideal that is not so commonly acceded to in practice. And so we can understand why Feldman as cited at the beginning of this editorial note observes metaphorically the regrettable estrangement of policy makers and [health] researchers even if they are aware of one another's existence.

---

[1] *Head of Department, Theology and Religious Studies, University of Swaziland*

Certainly, estrangement between researchers and policy makers is regrettable indeed as it is bound to impinge negatively on the effectiveness and efficiency of each party in its work. That is why the Chapter proposal also noted that the Millennium Declaration as a foundational document to the MDGs included a provision for "meeting the special needs of Africa" (Section VII). With regard to this special provision, leaders of developed countries were enjoined by former President of France, Nicholas Sarkozy to dedicate resources to supporting Africa in its efforts to achieve social development. In a press release during the 2010 Review Summit, Sarkozy reportedly warned leaders of developed countries against using the global economic recession as a pretext for failing to extend development aid to African countries. On his part, Sarkozy is said to have announced that his country would increase its contribution to the Global Fund set up to fight against HIV and AIDS, tuberculosis and malaria by 20% in the following three years.

Adding his voice to the chorus of expressed need for developed countries to assist Africa in pursuing its development goals, Ali Abdussalam Treki of Libya, as former President of the UN Assembly is reported to have pointed out that it would take more than goodwill and expressions of commitment to attain the improvements in social development which were itemised in the form of the MDGs. Treki further submitted that, "it would take *good policies*, tireless implementation and financial resources". Having underscored the necessity of good policies and other resources he went on to observe that some of the reports about the state of things in Africa that were already available to the UN Assembly contained "…everything needed for effective policies and programme".

The avowal of the necessity of policies for social development at UN ideally sets the stage for member states to follow the same thinking and to thus drive development efforts through specific policy frameworks. It is notable therefore that Africa, has its own Social Policy Framework (SPF) which was designed by the African Union (AU) as a strategy for directing the programme for social development. This programme is located within the work of the African Union Commission (AUC).

It is evident from the preceding that globally and continentally the pivotal role of policies in driving social development has been fully acknowledged and affirmed. Consequently, it would be expected that development work all over the world would be accordingly guided by good policies. However, this does not appear to be the case as the observation made by Feldman cited at the beginning of this editorial note suggests, with regard to the glib attention health service researchers and mental health programme managers pay to each other in Canada. What could be the cause of the unmet expectation for researchers and policy makers to engage one another towards effective and efficient development planning and implementation?

The reality is that in many African countries including those in the regions covered by OSSREA, there are various national policies intended to guide social development. Again, the question is why is the development charted in those policies not attained? Are the existing policies adequate in both scope and precision and accurate in strategic action? Are all critical areas of social development covered by policy or there is a policy gap in some areas? Are the other complementary factors such as a diversity of resources in order? These and other questions inevitably arise, for instance, when we realise that social development is not occurring at the pace and scope at which we desire it to occur. When we consider the rate of achievement of the MDGs in the continent and the likelihood of achieving these by the 2015 target date, these questions loom large.

In their various ways, the research papers contained in this Special Issue of the URJ can

be located within the questions raised above. The first paper, "Towards a national Policy on Collaboration between the modern and Traditional Health Systems in Swaziland" by H.L. Ndlovu indicates the existence of a policy gap in connection with the functioning of the two health-care systems operating in the country. The paper advances the rationale for recommending the creation of a policy that will regulate an ideal collaborative relationship between the two health-care systems by pointing out that these two health-care delivery systems do co-exist; the capacity of the modern health system to cope with demand is highly strained and that a policy for regulating the collaboration of both health systems would facilitate the tapping into and preservation of the indigenous knowledge that is embedded in the traditional health-care system. To demonstrate that this is not a far-fetched proposal, Ndlovu points out that collaboration between the two health systems is well established in global discourse, starting from the World Health Organisation's resolution to integrate modern and traditional medicine. The Ministry of Health in Swaziland has also expressed desire for such collaboration to take place albeit in a manner that Ndlovu discounts on the ground that it is based on a view that subordinates traditional healing to modern health-care. Ndlovu thus proposes a policy that needs to be formulated by a broad-based stakeholder community that is strategically positioned to bring all critical facets of the debate to bear in the policy planning process.

The second paper on "Re-envisioning Regional Integration: A Focus on the Southern African Customs Union" by A.K. Domson-Lindsay addresses a policy issue that is pertinent to Swaziland's economic performance since Swaziland is a member of the Southern African Customs Union (SACU). It is common knowledge that South Africa – the major partner in this regional body which also includes Botswana, Lesotho and Namibia has mooted pulling out of this body due to perceived diminished returns the country realises. The paper contributes to readers' understanding of the threats to the SACU's existence by demonstrating the fundamental flaw in its operations which are said to limitedly focus on trade issues rather than on a comprehensive development agenda. The author proposes that the SACU member states need to collaboratively adopt an industrialist focus on their integrative development efforts that will entail "diversification, complementarities and interdependent economic interactions". The thrust of this paper is in policy analysis in that it makes evident the need for re-drawing the policy framework for attaining the desired inclusive and equitable development within SACU.

"Beyond Gender Parity: Gender in the Context of Educational Leadership in Swaziland" is the title of the third paper co-authored by Sonene Nyawo and Njabuliso Nsibande. Based on data generated through face-to-face interviews of a non-representative sample of 21 female school administrators, the paper concludes that gender imbalance in the appointment of female head teachers continues to prevail in Swaziland's school system. The findings of the study include observation that in some instances women sometimes censor themselves with regard to aspiring to leadership. By demonstrating the persistence of gender inequalities in part of the educational sector in Swaziland, the paper shows the variance between policy ideals and translation of those ideals into practice. This country has a National Gender policy which was adopted in 2010 after being a long time in the making. Yet the existence of this policy does not begin to show any significant change in many areas of Swazi life. This might be a case of lack of political will to implement the ideals stated in the policy.

The next paper by M.N. Dlamini explored the "Impact of Anti-retroviral Therapy Scale-up in Swaziland". The study gathered data from 16 clients who came for ARV refills at one

of the oldest Voluntary Counselling and Testing (VCT) clinics in the Mbabane Government Hospital. Acknowledging the limitations which may be imposed by the small size of the sample of participants, the author confidently posits that the "policy implications of the study is clear". Reading the data, one can recognise its richness which is characterised by thick descriptions presented in the form of extensive verbatim quotes from the respondents. These help to informatively characterise the impact of ART on those who are taking it – indicating that it helps to reconstitute the immune system of patients and to lower the viral load. The policy implication here is that the Swazi government needs to guarantee the provision of ART to all people who need it.

Much as the paper by Dlamini demonstrates the positive impact of ART on the health status of those who are taking it, the paper that follows indicates that there is a troubling countervailing force in the form of healing beliefs and practices espoused in some Pentecostal Charismatic Churches. Written by E.Tofa, the paper titled "In Jesus' Name You are Free: HIV, ARVs and Healing Space in Selected African Initiated Churches" reports data that indicates how some faith healers dissuade HIV positive people who visit their churches from continuing with ART with the promises that the patients can be healed by either prayer or taking holy water that these churches sell. The paper makes a case for policy that can address this and other phenomena which demonstrably reverse the gains of ART uptake.

The paper on "The Implementation of the ICT Educational Policy in Selected Schools" by N.T. Vilakati adopted an evaluative approach. It examined the implementation of the 2007 National Information and Communication Infrastructure (NICI) Policy at school level. The data gathered from a selection of schools indicates inadequate implementation of this policy in that such implementation has been reduced to enrolling an equal number of male and female pupils in computer literacy programmes. Besides, the overall context of implementation is characterised by a diverse range of inadequacies, such as insufficient computer equipment and associated technological infrastructure, lack of qualified ICT teachers, requirement for learners to pay high fees to enrol for ICT programmes. Given the findings of the study indicating that both due to limited understanding of gender equity in education through provision of ICT curriculum and the inhibiting structural and logistical factors; the study recommends that there is need to develop a holistic approach to using ICT education towards attaining broader gender equity instead of limitedly focussing on statistics of boys and girls who are enrolled in ICT programmes.

In a highly technical paper on "Convergence and Asymmetries in the Common Monetary Era in Southern Africa" by D. F. Dlamini data gave rise to the finding that despite dissimilar trade shocks among countries on Common Monetary Area (CMA) there are ways of adjusting to these, making it possible therefore for the countries to eventually constitute a monetary union such as was envisaged by the African Union.

A. M. Zamberia and L. P. Mabundza conducted research on "The Role of Family Members in HIV Status Disclosure and Antiretroviral Therapy up-take in Swaziland". Data that they collected between 2006 and 2007 shows that despite the modifications in form, structure and values, the family remains an important avenue for providing the necessary psycho-social support to HIV+ people and People Living with HIV with regard to status disclosure and taking ART. Based on this finding, the paper recommends that agencies that provide knowledge on HIV and AIDS need to transmit such knowledge to family members so that family members are empowered to provide better care to the infected members. It is desired that such care be holistic in that with accurate knowledge of HIV and AIDS, family members are more likely

to provide moral support in the form of acceptance of the positive status of the infected and to also care for their physical needs.

The next paper titled “A Socio-cultural Narrative of Male Circumcision in Swaziland” by T.F. Khumalo situates the male circumcision Swaziland government’s 2009 policy, plan and strategy for Safe Male Circumcision for HIV Prevention within a social context that does not appear to be readily conducive to this undertaking. Khumalo importantly notes that the implementation of this programme takes place in a “non-circumcising culture” and one in which people largely show a propensity to hold on to traditionalist thinking when it comes to issues of human sexuality. It may not be altogether surprising that the number of males who have circumcised to date remains far below the target that was set initially (target was 100, 000 by 2014 yet 33, 000 have actually been circumcised). Anecdotal data suggests that there may be misperceptions of the benefits of male circumcision in that some people seem to think circumcision is a fool proof method of preventing HIV infection. The paper recommends that there is need for further evidence-based research in male circumcision; those who are providing male circumcision need to counter possible misperceptions about it through accurate information about its benefits and feasibility. The desirability and cost-effectiveness as a strategy to reduce the HIV infection rate in the country, needs to be assessed through research as well.

The final paper on “The WTO TRIPS Agreement, Domestic Regulation and Access to HIV/ AIDS Medicines in Southern Arica: The Case of Botswana and Zimbabwe” was collaboratively written by J. Pfumorodze1, E. Chitsove and S.T. Morolong. Pfumorodze et.al demonstrate though evidence from Botswana and Zimbabwe that these two countries have variously not taken full advantage of the flexibilities offered by the World Trade Organisation (WTO) Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement, to enhance access to HIV drugs for their respective citizens. While Botswana domesticated this agreement earlier than Zimbabwe, it did not comprehensively formulate a legislative framework that would accelerate availability of HIV medicines such as the cheaper generic but still effective ones. On the other hand, Zimbabwe which formulated policies for accessing HIV medicines later than Botswana, has come up with policies that are wholesome. However, Zimbabwe’s unstable socio-economic and political conditions impede the desirable access to HIV drugs as provided for in that country’s policies.

With this complement of papers that evince diverse policy implications, it is hoped they will provide valuable data for policy makers in our different countries to use for working towards the social development we all aspire for. One would hope that even if there would not be instantaneous recognition of the worth of the data and findings presented in these papers; they would at least instigate further discussions between researchers and policy makers in our countries. Researchers on their part perhaps need to think further about how they can successfully bring their studies to the attention of policy makers. It may very well be that launches are not enough if they are just going to be once off-publicity events for the publication of this edition of the URJ without leading to sustained interaction between policy makers and researchers. I would urge researchers in this volume to put their heads together to find a way of moving beyond the hazy recognition between them and policy makers and to create effective encounters that may put an end to this unfruitful estrangement.

TOWARDS A NATIONAL POLICY ON COLLABORATION BETWEEN THE MODERN AND TRADITIONAL HEALTH SYSTEMS IN SWAZILAND

Hebron L. Ndlovu[1]

ABSTRACT

This paper proceeds from the premise that professional partnership between the modern and traditional health systems in Swaziland is urgent and critical to effective delivery of health services in the country. Drawing on secondary and primary sources, I highlight the rationale, state, bottlenecks and prospects of the quest for integration of the two health systems. I suggest that a new national health policy should be formulated; a proactive policy that will take into account the views of a broad range of stakeholders, with the view to providing quality health care service to the greatest number of people, while regulating and consolidating the traditional health system.

Keywords: Health systems, collaboration, integration, modern medicine, modern medical practitioners, traditional/complementary and alternative medicine, traditional medical practitioners, stakeholders, treatment, health policy

INTRODUCTION

This paper discusses the challenges of formulating a national policy aimed at fostering formal collaboration between modern and traditional medicine in Swaziland. Modern medicine in this paper refers to the maintenance or restoration of human health by biomedical health care providers through scientific study, diagnosis, treatment and prevention of disease and injury where possible (Makhubu, 2009). The term traditional medicine, on the other hand, refers to "health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, to treat, diagnose and prevent illnesses and maintain well-being" [World Health Organisation (WHO) 2003: Fact Sheet, 134]. As is the case in other African countries south of the Sahara, Swaziland traditional medicine is closely intertwined with the Swazi cultural heritage.

Over the years there has been an on-going debate about the need for a national health policy aimed at collaboration between African traditional medicine and the modern health system (Makhubu, 1978; Green and Makhubu, 1983; Amusan, 2007; Makhubu, 2009). The envisaged Swaziland National Policy on collaboration between modern and traditional medicine should be a product of broad-based consultation and engagement between and among key stakeholders such as government, health practitioners, theologians/religionists, political scientists, economists, politicians, environmentalists, conservationists, traditional leaders, and leaders of faith-based communities, traditional healers and faith-based communities. The envisaged policy should, among other things, (1) delineate clear guidelines for formal cooperation between non-conventional and conventional medicine, (2) and spearhead the legal

[1] *Dr HL Ndlovu, Senior Lecturer, in the Department of Theology and Religious Studies, University of Swaziland*

recognition and regulation of traditional medicine in Swaziland. The current climate of medical pluralism in the country can contribute to a more nuanced collaboration between the modern and traditional health systems in Swaziland.

THE PROBLEM

To date Swaziland has not yet developed its own national policy that delineates the nature and scope of cooperation between modern and traditional medicine. While the current *National Health Policy* (Ministry of Health (MOH), 2007) recognises the existence of two health systems (modern and traditional) in the country, there is no attempt to promote and foster their integration. In addition, while the *National Health Policy* (MOH, 2007:3) states that the "informal sector consists of traditional health practitioners and other unregulated service providers" it does not provide a framework for its formal recognition, legalisation and subsequent regulation. What complicates the matter is that the current policy effectively negates the landmark strategic initiative of the *National Health Policy* (1998:37-38) whichexplicitly stated that "collaboration and cooperation with traditional healers will be strengthened" in "three priority areas of cooperation;" namely, through workshops, participation in disease prevention and research in the efficacy, safety and quality of traditional medicine.

Above all, Government has gazetted two bills on health related issues. Both bills, ironically, do not recognise traditional medical practitioners (TMPs) and traditional pharmacies unless they have been vetted by modern health practitioners and conventional pharmacies. These are *The Medicines and Related Substances Control Bill, 2012* and *The Pharmacy Bill, 2012*. The Medicines and Related Substances Control Bill, 2012 effectively renders traditional medical practitioners illegal since it defines a medical practitioner from the perspective of modern medicine as "a person registered under the Medical and Dental Practitioners Act, 1970," (*Medicines and Related Substances Control Bill, 2012,* Part I.2). Given that the Medical and Dental Practitioners Act, 1970, serves to regulate only the modern health system, this Act effectively makes it a criminal offence for a traditional medical practitioner to manufacture, sell or distribute traditional medicine unless such medicine is registered under this Act. In fact, the Act clearly states that any person who manufactures, packages, distributes or possesses a medicine or substance that is not registered under this Act commits an offence and "is liable, upon conviction, to a fine not exceeding twenty thousand Emalangeni, or to imprisonment for a period of fifteen years or both" (*Medicines and Related Substances Control Bill, 2012,* Part VIII.65.2).

The Pharmacy Bill (2012), on the other hand, undertakes to ensure that every medicine dispensed to clients in Swaziland must be properly registered with the Pharmacy Council, a body that will be created to, among other things, "control, promote, establish and maintain adequate standards in respect of pharmaceutical practice and education in the kingdom" (*The Pharmacy Bill, 2012* Part II.4.c). The Bill notes that it is an offence to not only manufacture but also dispense or administer any medicine that has not been registered with the Pharmacy Council. The *Medicines and Related Substances Control Bill, 2012* defines the term "medicine" as "any substance or mixture of substances which is used, or is manufactured, sold, or represented as suitable for use, in the diagnosis, treatment, mitigation, modification, prevention of diseases or any abnormal physical or mental state . . . and includes (i) veterinary medicine; or (ii) complementary medicine"*(Medicines and Related Substances Control Bill,*

2012, Part I). Ironically, the Bill expects the Pharmacy Council to consist of modern pharmacists, technicians/technologists and other related government health officials – none of whom represent traditional pharmacy.

Thus, whereas the above-mentioned bills have noble intentions of regulating, inter alia, the manufacturing, selling and dispensing of all medicinal drugs, medicines and related items in the country, in the absence of a national policy and legal framework that regulate and empower traditional African medicine, they unwittingly downplay the primacy of traditional medicine in Swaziland's health care system. In particular, these bills hardly accelerate previous and current efforts of fostering collegial relations and integral learning between medical practitioners belonging to the modern and traditional health systems in Swaziland.

METHODOLOGY

The data for this paper has been drawn from primary and secondary sources pertaining to the contentious subject of collaboration/integration of modern and traditional systems of healing. The primary data comprise Government policy documents, bills, legal frameworks and personal views of selected traditional medicine practitioners. Secondary data consists of an eclectic body of qualitative and quantitative sources representing various fields of study including chemistry, health sciences, medical anthropology, ethno-medicine, law and religious studies. Taken together, these secondary sources inform my analyses and interpretation of the primary data relating to the status quo, challenges and prospects of forging collaboration between modern and traditional health systems in Swaziland.

The underlying perspective undergirding the secondary sources is three-fold; namely, that: (1) a medically pluralistic society utilising both modern and traditional/complementary medicine is on the rise at local and global levels (Adler, 1999:215; Makhubu 2009: 110; Leonti, 2011:546; Nxumalo, Alaba, Harris, Chersich and Goude, 2011:134) ; (2) that traditional/ complementary and alternative medicine is perceived to be efficacious and generally cost effective to its users (Leonti, 2011:552; Pattanaik and Reddy, 2008:182; Adler, 1999:215) ; and (3) that traditional/complementary and alternative medicine complements biomedical medicine in one way or the other in the delivery of health care (Guerci, 2012:8; Leonti, 2012:552; Dey and Nath De, 2012:160; Gavriilidis and Ostergren, 2012;Pattanaik and Reddy, 2008:177, 183; Makhubu, 2009:12; Dlamini, 2002:80).

DISCOURSE ON COLLABORATION BETWEEN MODERN AND TRADITIONAL MEDICINE

Contemporary studies of health systems at global and regional levels attest to the urgent need to forge collaboration between modern and traditional/non-conventional modern medicine to enhance effective and universal health care delivery. Brief references to a few examples, with special attention given to current debates on the matter in South Africa and Swaziland, will suffice.

Writing from the perspective of the United Nations Conference on Trade and Development, Xhang (2004:3) observed that in recent times there has been a sudden increase in the use of traditional/complementary and alternative medicine in both developed and developing countries. Similar claims were made by Ernst, Cohen and Stone (2004:156) and Leonti (2011:546) that the popularity of complementary and alternative medicine in both developed and developing countries was considerable. More specifically, Gavriilidis and Ostergren

(2012) point out that several countries such as the United Kingdom, China, India and Ghana have integrated traditional/complementary and alternative medicine into their health-care system. For these observers, the demand for traditional/complementary and alternative medicine in both developed and developing countries indicates, among other things, that modern medicine has failed to meet the health needs of all people.

On the African continent, the African Union, at the 2001 Assembly of Heads of State and Government, adopted an action plan for health system integration of traditional medicine/ complementary and alternative medicine by 2010 (Gavriilidis and Ostergren, 2012). Significantly, Sama and Nguyen (2008:10) observe that in many African countries, deteriorating social and economic conditions, and pandemics like HIV and Aids and malaria put severe strains on the modern health system, rendering radical and pragmatic health sector reforms imperative, one of which should be the formal integration of traditional and modern systems of healing. In particular, Mugisha (2008:201) notes that in Uganda the government committed itself to forging formal co-operation between conventional and non-conventional medicine pre-eminently to ensure and optimise good health for the Ugandan populace. Relatively recently, Suleman and Alemu (2012:36) noted that in Ethiopia, the majority of the population still relied on traditional medicine to meet its basic health care needs; and that the Ethiopian government has shown interest in promoting and developing traditional medicine alongside modern medicine.

In the case of South Africa, Gavriilidis and Ostergren (2012) observe that in 2008 the Government Department of Health drafted a traditional medicine policy that endorsed the integration of African Traditional Medicine into the modern health system. The policy was rationalised on the basis of the World Health Organisation's official declarations calling for the creation of national policies that promoted traditional or complementary medicine and alternative medicine. The policy was also justified on the grounds that most South Africans use traditional medicine for preventive, curative and palliative purposes (Nxumalo et al, 2011 and Gavriilidis and Ostergren, 2012).

Of critical importance about the South African traditional medicine policy, according to Gavriilidis and Ostergren (2012), is its clear objective to empower individuals and communities that profess, practice and utilise traditional medicine. In their non-partisan evaluation of the policy, Gavriilids and Ostergren (2012) contend that, to some extent, the traditional medicine policy of South Africa does empower individuals and communities connected to traditional medicine through the creation of programmes and initiatives that include the : (1) education and training of traditional medical practitioners, health science students, public school pupils and the general public via publications, journals, and the media; (2) employment and entrepreneurship opportunities; (3) and for traditional medical practitioners and other persons who have an interest in researching, teaching, cultivating and preserving African traditional medicine.

However, the South African traditional medicine policy, in the opinion of Gavriilids and Ostergren (2012), has two major shortcomings. First is the absence of a legislative framework that provides for the involvement of traditional medical practitioners, affected communities and constituencies in the drafting of the policy. They show that the said policy was crafted by a panel of technocrats with vested economic interests that were at variance with those of traditional medical practitioners. Yet key stakeholders such as the traditional medical practitioners and lay representatives of the consumers of traditional medicine, or those dissenting voices that had reservations about traditional medicine were reportedly not involved

in the process of drafting the policy.

The second weakness of the South African traditional medicine policy, according to Gavriilidis and Ostergren (2012), is its top-down implementation. The policy is planned and implemented by the central government, and supervised by a centralised body called the National Institute of African Traditional Medicine. In this state of affairs, there is no provision for a decentralised implementation organ.

In Swaziland, the discourse on the need to formulate a policy that establishes a formal working relationship between traditional/non-conventional and modern/conventional medicine has spanned a period of about three decades (Makhubu, 1978; Green and Makhubu, 1983; Dlamini, 2002; Mdluli, 2002; Amusan, 2007; Maseko, 2007; Makhubu, 2009). The need for such a policy is rationalised on several grounds, and these include: enhancing the delivery of health services, protection and regulation of non-conventional medicine, promotion of the traditional healing industry, and conservation of indigenous knowledge systems for socio-economic and ideological reasons (Makhubu, 2009:107; Maseko, 2007:68; Dlamini, 2002:60; Khumalo, 1989:16).

In particular, Makhubu (2009) ; Dlamini (2002) ; and Mdluli (2002) contend that in Swaziland the modern health system needs to be complemented by non-conventional medicine to meet the increased demand for medical services due to the HIV and AIDS pandemic, tuberculosis and other diseases that have spread at an alarming rate in recent times.

THE POLITICS OF SWAZILAND'S PLURAL HEALTH CARE SYSTEM

As in other countries worldwide (Adler 1999; Guerci 2012), a prominent feature of the country's plural health sector is the privileged position of the modern health system *vis-a-vis* the traditional heath system. The modern health system enjoys government backing through funding, policies and legal instruments. The main service providers in the modern health system are government, Christian churches, industry and private practitioners. According to the *National Health Policy* (2007:3), this cluster of service providers has the mandate to shoulder the primary health care needs of the country. The Medical and Dental Practitioners Act, (1970) guarantees all modern health practitioners legal protection, guidance and regulation as they discharge their responsibility in the country.

The traditional health system, in comparison, is mostly non-governmental, and is generally ignored and unregulated; and its personnel has no legal status (*National Health Policy 2007:3;* Makhubu, 2009:12 *),* notwithstanding that the majority of Swazis rely on it for their basic health care requirements (Makhubu, 2009:11; Ndlovu, 2011:579; Dlamini, 2002: 60; Mdluli, 2002: 15).

The privileged position of the MHS stems from the colonial era wherein western Christian missionary churches and the British colonial state in Swaziland collectively positioned the modern health system over the traditional health system under the auspices of Christian evangelism, western education and social progress. Christian mission churches - which aimed at wholesale conversion of the Swazi from their 'God-forsaken' cultural heritage - branded traditional healing as demonic, evil and superstitious; while the colonial legislation criminalized the practice of witchcraft accusation by traditional medical practitioners through the *Suppression of Witchcraft: Crimes Act 6/1889* (Dlamini, 2002:33). Khumalo, (1989:16) correctly observes that this legislation inhibits the art of traditional healing since the diagnosis of an ailment or mishap is normally traced to another human being.

Ironically, the stigmatisation and proscription of traditional healing practices has persisted overtly and covertly dating back to the colonial period, despite the concerted efforts by the *Ingwenyama* (the King) Sobhuza II (1921-1982) to protect and regulate it via ordinances and government policies (Kuper, 1978).Overtly traditional medicine has been (and still is) criminalised via the Suppression of Witchcraft legislation of 1889, and it has been stigmatised through national health policies (1998 and 2007) that define it as an 'informal health care' system despite that fact that traditional medicine is an established cultural institution in Swazi society (Makhubu, 2009 and Ndlovu, 2011). Nonetheless, the *Ngwenyama* (Sobhuza II) did make concerted efforts to protect traditional medicine as an institution. He believed that traditional healing should be investigated scientifically to determine its efficacy (Makhubu, 2009:7). Makhubu has observed that during the year of his demise (1982), Sobhuza II had initiated the formulation of a legislation that would legalise and regulate the traditional healing system (2009:7). But his efforts were not vigorously pursued after his death, and the traditional health system is still largely viewed in a negative light by the Swaziland government.

The government policy to place the modern health system at a supervisory level vis-à-vis traditional healing is also evident in the *National Health and Welfare Policy, 1998* which attempted to foster collaboration between the two health systems. In its definition of the nature and scope of the proposed collaboration, the policy suggests that traditional healing will be integrated to modern healing via, among other things, orientation, seminars and research findings on the efficacy of selected medicinal plants (1998: 37-38). While this initiative was laudable and progressive in certain respects, this kind of collaboration positioned traditional healing as an apprentice of modern healing. This development was unfortunate given the widely held scholarly view that the two health systems represent two diverse systems of knowledge with different notions of truth about health care which can complement each other (Dlamini, 2002; Makhubu, 2009). It was largely in recognition of this fact that the WHO has passed several resolutions and declarations advocating for the integration of traditional health systems into national health care systems (Gavriilidis and Ostergren, 2012). In this regard, as we noted above, the African Union adopted a plan of action to mainstream African traditional medicine in the national health systems of all its member countries by 2010 (Gavriilidis and Ostergren, 2012).

That the playground of the health sector in Swaziland is too skewed in favour of the modern health system is amply shown in the current bills (*The Medicines and Related Substances Control Bill, 2012* and *The Pharmacy Bill, 2012)* that seek to promote the quality of health care in the country by regulating, inter alia, the production, sale and dispensing of medicines. The critical issue here is that in both Bills the composition of the technocrats entrusted with regulating the medical industry with respect to medicines and related items exclude representatives of practitioners of traditional medicine. In addition, *The Medicines and Related Substances Control Bill, 2012* prohibits a traditional medical practitioner to sell or supply any medicine that has not been registered and vetted by the Medicines Regulatory Authority. For any medicine to be approved, it has to be labelled with its name, registered number and directions for use. These rigorous stages make it difficult, if not impossible, for the vast majority of traditional healers to register their medicine given that most of them are hardly literate.

However, the desire of the modern healing system to meet the primary health care needs of Swaziland should not blind one to the fact that the current government policy bolsters the material interests of the global medical industry. In Swaziland, as in other African states, the

accelerated increase in the number of private clinics, pharmacies, and health insurance companies is a pointer to the rapid penetration and expansion of the multinational medical industry. In fact, there is consensus among many health analysts, that more often than not, local social policies on health issues are engineered by multinational entities located in the developed economies (Sama and Nguyen, 2008:9; Xhang, 2004:3; Banerjee, 2004:91). Disturbingly, it is claimed that much of the raw materials used by modern medicine to produce herbal medicine and related products for the global market are procured from developing countries but patented in the developed countries without the consent and knowledge of the peoples from which it was obtained (Ricupero, 2004:iii; Xhang, 2004:5; Mhame, 2004:17)

But the traditional health system, likewise, is equally driven and sustained by the material interests of traditional medical practitioners and their clients. As noted above, the traditional heath system is not only patronised by most Swazis (Makhubu, 2009:11), but also by the *Ngwenyama* in his capacity as the ultimate custodian of Swazi Law and Custom. Further, the traditional healing in Swaziland is culturally recognised as a constituent element of the Swazi indigenous cultural heritage, and traditional healers are widely respected in contemporary society (Ndlovu, 2011:579).

Yet the moral authority of the traditional healing system has, over the years, been tainted by propensity for secrecy and belief in magical powers (Makhubu, 2009:13). A case in point is the witchcraft-related issue of ritual murder. As in several Southern African countries such as South Africa and Botswana, similarly in Swaziland specific traditional medical practitioners or healers have been convicted and sentenced to death for killing persons for medicine to be used to further personal ambitions (Kasenene, 1993; Akiiki and Kealotswe, 1995; Niehaus, 2001). Although no African government condones it, its provenance among some traditional medical practitioners undermines the social esteem of traditional healing.

In recent times, the ingenuity of the traditional healing system is also compromised by the exponential increase in the number of traditional medical practitioners in the peri-urban sectors. This trend has contributed to the transformation of traditional healing into a lucrative informal business enterprise. Makhubu notes that this trend has given rise to the emergence of unscrupulous traditional medical practitioners; a scenario that is exacerbated by the absence of social controls and legal instruments for regulating the traditional system of healing (2009:9-10).

Above all, the moral authority of the traditional system of healing is compromised by uncertainty about its efficacy. This is due to the fact that its efficacy can hardly be quantified. As Ernst, Cohen and Stone (2004:159) and Leonti (2011:552) correctly observe, traditional or complementary and alternative medicine operate on principles that take cognizance of a continuum between belief and rational inquiry. This scenario engenders doubt or blind faith on the part of the general public and patrons, and it also opens the doors to vices such as pretentiousness, extortion and fraud on the part of the providers of traditionalor complementary and alternative medicine (Ernst *et al.,* 2004:159).

The shortcomings of traditional healing outlined in the preceding paragraphs, taken together with the political dynamics of Swaziland's health care system described above, suggest, among other things, that the desired goal to formulate a national health policy that shall mainstream traditional medicine in the national healthcare system should be pursued carefully, taking into considerations the social, cultural, economic and political factors that have an adverse impact on effective delivery of health care in the country.

THE WAY FORWARD: TOWARDS FORMAL COLLABORATION BETWEEN MODERN AND TRADITIONAL HEALING

I. Rationale for collaboration

From the foregoing discussion it is evident that both modern and traditional healing systems co-exist and co-habit, albeit as unequal partners. It must be emphasised, as well, that the modern and traditional health systems represent diverse modes of thoughts bolstered by distinct belief systems. As alluded to earlier, the modern system is based on western science and Christianity while the traditional system (in the case of Swaziland) is based on indigenous knowledge and interactions with trans-empirical powers. The critical point, however, is that the two systems of healing need to complement each other, formally, and as autonomous partners, in the interest of the common good.

In the Swaziland context, there are two compelling reasons for forging linkages between the two systems. First and foremost, the modern system is currently failing to meet the health care needs of the nation; and, considering evidence-based analyses and prognoses of the national health care system made by local based studies (Makhubu 2009 and Dlamini, 2002) and the government Ministry of Health, it is unlikely to be able to do so in the immediate and medium term future. Makhubu correctly observes that presently the demand for modern medical services is exacerbated by the HIV and AIDS pandemic and other widespread diseases such as tuberculosis (2009:14) ; while Dlamini contends that the modern health system cannot meet the health care needs of the Swazi populace without the collaboration of the traditional health system, "especially with reference to chronic illnesses such as diabetes and hypertension" (2002:60). The National Health and Welfare Policy (MOH, 2007) concedes that the modern health system "faces intricate human resource demands." According to the WHO (2004), the ratio of doctors and nurses to the population was 1:5 953 and 1:356, respectively" (MOH, 2007:4). This scenario is "complicated by the burden of disease due to HIV and AIDS, poverty and migration of skilled health workers" (MOH, 2007:3-4). Meantime, the ratio of traditional medical practitioners to the population was 1:110 (Makhubu, 2009:8).

In Uganda, the modern health system faced a similar challenge. Mugisha (2008:203) observes that the ratio of traditional medical practitioners to the population was 1: 400, while that of modern medical practitioners was 1:20, 000. These ratios highlight the pivotal place of the traditional health system in the health care sectors of developing countries such as Swaziland; and the imperative of formal cooperation between the two systems to ensure effective health care delivery.

The second compelling reason for fostering a working relationship between the modern and traditional health systems is the need to promote the regulation, conservation and marketing of traditional healing as indigenous knowledge treasure (Makhubu, 2009). For Makhubu (2009:12), Dlamini (2002:61) and many other analysts (Kiev, 1989:163-164; Guerci, 2012:5; Pattanaik and Reddy, 2008:177; Dey and De, 2012: 160), formal collaboration between the two systems can foster the appreciation of the unique contribution of the traditional healing to modern medicine; namely, the utilization of healing techniques that focus not only on biomedical symptoms of a disease but also on psychological and sociological factors. Significantly, Makhubu (2009:12) and Dlamini (2002:79) observe that most Swazi (as other peoples in many other developing nations in Africa and beyond) utilize both the modern and traditional health systems when they fall sick. Nxumalo *et. al* (2011) also observe in the South African context that many people use both the modern and traditional health systems when they

are ill, and most of them rationalize their utilization of traditional medicine on the ground that they perceive its treatment to be effective (2011:130).

The fact that collaboration between modern and traditional healing contributes to the conservation of indigenous knowledge is attested by Mhame (2004). Relating the Tanzanian experience, Mhame contends that formal collaboration ordinarily engenders laws and policies that protect the intellectual property rights of traditional healers, with special emphasis on "equitable sharing of benefits derived from the natural wealth of the country" (2004:19).

II. Views of some Swazi traditional medical practitioners on collaboration

By and large, Swazi traditional medical practitioners are fully supportive of government sanctioned collaboration between modern and traditional healing since it would formalise and legalise their current delivery of primary health care in the country. A few examples will suffice:

1. Ms Khumbulile Mdluli, a prominent traditional medical practitioner and a member of the Traditional Healers Organisation, addressing delegates at a Workshop on the Management of HIV and AIDS held in 2002 at the University of Swaziland, submitted that most Swazi would first contact traditional healers before seeking assistance from modern medical practitioners when they have medical problems. When contacted about HIV and AIDS related ailments, she gives them some counselling and "refer them to hospital" (2002:15). For Ms Mdluli, formal collaboration between the modern and traditional healing systems would help facilitate the involvement of traditional healers in the management of HIV and AIDS at grass-root level. As well, collaboration would help engender understanding and appreciation of the traditional healing system given the "derogatory and stigmatising attitude of many modern medical workers towards traditional medicine" (2002:16).
2. Mr Nhlavana Maseko, a prominent traditional medical practitioner and current President of the Traditional Healers Organisation, addressing delegates at a Workshop on the Integration of Traditional Medicine with Conventional Medicine in the Health Delivery System held at the University of Swaziland in 2007, submitted that the members of his organisation supported collaboration between the two health systems, but not the integration of traditional healing to modern healing (2007:60).
   He maintained that Swazi "traditional medical practitioners would like to have cooperation on equal terms with conventional medical practitioners in the delivery of health to the people" (2007:62). When I requested Mr Maseko to elaborate on his position he said: "We do not want integration. We want collaboration. We do not want to be swallowed by modern medicine ((personal communication, October 1, 2012).
3. Mrs Kate Mbuyisa, a prominent traditional medical practitioner and a member of the Traditional Healers Organisation, during an interview at her residence in 2012, submitted that she was fully supportive of collaboration with modern medicine because many traditional medical practitioners – other than herself who has attended several workshops and seminars on HIV and AIDS - would receive proper training on HIV and AIDS related illnesses. She stressed that "currently there are very few traditional healers who are knowledgeable about the HIV and AIDS pandemic; this is a cause for concern to many Swazi" (personal communication, March 30, 2012).
   Commenting on the issue of the nature of the envisaged collaboration between modern and traditional healing, Mrs Mbuyisa contended that modern and traditional medical practitioners should cooperate on equal and autonomous terms, claiming that the latter's

depth of knowledge was actually superior: "The traditional healer is superior to a modern medical practitioner. S/he knows everything about medicine and healing. I cannot fail. I can begin with divination; followed by a witch-finding séance. I cannot fail to treat you. If I do not succeed, I will refer you to another traditional healer".

4. Mr. Julius Ndlovu, in an interview at his residence in 2012, submitted that he was supportive of a policy that fosters collaboration because it will spearhead the legalisation of traditional healing, the conservation of indigenous plants, and the promotion of scientific study of medicinal plants. He lamented over what had obtained in the recent past (colonial era) when Europeans plundered Africa's traditional medicines: "Our medicines were taken away; they were stolen by Europeans. Our grandfathers were flogged by Europeans; they were compelled to reveal their medicinal plants. They are now using the same medicines to treat HIV and AIDS".

The above submissions by the Swazi traditional medical practitioners (TMPs) do not only highlight their perceptions and concerns about collaboration. Rather they are pointers of deeply ingrained prejudices about, and mistrust of, modern healing held by TMPs in the country. One common feature about the views of the four prominent TMPs cited above is their strong suspicion of the motives of modern medical practitioners (MMPs) and other categories of analysts who work in concert with them, since it is assumed that the MMPs generally espouse negative views about non-western medical knowledge. It is in this regard that all four TMPs strongly emphasize that they wish to function independently of the MMPs in order to guard against traditional medicine being "swallowed" by modern medicine. Another common feature about the above-cited views of the TMPs is that they hold dogmatic opinions about the efficacy of traditional medicine vis-`a-vis western medicine. In this regard, the TMPs perceive some of their medicines and their medical profession to be qualitatively superior to western medicine. For example, Mrs Kate Mbuyisa asserts that TMPs are better placed to heal various ailments because of the holistic nature of their medical practice wherein they make a diagnosis, prescribe medicine or manufacture it, administer it and monitor the patient's condition. Mr Julius Ndlovu, on the other hand, claims that TMPs are essentially endowed with better medicines that are envied, and even expropriated, by European colonialists and re-sold to the African in the form of well packaged tablets.

Given that traditional medicine in the Swaziland context is a culturally standardized institution that reflects and affirms dominant ideas and values held by most Swazi (Makhubu, 2009:6; Ndlovu, 2011:579), these suspicious and prejudicial views held by traditional medical practitioners about modern medicine manifest deep-seated misinformation and suspicion that prevail in Swazi society about modern medicine. Likewise, however, modern medical practitioners (MMPs) as represented by the Swaziland Medical and Dental Association hold strong, unequivocal views about their objection to collaboration with traditional healing. Simply put, they find it difficult to collaborate with the traditional health system because its *modus operandi* is not amenable to scientific measurement and validation (Makhubu, 2009:109-110).

In this regard, one may draw two insightful cues from the recent evaluation of the South African Traditional Medicine Policy by Gavriilidis and Ostergren (2012). First, an ideal policy that strives to forge meaningful integration of African traditional medicine to the modern health system should aim to empower traditional health care practitioners and their various clients through programmes and legislations that are designed to foster self-reliance, create new career opportunities and promote entrepreneurship at grass-root level. Second, an ideal

policy that integrates the two health systems must ensure active involvement of the principal drivers and consumers of traditional medicine in the formulation and implementation of the policy given that in the final analysis they are its main beneficiaries.

In the Swaziland context, the South African experience sheds some light on, among other things, the need to formulate a national policy on traditional medicine that strives to champion the cause of the cultural, social and economic advancement of the large majority of Swazi (the key stakeholders) whose livelihood and health care needs revolve around traditional medicine.

CONCLUSION

The roadmap to collaboration is premised on the existence of political will and nationwide consultation. This paper has attempted to demonstrate that the quest for forging collaboration between the modern and traditional health systems in Swaziland is both a national and ethical matter. This matter can no longer be deliberated upon with sincerity by partisan stakeholders in the flourishing medical industry whose material interests are disguised via appeals to scientific rationality, or Swazi indigenous beliefs and heritage. Nor can the quest for collaboration be delegated to the Government alone given its prolonged history of giving financial, technical, and administrative backing to the modern health system while it generally ignores the traditional heath system. Rather, this matter needs to be addressed by a broad array of stakeholders that will assume a clear and unequivocal mandate, namely: to ensure primary health care delivery to the greatest number while conserving the cultural heritage.

Building on the *National Health and Social Welfare Policy of 1998* and the *Public Health Bill*/1999 cited above, the task of these various categories of stakeholders would be to serve as a think-tank that would spearhead the crafting of a proactive national policy that shall take into consideration the following concerns that were noted in the paper:

(1) The politics of the health sector in Swaziland;
(2) The political economy of the global medical industry;
(3) The imperative to formulate a national health policy that would facilitate the creation of legislation and regulations aimed at promoting, preserving and empowering traditional medicine ;
(4) The need to forge formal collaboration between the modern and traditional health systems.

All in all, the future direction of health care delivery in the Kingdom of Swaziland will ultimately be determined by the political will of all concerned Swazi.

REFERENCES

Adler, S. R. (1999). Complementary and Alternative Medicine Use among Women with Breast Cancer. *Medical Anthropology Quarterly. New Series*. 13(2) : 214-222).

Akiiki, A. B. T. and Kealotswe, O. N. N., (Eds.). (1995). *In*: *Healers and Protective Medicine in Botswana.* University of Botswana, Gaborone.

Amusan, O.O.G. (2007). Integration of Conventional and Traditional Medicines: A Researcher’s Perspective. *In*: Amusan, O. O. G. (Ed.). Proceedings of the Workshop on the Integration of Traditional Medicine With Conventional Medicine in the Health Delivery System University of Swaziland, Kwaluseni, Swaziland. 4 April 2007.

Banerjee, M. (2004). Local Knowledge for World Market: Globalising Ayurveda. *Economic Political Weekly* 39: 89-93.

Dey, A. and De, N.J. (2012). Anti-snake Venom Botanicals Used by the Ethnic Groups of Purikia District, West Bengal, India. *Journal of Herbs, Spices & Medical Plants* 18: 152-165.

Dlamini, P. M. (2002). The Witchcraft Act: The Attorney General.pp. 24-41. *In*: Makhubu, L.P., Amusan, O. O. G., and Shongwe, M. S., (Eds.). Management of HIV/AIDS with Traditional Medicine: Proceedings of the Workshop on the Management of HIV and AIDS with Traditional Medicine.University of Swaziland, Kwaluseni, Swaziland,

Dlamini, P. S. (2002). Collaboration Among Traditional Medical Practitioners and Orthodox Medical Practitioners. pp. 59-84. *In*: Makhubu, L.P., Amusan, O. O. G., and Shongwe, M. S., (Eds.). Management of HIV/AIDS with Traditional Medicine: Proceedings of the Workshop on the Management of HIV and AIDS with Traditional Medicine.University of Swaziland, Kwaluseni, Swaziland.

Ernst, E., Cohen, M. H. and Stone, J. (2004). Ethical Problems Arising in Evidence Based Complementary and Alternative Medicine. *Journal of Medical Ethics* 30(2) : 156-159.

Gavriilidis, G and Ostergren, P. (2012). Evaluating a traditional medicine policy in South Africa:phase 1 development of a policy assessment tool. *Global Health Action 2012, 5: 17271. http://dx.doi.org/10.3402/gha.v5i0.17271*

Green E. C. and Makhubu, L. P. (1983). Traditional Healers in Swaziland: Toward Improved Cooperation Between the Traditional and Modern Health Sectors. Ministry of Health, Swaziland Government. Swaziland.

Guerci, A. (2012). Between anthropology and ethno medicine. *European Journal of Integrative Medicine* 4S: 5-8.

Kasenene, P. (1993). *Swazi Traditional Religion and Society.* Websters, Mbabane.

Khumalo, B. R. (1989). Traditional Medical Practice and the Law in Swaziland. LL.B Project, University of Swaziland, Kwaluseni Campus.

Kiev, A. (1989). The Psychotherapeutic Aspects of Primitive Medicine. *In* : Lehamn, C. A. and Myers, J. E., (Eds.). *Magic, Witchcraft, and Religion: An Anthropological Study of the Supernatural*. Second edition. Mayfield Publishing Company, Mountain View, California.

Kuper, H. (1978). *Sobhuza II: Ngwenyama and King of Swaziland.* Africana Publishing Company, New York.

Leonti, M. (2011). The future is written: Impact of scripts on the cognition, selection. Knowledge and transmission of medicinal plant use and its implications for ethnobotany and ethnopharmacology. *Journal of Ethnopharmacology* 134: 542-555).

Makhubu, P. (1978). *The Traditional Healer*. University of Swaziland, Kwaluseni, Swaziland.

Makhubu, L. P. (2009). *Traditional Medicine and Healing in Swaziland.* University of Swaziland Research Centre, Kwaluseni, Swaziland.

Maseko, N. (2007). Integration of Conventional and Traditional Medicines: A Traditional Medical Practitioner's Perspective. pp. 60-68. *In*: Amusan, O. O. G. (Ed.). Proceedings of the Workshop on the Integration of Traditional Medicine With Conventional Medicine in the Health Delivery System.University of Swaziland, Kwaluseni, Swaziland. 4 4 April 2007.

Mdluli, K. (2002). Management of HIV with Traditional Medicine. pp. 14-18. *In*: Makhubu, L.P., Amusan, O. O. G., and Shongwe, M. S., (Eds.). Management of HIV/AIDS with Traditional Medicine: Proceedings of the Workshop on the Management of HIV and AIDS With Traditional Medicine.University of Swaziland, Kwaluseni, Swaziland..

Mhame, P. P. (2004). The Role of Traditional Knowledge in the National Economy: Traditional Medicine in Tanzania. pp. 17-19 *In*: Tworog, S. and Kapoor, P.. (Eds.). Protecting and Promoting Traditional Knowledge: Systems, National Experiences and International Dimensions. United Nations Conference on Trade and Development, United Nations, New York & Geneva. Ministry of Health and Social Welfare. (1998). *National Health Policy*. Swaziland Government, Mbabane, Swaziland.

Ministry of Health and Social Welfare. (2007). *National Health Policy*. Swaziland Government, Mbabane, Swaziland.

Mugisha, M. M. (2008). Should We 'Modernise' Traditional Medicine? pp. 201-224. *In*: Sama, M. and Nguyen, V., (Eds.). . *Governing Health Systems in Africa*. CODESRIA, Dakar.

Ndlovu, H. L. (2011). Sangomahood, abstinence and celibacy among *tangoma* in Swaziland, in edit., Tamale, S., *African Sexualities: A Reader*. Pambazuka Press Cape Town, Dakar, Nairobi and Oxford.

Niehaus, I. (2001). *Witchcraft, Power and Politics: Exploring the Occult in the South African Lowveld.* Pluto Press, London.

Nxumalo, N., Alaba, O., Harris, B., Chersich, M, and Goudge, J. (2011). *Journal of Public Health Policy* 32: 124-136.

Pattanaik, C. and Reddy, C. S. (2008). Medicinal Plant Wealth of Local Communities in Kuldiha Wildlife Sanctuary, Orissa, India. *Journal of Herbs, Spices and Medicinal Plants* 14 (3-4) : 175-184.

Ricupero, R. (2004). Foreword. p. iii. *In*: Tworog, S. and Kapoor, P., (Eds.). Protecting and Promoting Traditional Knowledge: Systems, National Experiences and International Dimensions. United Nations Conference on Trade and Development, United Nations, New York & Geneva.

Sama, M. and Nguyen, V. (2008). Governing Health Systems in Africa. Pp. 1-11. *In*: Sama, M. and Nguyen, V., (Eds.). *Governing Health Systems in Africa*. CODESRIA, Dakar.

Suleman, S. and Alemu, T. (2012). A Survey of Utilization of Ethnomedical Plants in Nekemte Town, East Wellega(Oromia), Ethiopia. *Journal of Herbs, Spices & Medicinal Plants* 18: 34-57.

The Medicines and Related Substances Control Bill, 2012. *Swaziland Government Gazette,* September 14, 2012. Websters Print, Mbabane, Swaziland.

The Pharmacy Bill, 2012. *Swaziland Government Gazette,* September 7, 2012. Websters Print, Mbabane, Swaziland.

WHO, (1978). The Promotion and Development of Traditional Medicine. *Technical Report Series* 622. Geneva, Switzerland.

Xhang, X. (2004). Traditional Medicine: Its Importance and Protection. pp. 3-6. *In*: Tworog, S. and Kapoor, P. (Eds.). Protecting and Promoting Traditional Knowledge: Systems, National Experiences and International Dimensions. Paper presented at a Conference on Indigenous Knowledge Systems in 2000. United Nations Conference on Trade and Development, United Nations, New York & Geneva.

World Health Organisation. (2003). *World Health Organisation, Factsheet 134: Traditional Medicine*. WHO, Geneva:

World Health Organisation. (2004). *3 By 5 Update Report for Swaziland*. Mbabane, Swaziland.

RE-ENVISIONING REGIONAL INTEGRATION: A FOCUS ON THE SOUTHERN AFRICAN CUSTOMS UNION

A.K. Domson-Lindsay[1]

ABSTRACT

A careful reading of the 2002 SACU Agreement shows that trade and development issues dominate the SACU agenda. The Agreement reveals the intent of SACU states to promote trade and industrialisation in the integrative zone. But as some commentators have pointed out, in practice, the focus is on "trade integration" which is not enough to achieve broader development objectives. Presently, SACU faces some challenges. For example, there are doubts over the sustainability of the revenue sharing mechanism; the revenue pool is steadily declining because of global recessionary effects and tariff liberalization schemes; the polarized pattern of development persists and there are subterranean tensions between South Africa and the other participating states. Guided by empirical data and normative theoretical framework, the article will discuss the challenges faced by SACU and show what ought to be done to address the challenges and promote equitable, balanced and inclusive forms of development.

Keywords: Agreement, integration, liberalization, trade, fiscal, polarised

INTRODUCTION

The Southern African Customs Union, hereafter SACU, comprising South Africa, Botswana, Lesotho, Namibia and Swaziland (BLNS) owes its existence to the 1910 Customs Union Agreement between the Union of South Africa and the High Commissioned Territories—colonial Botswana, Lesotho and Swaziland. Namibia joined after independence in 1990. SACU is often cited in the integrative literature as one of (if not) the oldest and successful integrative zone in the world (see Gibbs, 1997; Vale, 2001). For some, its success and longevity are due to the commitment of the member states to the idea of SACU and the revenue sharing arrangement underpinning it. Simply, the view is that in a customs union, members remove barriers to trade and impose common external tariffs on imports from outside the customs zone. According to the classical economic doctrine this arrangement leads to 'trade creation' and 'trade diversion'. Protective trade policies enable efficient producers in participating states to displace imports into the customs area. Trade barriers make imports more costly and therefore compel member states to significantly direct trade away from traditional partners –external efficient producers. In the case of SACU, trade loss – for both external producers and the BLNS States – largely leads to trade gains for South Africa, the leading economy. The SACU Revenue Pool can thus be regarded, in one sense, as a compensatory mechanism. This pool is shared among the member states according to their "annual imports, production and consumption of dutiable goods" (see Gibbs, 1997:77). But many analysts have pointed out that the BLNS States draw disproportionately more than they bring to the pool. SACU therefore rests on a *quid pro quo* arrangement in which South Africa has a near monopoly over the BLNS

[1] *Department of Political & Administrative Studies, University of Swaziland*

States markets and in return the BLNS States gain considerable revenue compensation. For most of the BLNS States the SACU revenue has, for decades, become a reliable and major source of national income. However, SACU has its own challenges. These include the growing fears of steady decline in SACU revenue as a result of recessionary effects on global trade and multilateral trade arrangements, the polarised pattern of development and the subterranean tensions between South Africa and its immediate neighbours. In the light of these and other challenges, the 'categorical imperative' for SACU states is to prioritise the development component of the SACU agenda. It is the view of this author that Bjorn Hettne's view on development regionalism offers pathways of promoting total development of the customs area and fostering equitable distribution of the benefits of integration. Within Southern Africa, analyses based on this theoretical variant of integration focus on the macro-regional level – SADC—(see Tsie, 1996, 2001; Hettne, 2001; Hentz, 2001; Soderbaum, 2004; Amani *et al.* 2012). These analyses are mostly theory based with less emphasis on concrete steps to achieve the goals of development regionalism. The article breaks with such analyses in two ways. First, it deploys the concept in analysis of integration at the micro-level – SACU. Secondly, it takes a practical turn, suggesting ways to promote balanced, equitable and inclusive forms of development. The choice of SACU is justified on the grounds that the probability of realising the objectives of development integration is higher in SACU than other integrative schemes in southern Africa. One reason for this claim is that SACU remains, comparatively, the most cohesive and workable regional arrangement in southern Africa. The other is the shared trade, monetary and fiscal policies, the existence of convertible currency and long history of economic interactions among the participating states. All these provide a good foundation for the pursuit of collective goals which are central to development regionalism. The article is organized as follows: the first section reviews past and present academic literature on integration in southern Africa, with emphasis on SACU and discusses Bjorn Hettne's views on development regionalism. The next section looks at the present state of SACU, dwelling on some of its successes and challenges. The last part of the article shows concrete steps needed to address the challenges in ways that set SACU on a path of mutually rewarding interactions.

LITERATURE REVIEW

There was intense debate in academic literature on the merits and demerits of SACU. Two contending theoretical strands dominated the debate. The first is the Dependence theory. Its proponents were highly critical of the SACU arrangement and South Africa's economic interactions with its neighbours. Blumenfeld reported that for the Dependence writers:

Any analysis which implied that there was anything beneficial, normal or even defensible in the structure and content of economic relations (with South Africa) was to be denounced not only as analytically invalid, but also morally reprehensible and politically unacceptable (see Blumenfeld, 1991:5).

Perhaps the most notable definition of Dependence is the one offered by Dos Santos, who wrote that dependence is "a situation in which the economy of certain countries is conditioned by the development and expansion of another economy" (see Dos Santos, 1970:231). Arguing from a neo-Marxian perspective, the Dependence scholars claimed the global capitalist economy has two sides: the developed and prosperous centre and the under-developed and impoverished periphery. They pointed out that international capitalism in alliance with local capital creates conditions of impoverishment and under-development by exploiting the

resources of the periphery to further develop the centre. For example, they argued that international capital invests in the mineral sectors of the periphery and repatriates profit to the centre (see Gibbs, 1997). So, for the Dependence writers, the gains of economic interactions are one-sided: the engagement enriches the centre and impoverishes the periphery. As a remedy, the school recommended self-reliant strategies which range from proposals for import substitution industrialisation to disengagement from the international capitalist economy. The call for dissociation emanated from a deep distrust for international capital.

Although the Dependence argument was used primarily in the analysis of the international capitalist economy, it was also deployed in regional analysis because the regional economy was regarded as a sub-set of the global one. South Africa was considered a semi-peripheral economy in the Dependence literature. The origin of this status is explained through the 'Kondratieff cycle'. The assumption is that Capitalism thrives on markets, growth and profits. So on some occasions, albeit rare, the industrial and capitalist class from the centre shift investment, capital and technology to alternative potential growth centres in the global periphery when there is no longer capacity for expansion in the centre (Wallerstein, 1992). In the 1930s, partly because of the negative effects of World War I on core economies, the industrial class shifted capital and technology, first to the mineral and later the manufacturing sectors, in South Africa. This development helped establish centre-periphery relations between South Africa and its neighbours (see Martin, 1991, Wallerstein and Vieira, 1992).

The Dependence literature cast SACU as a device designed to serve the interests of South Africa (Martin, 1991). These writers characterized South Africa's relations with its immediate neighbours as one of "economic domination and subordination, which enabled South Africa to derive substantial benefits from economic interactions (Davies, 1990, see also Gibbs, 1997:73). They drew attention to the growing trade imbalance between South Africa and the other participating countries (see Hentz, 2001, see also Blumenfeld, 1991) and criticised South Africa for using its management of the common external tariff to 'adopt tariffs and duties to promote South Africa's own development needs" and deindustrialization in the neighbouring states (for this see Bischoff, 1990). Matsebula and Simelane claimed South Africa was not interested in industrial development of the BLNS states but rather as dumping ground for its manufactured goods (Matsebula and Simelane, 1996; Cheru, 1997). For others South Africa had a 'predatory mentality' (Hentz, 2001:199; see also Cheru, 1997:222). Some Dependence theorists focused on the negative impact of trade diversion on the weak economies. They argued that increase of intra-SACU trade took place at the expense of lower cost imports and that South Africa was the major beneficiary of trade diversion while the other participating countries bore the cost of trade diversion (see Green, 1991; Hentz, 2001). According to these writers trade diversion imposes welfare cost on the BLNS States because they import highly priced but inferior goods from South Africa. They emphasized that the BLNS States will receive more revenue outside SACU than within (for details see Leith, 1992; Lundahl and Peterson, 1991) The Dependence writing on SACU showed that the BLNS States, in view of the Common External Tariff (CET) managed by South Africa and the parity of their currencies to the Rand, were denied the discretion to manipulate fiscal policy to engineer domestic development (for this argument see Mayer and Zarenda, 1994: 41). This portrait of extreme asymmetry in integrative gains led the Dependence scholars to recommend disengagement from South Africa and the pursuit of self-reliant development.

Whereas the Dependence school stressed the one-sided nature of the integrative gains and recommended disengagement, the Interdependence school emphasized reciprocal benefits of

economic interaction and costs of dissociation. For its adherents the relations between South Africa and the rests of SACU members is based on “mutual dependence” and gains, which makes disengagement costly for all parties. They drew attention to historical and structural factors to buttress this point (for the Interdependence argument see variously, Blumenfeld, 1990; Leistner, 1981, 1985; Malan, 1983; Maasdorp, 1982, 1985) Erich Leistner, for one, pointed to the structural interconnections and concluded that the fate of South Africa and its neighbours were intertwined (Leistner, 1985). The Interdependence school stressed that the trade diverting impact of SACU, de-industrialization and the loss of fiscal discretion were compensated by the revenue sharing formula. They argued that the BLNS states received disproportionately more through the compensatory and stabilization mechanism (see Walters) and that these receipts progressively increased (Gibbs, 1997). The adherents of the Interdependence paradigm believed that the SACU fiscal transfers constituted very vital and stable sources of revenue for the BLNS states. In fact they received more from the pool than other domestic sources. Matthews (1983) and Massdorp and Whiteside (1993) emphasized this point by claiming that these states could have withdrawn from SACU after independence. However, they chose to stay in SACU. The Interdependence scholars pointed to other benefits. They claimed SACU gave the neighbours free access to goods and services from South Africa and freed them from the burden and cost of operating their own customs services. In addition, they have access to foreign exchange and convertible currency. South Africa, in the interdependence literature, for its part, acquired a near “captive market” for its “internationally uncompetitive” exports. The Interdependence idea of mutual gains assumes there is harmony of interests and absence of conflict between parties in the integrative process. However, as some critics have pointed out, the Interdependence literature, “overlooked the political relevance of the extreme asymmetries in the structures of regional economic relations” (see Blumenfeld, 1991:4) and the disagreements these inequalities engender. Within SACU, these tensions, at one level, took the form of BLNS states’ dissatisfaction over what they perceived as insufficient financial compensation, uneven development and South Africa’s dominance of the SACU processes.

Post-Apartheid Integrative Literature

Apartheid contributed to the highly polarized literature on integration. The gains and losses of economic exchange took a racial dimension in which the white minority in the region were seen as the main beneficiaries and the black majority, as the major losers (Blumenfeld, 1991:4). So, as expected, the polarized nature of the integrative discourse faded on the demise of Apartheid. Another explanation for the absence of polar positions is that Dependency, as an analytical category, lost its appeal because of its glaring deficiencies. For example, the school’s policy prescription of disengagement from South Africa disregarded the constraints of geography and the extensive economic interactions between South Africa and its immediate neighbours dating back to the 19th century — the disengagement argument, as some critics put it, “fly in the face of economic realities and the self-interest of the neighbouring states”. In fact for the BLNS states the intent has never been to disengage, instead, to reduce dependence and increase mutual dependence. This intent explains why Botswana, Lesotho and Swaziland joined the Southern African Development Co-ordinating Conference (SADCC) whiles maintaining membership in SACU.

Although the post-apartheid integrative discourse and practice is dominated by the market paradigm anchored in progressive steps towards economic and political union, regional policy-

makers agree, at least at the rhetorical level, that the integrative project should also aim at reducing unevenness and promoting balanced development. This concern for an equitable and development based regional order also finds expression in an emerging body of work called development regionalism (see Tsie, 1996, 2001; Hettne and Soderbaum, 1998, Du Pisani, 2001; Hettne, 2001; Soderbaum, 2001, 2004; Amani et. al. 2012). In fact the imperative for a development-focused integration is reinforced by the reluctance of the states – in the case of SADC—to implement trade agreements. Some analysts, for example, point out that the progression from an FTA to Customs Union envisaged by SADC is unfeasible. The reason is, for most states, external tariffs, given low levels of development, remain major sources of national revenue. Therefore they will be reluctant to accept the "institution of external common tariff" which may well be lower than their current external tariff (Amani et al, 2012: 3). Others contend that the states are still "battling to implement the commitment they made towards SADC FTA" because of expected loss of tax revenue (Hartzenberg, 2012:12). This limitation, of market integration, has led some to argue that the "predominant focus of the trade integration agenda … is not sufficient to achieve the broader development objectives" (see Hartzenberg, 2012: 12). This takes us to a discussion of Hettne's theoretical views on development regionalism.[1] It must be noted that assumptions on development regionalism are broader than what is discussed below. The ideas discussed here are elements of the theory which are germane to the thesis of this article.

Theoretical Assumptions

Bjorn Hettne defines development regionalism this way:

By development regionalism I refer to concerted efforts from a group of countries within a geographical region to increase the efficiency of the total regional economy and to improve its position in the world economy (Hettne, 2001:108).

We can gather from Hettne's description that development regionalism is anchored in a 'symmetric and solidaristic' pattern of development. In this approach states take collective steps to bring about both national and regional development. In short, it aims at promoting equitable and balanced forms of development in a region. According to Hettne this development project embraces what he calls a "strategy of development from within"– a self-reliant strategy based on co-ordination of production, improvement of infrastructure and exploitation of various economic complementarities (Hettne, 2001:104). Although this development paradigm acknowledges the role of market forces in the integrative process, the view is that the market, on its own, cannot be relied upon to promote development goals. It is claimed that market forces, unguided, accentuate polarized patterns of accumulation. For instance, the quest for profit inexorably leads the market to growth poles within a region. It therefore requires political intervention to develop the total regional economy. For this reason, the state is assigned a strategic role in the integrative process. The State, for example, initiates the regional hegemonic agenda and mobilizes societal stakeholders behind it. Hettne acknowledges the importance of a realistic political intervention in the economic process in his claim that "if the great discovery of the 1980s was that political intervention is not necessarily good, the discovery of the 1990s has been that it is not necessarily bad either" (Hettne, 2001:106).

[1] *Development regionalism is a normative theory because it has both practical and ethical dimensions. It answers the question how we should act to bring into being a balanced, equitable and inclusive micro-regional order.*

This paradigm accepts the sufficient-size argument of classical economic theory. The assumption is that micro-states – states with small territorial size, population and market— can benefit from integrated economic development. The integration of economies, for example, leads to economies of scale – expanded production, markets, profits and efficiency (for an elaboration of this view see Lipsey, 1960; Ravenhill, 2008:182-3). Beyond the classical point, Hettne holds that a cooperative arrangement gives small states in the international system the opportunity to avoid being "clients" of powerful states and to collectively bargain to improve their economic position (Hettne, 2001: 104).

For Hettne, the viability and stability of any regional order rests on its ability to address social security issues. This social stability argument is important because any neglect of social needs can create social tensions and conflicts, which can undermine the viability of the regional order. For this reason, development regionalism entails the participation of people, at both policy and implementation stages, in the development process. It aims at creating a development community which promotes greater social equity and the development of human potential (Du Pisani, 2001:207). To meet societal needs, Hettne recommends that an element of regional redistribution ought to underline the regional order. This can be done through establishment of regional funds and specialized banks that cater for the development needs of the region's people. This brings us to the question, what conditions are favourable for the pursuit of development regionalism?

Some have suggested that development integration suits regions where there is increasing convergence of economic and political policies (Tsie, 2001). This convergence creates trust and the space for the pursuit of collective goals. Others believe that it is only possible in a region where the largest economy is willing to provide benign hegemonic leadership (Oden, 2001:189). Certainly the viability of the regional development process depends on the political commitment of the leading economy. Its participation can help foster a strong economic base (Hettne, 2001). This state has the economic and institutional capacities to drive the development process (see Tsie, 2001; Oden, 2001). Again, some argue, this approach to integration works when states surrender part of their sovereignty for the common good. Indeed, one of the major constraints on efforts towards collective goals is the "national interest". In a region where states are guided by parochial national agendas, regional issues tend to be placed low on the political agenda while focusing more on domestic issues. This nationalism sometimes explains the lack of commitment to cooperative arrangements – states sign agreements but fail to implement them because they are not obliged to do so. So, for Hettne, the credibility of any regional order depends on the existence of an "arrangement which cannot be broken by a participant country without provoking some kind of sanction from the others" (Hettne, 2001:104) —he proposes that the regional arrangement should be rule-based to induce commitment from participating states.

Briefly, for Hettne, the conditions needed to build a regional order anchored in mutually rewarding interactions include the:

- Ability of member states, cooperating with each other, to promote self-reliant forms of development—these include coordination of production, improvement of infrastructure and exploitation of economic complementarities or interdependent economic relationships.
- Capacity of member states to bargain collectively with extra-regional economic actors.
- Commitment to people-centric objectives.
- Political commitment of the participating states to regional arrangements.

- Commitment of the regional hegemony to the pursuit of collective goals

These assumptions inform the discussion of the steps needed to realize mutually rewarding, developmental goals within SACU. Put another way, the article utilizes these views to show:

1. How the regional states, along with capital, can collaborate to promote balanced development.
2. What solidarity steps are required in member states' interactions with economic actors outside the integrative zone.
3. What must be done to foster people-centric development goals
4. How to promote adherence to cooperative arrangements by participating states.
5. What role the hegemonic state (South Africa) can play in the pursuit of collective objectives.

METHODOLOGY

The study is based on deductive analysis of primary and secondary data. The main primary sources are participatory observations and texts: treaties, statements, policy documents and Internet resources. The participatory observations are based on various meetings and workshops the author attended on security and development issues in southern Africa. The author got the opportunity, in these forums, to interact and importantly listen to the views of representatives of civil society groups, development partners, SADC officials, academics and experts. The secondary sources consist of books, book chapters, articles, research reports, newspaper articles and newsletters. The study adopts a reflective approach through examination of the politics and economics of integration. It thus focuses on the nature of the integration project, the role of state, capital and people, relationship between the micro-regional space and external actors and the regional distribution of power and integrative gains. The major advantage of this approach is that it offers a holistic view of the integrative process and broadens our understanding of the regional process and its limitations. The study is also, methodologically, normative. It has a two-pronged analytical focus—a critical account of the existing micro-regional integrative order and a practical guide on how to bring into being an equitable and balanced forms of development. This normative orientation is guided by the principle that any productive account of a regional process must have both empirical and philosophical basis- showing the 'is' and the "ought" of the integrative project (Reus-Smit and Snidal, 2010:7).

A LOOK AT THE PRESENT SHAPE OF SACU

As already stated, SACU can be said to be the most successful integrative arrangement in Africa. Its success can partly be measured by its longevity. It has been in existence for more than a century. This length of time clearly shows the enduring commitment of the participating countries to the idea of SACU. Of course, there have been disagreements over the distribution of integrative gains. Nonetheless there has also been a remarkable willingness by members to resolve differences. One of the sources of discontent by the BLNS States in the past was the dominance of SACU operations by South Africa. The 2002 Agreement institutionalised and somehow "democratized" SACU. For example, it now has a Secretariat which has a coordinating and monitoring role. If in the past South Africa independently managed the Common External Tariff, now SACU has a Tariff Board comprising experts drawn from the participating states. This body makes recommendations on tariff and other trade-related issues

to the Council of Ministers—consisting of Finance Ministers from member states. This structure is said to be the supreme policy and decision-making body on all SACU matters. From 1910 to the present the participating countries have managed to keep the SACU redistribution mechanism based on collective revenues from customs and excise duties. In fact there is now a SACU development fund which increases the revenue the BLNS States derived from the common pool. The fiscal transfers thus continue to be a major source of revenue for the BLNS States. For example, the SACU revenue accounts for about 60% of the national income of both Swaziland and Lesotho (Bertelsmann-Scott, 2010). But SACU has its challenges too.

Challenges

To start, there have been some disagreements over the SACU revenue. There are some within South Africa who believe that the revenue sharing mechanism is unsustainable (Bertelsmann-Scott, 2010). They think it is a financial burden on South Africa, particularly because of its growing domestic challenges such as poverty and unemployment. This view is held by those who think the revenue transfers are donations from South Africa (Qobo, 2010: 26). Others, including some South African officials, propose that SACU should be converted to a Free Trade Area (FTA). If conversion happens, the revenue sharing mechanism falls away. There are some policy makers in South Africa who feel that the revenue sharing system should be reviewed so that the development fund forms a greater component of the revenue pool. These also want stringent criteria for utilization of the development fund. At present each state uses its own discretion on how this fund should be used (see *Mail &Guardian*, July 13-19, 2007, p. 20). The BLNS states, for their part, reject any attempt to set criteria for the use of the development fund and argue that the revenue transfers cannot be regarded as charity or donations from South Africa; instead, they are revenues from the common external tariffs. They justify the compensatory payments on grounds of polarisation (Bertelsmann-Scott, 2010).

Presently SACU revenue levels have dipped – in fact the pool has shrunk by 40% on account of global recession, which has put ‘pressure on members fiscuses” (Bertelsmann-Scott, 2010:11).[2] Additionally, the revenue pool keeps shrinking because of tariff “liberalization initiatives” at both the WTO and preferential levels like the Trade, Development and Cooperation Agreement (TDCA) between South Africa and the European Union. And the pool is set to further decline in coming years once an Economic Partnership Agreement between SACU and the European Union come into being. Prior to 1969, trade was the over-riding rationale of SACU. However, following concerns of the BLS States over unevenness in development, the 1969 SACU Agreement placed both trade and development on the SACU agenda. For example, the Agreement called for the protection of infant industries and measures to attract investment into Botswana, Lesotho and Swaziland—the BLS States. However, there were no real interests by the Apartheid State and its industrial and commercial classes to see industrial growth in the neighbouring states (Bischoff, 1990). The demise of Apartheid therefore provided an opportunity to place development back on the agenda. So, the 2002 SACU Agreement re-emphasized the promotion of industrialization in all the member states. But there was little or no enthusiasm by the member states towards the developmental agenda. In 2010, on the centenary anniversary of SACU the regional states met to re-affirm their

[2] *This pressure takes the form of reduced national revenue and its constraints on the state’s financial obligations. Some member states, like Swaziland, have adopted cost-cutting or austerity measures on account of decline in revenue.*

commitment to development goals. For example, part of the 12 point agenda which emerged out of the Summit focused on a strategy to support industrialization in the integrative zone (see Bertelsmann-Scott, 2010). This brings us to this question: what explains the perennial anaemic attention to the development component of the SACU agenda in a post-Apartheid order? Some have pointed out that South Africa's interest centres on the trade dimension of integration and the search for expanded markets (for this see Du Pisani, 2001; Leysen, 2001; Soderbaum, 2004:72; Bertelsmann-Scott, 2010; Tjemolane, Neething & Schoeman, 2012:98). Others claim South Africa has no intention to "give the regional states room to develop and progress, particularly in the strategic area of industrial development" (Makgetlane, 2011:85). Ian Taylor situates the lack of "hegemonic developmental agenda" pivoting on a broad based productive economy in the attraction of "gainful utilization of resources for the individual advantage of the ruler and his clientelistic networks" (Taylor, 2010:10).

In the absence of a strong commitment to the new SACU vision to construct "an economic community with equitable and sustainable development, dedicated to the welfare of its people" the asymmetry between South Africa and the other participating countries continue to widen. Most FDI in the integrative zone flows to South Africa and its trade surplus with its immediate neighbours keep rising. Some policy practitioners in South Africa acknowledge this unevenness. Rob Davies, the South Africa Minister for Trade, conceded that the "pattern of trade is very uneven and unequal" and recommended "equitable regionalism" (for this view see *Amandla*, December 5-6, 2008, p. 40).

The recent tensions between South Africa and the BLNS States over the EU Economic Partnership Agreement (EPA) helped expose the fragile cohesion within SACU and the enduring nationalistic interests. South Africa's immediate neighbours, Botswana, Lesotho and Swaziland, signed interim Economic Partnership Agreements with the EU. However, South Africa opposed such. Clearly, the fear of losing the European market drove these commodity exporting states into free trade agreement with the EU. The Swaziland government claimed it signed the interim EPA to have "a legal instrument to continue to benefit from the EU trade regime, as required by the WTO (see the *Swazi Observer*, 2009, p.16). Central to South Africa's opposition to the EPA was its worry that the EPA's "lower tariffs [can] lead to "a flood of goods entering Botswana, Lesotho and Swaziland, furtively destined for South Africa" (*Financial Mail* [South Africa] June 12, 2009, p.57). Consequently, the South African Minister of Trade and Industry, Rob Davies, warned, on discovering that Botswana, Lesotho and Swaziland had signed interim EPAs with the EU that South Africa would not be:

> admitting things which do not comply with the rules of origin under TDCA. We will not be allowing them to come to South African market and if that means we have to introduce border control issues with Botswana, Lesotho and Swaziland and they have to do likewise, then so be it (*Swazi News*, June 16, 2009, p.4).[3]

If in the past the decisional style of SACU was monopolistic, today it is inclusive. However, there is a limit to this inclusivity. A look at SACU's policy-making structure shows it is statist and technocratic: it is inhabited by politicians – ministers—and technocrats or bureaucrats from the member states. The missing link is an institutionalized procedural interaction between

[3]Sensing that this schism can lead to the break-up of the organization, the heads of state met and resolved to develop common trade and tariff policies that support industrialisation in SACU (see SACU/ HOSGM "Communique" 22 April 2010, http://www.sacu.int/list.php2type=press/ 20Statements&year+2010.

society and SACU institutions and processes. This omission robs SACU of a people-centric developmental approach. The next section recommends concrete steps which can help bring into being a development focused integrative zone— a space anchored in equitable and balanced patterns of development.[4] These recommendations will be guided by Hettne's assumptions on development regionalism.

RE-ENVISIONING SACU

To repeat a point in the theoretical section, for Hettne, the development of the "total regional economy" depends on a "strategy of development from within", which includes the co-ordination of production, improvement of infrastructure and exploitation of various economic complementarities (Hettne, 2001:104). How might this be achieved?

Any meaningful focus on a development agenda must begin with a restructuring of the micro-regional economy. At present, South Africa has a mixed economy, partly dependent on resource-extraction and partly on manufacturing (Tsie, 2001). The BLNS economy is largely resource dependent. Most of the natural resources from both South Africa and the other states are exported as raw material. It has also been noted that there is imbalance in development – seen through trade and investment flows—between South Africa and its immediate neighbours. To correct the development deficit, the regional states ought to adopt a common industrial strategy which aims at diversifying the regional economy, creating complementarities and interdependent economic interactions. The mineral sector is one area where this goal can be achieved. We know that the micro-regional space has a rich diversity of mineral resources. These include gold, platinum, coal, iron, diamond, uranium, chrome, copper, zinc, nickel, lead, soda ash and so on. Presently, there is very little value-addition. For example, South African refined gold is exported to Europe and North America; there is no enthusiasm to develop a gold jewellery industry (African Development Bank, 1993:55). Similarly Namibia's uranium and Swaziland's iron ore are shipped overseas. Yet available data suggest that the transnational corporations, mostly South African, which engage in mineral exploration in the region have considerable expertise, technical knowledge and capital for both mineral exploration and development (see African Development Bank, 1993; Jourdan, 1995; Oden, 2001:191). However, they prefer to invest largely in mineral extraction, plough profits into offshore ventures and locate processing plants nearer to the markets – in Europe and North America (African Development Bank, 1993; Ashman, Fine and Newman, 2010; Ashman, 2012). They justify setting up processing plants abroad on the ground that it reduces costs. The region therefore has all the minerals and sufficient capital, expertise and technology needed for industrialization. In fact, given the region's comparative advantage, the mineral sector can lay the foundation for a strong economic base anchored in downstream (beneficiating industries) and upstream (capital goods industries) serving national, regional and global markets. It will require political interventions to bring this development goal into being. SACU states ought to adopt common policies and programmes aimed at fostering industrial growth

[4] *In this article, the phrase 'equitable and balanced industrial development' refers to the promotion of universal rather than one-sided gains in the integrative project. It is a movement away from polarized patterns of accumulation or development— creation of 'winners and losers' in the integrative enterprise. It is therefore, for example, about creating opportunities to bridge the industrial/development gap between states, particularly between the dominant economy and the peripheral ones. More centrally, the notion of 'equity' and 'balance' relates to the creation of a regional order catering for the needs of people, states and capital in a fair or just manner.*

in the mineral sector. For example, they will have to craft investment codes that favour companies committed to mineral research, technology and development. While incentives like tax reduction could be offered to promote domestic value addition, financial penalties such as higher taxes and royalties could be imposed in cases where capacity for beneficiation exists and there is reluctance to do so. As already stated, South African companies dominate trans-national mineral exploration in the region. South Africa can therefore lead a regional effort to further process and beneficiate the mineral resource in the integrative area. It can serve as the centre for transfer of technology and training of skills for mineral development in the SACU area. This takes us to possible forms of economic interactions in the mineral domain.

There could be industrial complementation schemes based on economies of specialization between firms and between states. This arrangement, at one level, is based on sharing of industrial activities in which firms located at different countries specialize in the production of different components of a product. In this way, the regional mineral economy could be "organized in multi-layered subcontracting production networks" (Ho-Fung, 2009). South East Asian states have adopted this industrial development strategy. Each state specializes in "goods at a particular level of profitability and technological sophistication" (Ho-Fung, 2009). For example, China's electronic industry imports components from Hong Kong, Japan, Korea and Taiwan. It should be possible for Swaziland to use its phosphorous coal and chrome ore from South Africa to produce ferro-chrome for the production of stainless and high-tech steel in South Africa. There could also be the establishment of "regional industrial giants". In fact this approach is economically rational because of the high degree of similarity in resources available in each of the participating states which can lead to the duplication of industrial activities and market fragmentation or separate national markets. The approach, however, can bring into being "a unified regional market of sufficient size to make production attractive" (Ravenhill, 2008:182). It will also foster mutual gains and deepen integration. So, there could be joint ventures through the establishment of a Regional Consortium, comprising states and business. This Consortium would invest in refining and processing facilities in the region and beyond targeting the national, regional and global markets.

Indeed Botswana has shown that it is possible for both state and capital to cooperate to foster a seamless transition from raw material production to value-addition in the mineral sector. Botswana produces rough diamond through Debswana, which is a joint venture between the Botswana government and De Beers, South Africa. Through policy interventions, there have been other associated industries since the turn of the millennium – polishing and cutting of diamond and jewellery production. Recently, a Botswana official revealed that the diamond industry intends to move its headquarters to Gaborone, which weakens the argument that processing plants ought to be sited close to the final market. Other forms of interdependent links can be forged to reduce extreme asymmetry in economic interactions. To these we now turn.

Deepening Interdependent Relations

Historically, state formation in southern Africa followed the idea of a region pivoting on South Africa. Mineral production and industrialization in South Africa produced demand for labour for South African mines and markets for its manufactured goods. These "flows were facilitated through a network of transportation facilities" [road, railways and ports] linking South Africa to the region (Niemann, 2001:70). The immediate neighbours, particularly the land-locked states heavily rely on South Africa's transport facilities for their imports and exports. South

African ports handle 90% of the region's cargo volume and Spoornet, the South African Railway Company, owns 85% of the rolling stock in the region (Oden, 2001:179). Clearly South Africa's capacity is superior in the transport sector and the main beneficiaries in transactions in the sector are South African operators. But the transport sector can be re-envisioned in ways that foster mutual gains. There could be joint ventures in the rail sector where states built rail facilities and the national companies jointly operate, manage and maintain them. Swaziland and South Africa recently signed an MOU to jointly construct a 146 Kilometre railway line to run from Lothair in Mpumalanga, South Africa, to Sidvokodvo in Swaziland. This line, once completed, could be co-managed by the Swaziland Railway and Spoornet in South Africa. The same could be done in road construction in development corridors. Here the Gauteng-Maputo Highway which links Mpumalanga and Gauteng provinces in South Africa to the refurbished and expanded Maputo port in Mozambique provides an example. It is reported that this transport corridor, once the concession period given to the private consortium – TransAfrica Concessions (TRAC) — in charge of the corridor is over, will be jointly managed by the two states (Soderbaum, 2004:170). While most states, particularly South Africa's immediate neighbours, continue to rely heavily on South Africa's trade routes, there has not been any corresponding reliance by South Africa on alternative trade routes. For example, Namibia has a maritime corridor and as Tsie (2001:139) has suggested, South Africa can use the Trans-Kalahari Highway (Botswana) and the Walvis Bay (Namibia) port. It is believed that using these facilities can "significantly reduce transport cost for exports from the Gauteng region destined to West Africa and the EU" (Tsie, 2001:139).

The discussion of co-management of transport infrastructure brings us to the idea of a development corridor. This is not a novel concept; it is at the heart of SADC Spatial Development Initiatives which aim at creating development corridors within states and between states. The intent, at the inter-state level, is to promote industrial development in "specific spatial locations" or micro-regional spaces (see Jourdan, 1998:718). It is expected that in this space governments, from two or more states, and business will cooperate to build and rehabilitate productive infrastructure such as road, rail, ports and invest in mineral, energy, agro-industrial, agricultural, forestry and tourism projects. So far about twelve such micro-regional development corridors have been identified (see Soderbaum, 2004:161-3). These include the Maputo Development Corridor, comprising the Gauteng and Mpumalanga provinces in South Africa and Maputo in Mozambique; the Coast- 2- Coast Corridor, comprising Namibia, Botswana, South Africa, Swaziland and Mozambique; the Platinum SDI, comprising Pretoria and the northern province of South Africa, and Botswana, and the Lubombo Initiative, comprising Northern Kwa-Zulu Natal, eastern Swaziland and southern Mozambique. There is however very little commitment to the SDIs. The only active corridor is the MDC with its flagship projects, the Mozambique Aluminium Smelter (Mozal) and the Maputo Iron and Steel project. Yet, the strength of the development corridor is that it can help promote development of peripheral economies, deepen interdependence and foster mutual and equitable gains. For example, the Platinum SDI would create alternative trade routes for South African exports – it will link South Africa to the trans-Kalahari highway in Botswana and Walvis Bay in Namibia. It is expected that the Platinum SDI would promote mineral and other industrial projects within the development corridor and the Lubombo Initiative will promote tourism, agriculture, marine culture and transport projects (see Soderbaum, 2004: 161). So the SDI concept offers opportunity for mutually rewarding industrial development.

Water can also be used to build interdependence. The Lesotho Water Highland Scheme,

which is a joint project between South Africa and Lesotho, is an example of this mutual dependence. This project transfers water from the water rich highlands of Lesotho to the dry industrial heartland of South Africa, — the Gauteng province. It also generates hydro-electric power for both Lesotho and South Africa. In return Lesotho receives revenue from the sale of water. This is now an important component of its export and revenue. Comparatively, South Africa's water consumption far exceeds its neighbours because of the size of its population and its industrial activities. However, South Africa's capacity to provide water domestically is increasingly diminishing. In fact, some have suggested that by 2020 it will be in a "condition of absolute water scarcity" (Swatuk, 2001:271). Given South Africa's growing demand for water, it will eventually have to look beyond Lesotho. The neighbours have what South Africa needs. There could therefore be more trans-border co-operation in water use and management. Certainly, there are more areas for mutually dependent interactions. The task is to identify these areas.

PROMOTION OF FAIRNESS AND JUSTICE IN ECONOMIC INTERACTIONS

Hettne (2001:104) recommends that member states in cooperative arrangements, particularly of micro states, must collectively bargain to improve their economic position and avoid being "clients" of powerful state and non-state actors within the global political economy. Following Hettne, the participating states must unite around normative principles that stress fairness and justice in economic interaction. The pursuit of this mission must begin with SACU. We have noted the polarized effect of SACU's liberalized trade regime – South Africa's products flood the peripheral markets, creating de-industrialization. But, South Africa industrialized behind tariff walls (see Martin, 1990). It is fair therefore to have provisions in the trade agreement to protect infant industries in the BLNS States. More importantly, SACU states must vigorously pursue this just principle at the global level. The global trade regime anchored in the World Trade Organization's free trade tenets condition states to form free trade areas. It has led to moves by industrialized states— for example the EU— to establish free trade areas with developing states. History shows that the industrialized states first created protective walls to build powerful domestic industries that could subsequently compete for markets beyond the state boundary (see Amin, 2002; Gelinas, 2003). SACU states must therefore seek trade arrangements with external actors that do not undermine their domestic capacity for industrial development and job creation—there ought to be common trade policies that protect vulnerable and labour intensive sectors of the economy.

BRINGING PEOPLE INTO THE DEVELOPEMNT PROCESS

As noted, development regionalism entails the pursuit of people-centric developmental goals. Hettne sees this vocation as important because the peace and sustainability of a regional order rest on its ability to address social security issues. So, what must be done to further the interests of people? To repeat, policy-making in SACU is a state monopoly. This state bias is partly because of the trade-centric character of SACU. However, repositioning the organization on a development trajectory entails the participation of non-state actors in its affairs, which will help ensure the realisation of people-centric objectives. This engagement begins with an institutionalised procedural interaction between civil society— conceived broadly to include business associations, trade unions, the intellectual community, community based groups, development-oriented organizations and social movements— and SACU institutions and

structures. On this procedural path, civil society through state and donor sponsored regional meetings, workshops or conferences will periodically have the opportunity to deliberate on the development process. It is expected that the views, suggestions, opinions, positions or decisions coming out of such gatherings should help guide SACU policies and programmes. At the national level, civil society groups ought to be empowered both financially and technically to participate in the affairs of all SACU working groups and monitor implementation of programmes and policies. Overall, the regional order should have empowerment goals. Social groups should be empowered to contribute towards the design of development goals. There ought to be a commitment towards human resource development, equipping disadvantaged groups with skills to take advantage of the opportunities in the integrative zone. In fact the SACU development fund and other specialized or development banks can be used to assist disadvantaged communities, individuals and families in micro-level enterprises such as informal cross border trade[5], retailing[6], tourism[7], agriculture[8], construction and the industrial sector[9].

FINANCING DEVELOPMENT

Certainly, the feasibility of this new regional order depends greatly on the ability of regional states to rely increasingly on their own resources and lessen dependence on foreign capital: unrestrained reliance on external sources of finance will obstruct the goals of a development focused agenda. Foreign capital often seeks short term gains through investment in financial market. It shifts capital from place to place in search of higher returns. Therefore, there ought to be a more introverted approach to the search for development finance. It has been observed that "capital flight" which can be described as the "voluntary exit of a private resident's capital" remains one of the major causes of de-industrialization in the region (Ashman, Fine and Newman, 2011:7). It results in significant decline in domestic investment and productive activities which can deepen unemployment, poverty and inequality (Ashman et.al., 2011:7). By its nature capital flight constitutes a "net savings gain for the recipient countries" while depriving the domestic economy the vital capital base for development (Ashman *et al.* 2011:16). Individuals and corporations invest their earnings abroad. In addition, the bulk of the region's private/public pension and provident funds are invested offshore. Mostly the investments take the form of financial assets: bank deposits, foreign currency and the stock market. Capital flight accounted for 20% of the South African GDP in 2007 (see, Ashman, Fine and Newman, 2011:18). Certainly, this wealth flowing out of South Africa, and elsewhere, can be invested in the region to serve as locomotive for regional growth. So, measures to restrict kinds of capital outflows which undermine development are necessary. These will include ways to encourage capital repatriation and means to restrict capital outflows which impact

---

[5] *For detailed account of the rationales and the significance of informal border trade in the lives of ordinary groups, like women, see variously Nugent, (1998:21), Soderbaum and Taylor (2001), Soderbaum and Taylor (2003) and Rodriguez, 2010:464).*

[6] *On steps to promote the interests of small traders in the retail sector see Abrahams (2010) and Crush and Frayne (2010)*

[7] *For elaborate account of how tourism can be harnessed to serve the interests of disadvantaged communities see Swatuk, (2001)*

[8] *On using regional integrative schemes to promote rural agriculture see Zondi and Mulaudzi (2010:35-52).*

[9] *On creation of SMMEs in the industrial sector see for example, Chapter 8 in Soderbaum (2004)*

negatively on development. Domestic capital can also be raised by encouraging savings. Currently the rate of savings in the region is low, partly because of excessive consumerism (see the Special Advertising Supplement of *Mail &Guardian,* July 27-2 August 2012). Confirming this, the South African Minister of Finance, Pravin Gordhan said, “South Africa had to attract foreign investment because savings in South Africa are very low” (*Times of Swaziland*, July 24, 2009, p.29). So, people should be encouraged to save. This can be done through education and offering of incentives. People need to be educated on the benefits of savings and investments, and the dangers of not doing so; for example its implications on retirement. This message can be conveyed through the media and the advertising industry. It is said that it is easier to get loans and other credit facilities than to open a savings account because of bank requirements (see Special Advertising Supplement of *Mail& Guardian*, July 7-August 2, p.1). The priority should be to make it easier to save. To attract more savings, those who save should get higher returns on their investment. There must also be more banking opportunities at the grass-root level such as community/cooperative and postal banks. Capital for development projects could also come from a regional development fund and bank.

SOUTH AFRICA’S POLITICAL LEADERSHIP

It was noted that the role of hegemony in the integrative project is indispensable because of its economic and institutional power. It was also noted that the realization of collective goals depends on the political commitment of participating states to regional arrangements. As we have seen, regional states have shown more willingness to sign agreements than implementing them: sovereignty and parochial national interests stand in the way of collective goals. So, how can the states be encouraged to surrender part of their sovereignty to attain common goals? Certainly there can be no easy answer to this question. The only certainty is that without South Africa’s leadership it will be impossible to achieve the goals of development regionalism. First, South Africa will have to use its hegemonic resource – its economic and political influence – to nudge its immediate neighbours towards development based integration. This process must start with a policy shift within South Africa— a new policy direction which emphasizes a constructive balance between trade and development in the integrative project. It is hoped that the policy-makers within government who believe in production-led integration along with development oriented intellectuals and civil society can help bring this change into being. Secondly, the regional arrangement must be rule-based instead of the discretionary system in which “breaches of rules are allowed to persist and remain unchallenged” (Amani *et. al.*, 2012:3). The participating states must be bound by rules which cannot be broken without sanctions. The rules governing agreements can help foster commitment. But, who will enforce the rules binding on sovereign states? It should be supra-national structures – like the SACU tribunal— backed by the hegemony, South Africa. The economically powerful state, South Africa would largely provide the public goods or incentives for cooperation. It can also withdraw these incentives to punish non-cooperation or violation of agreement. This leads us to the question: what happens when the hegemon breaks the rules? The assumption is that the regional arrangement exists because of the action and the interest of the hegemony (see Keohane and Nye, 1989). It is also assumed that the economically powerful state is bound to keep the rules because it derives more benefits from the cooperative arrangement.

CONCLUSION

We noted that despite the intent to foster trade and development, trade issues remain the priority of SACU and that this focus is not enough to achieve broader development objectives. The article thus proposed a constructive balance between trade and development, arguing that production-led integration has become very necessary in the light of the present SACU predicaments. To this end the paper proposed that SACU states ought to take collective steps towards industrialization anchored in diversification, complementarities and interdependent economic interactions. The view is that this restructuring can lead to the total development of the micro-regional economy and foster equitable and balanced development. Beyond state oriented interests, the article proposed a procedural interaction between civil society and SACU structures and institutions which will ensure that the interests of people are taken care of. We argued that SACU states ought to look more inward than outward in the search for development finance because dependence on external actors can impede the attainment of developmental goals. Further, the article drew attention to the point that the realization of the objectives of development regionalism rest greatly on the commitment and political leadership of South Africa and the ability of participating countries to soar above narrow national interests and agendas. To recall a point made in the introductory section, the cohesion within SACU offers a good foundation for the pursuit of collective goals which are central to development regionalism. So, what is sorely needed is the political will. Finally, it is hoped that this article will help generate more work on innovative practical ways of fostering industrial development and mutually rewarding interactions in the integrative zone.

REFERENCES

Abrahams, C. (0000). Transforming the Region: Supermarkets and the Local Food Economy. *African Affairs* 109(434) :115-134.

African Development Bank. (1993). Economic Integration in Southern Africa: Integrating the Region's Natural and Human Resources, 3

Amani, H.K.R., Chipeta, C., Rweyemamu, D. and Mkandawire, M.L.C. (2012). Drivers of Regional Integration in Southern Africa: Implications for Poverty and Development. Paper presented at the SADC Regional Think Tank Conference, Maputo, Mozambique.

Amin, S. (2002). *Obsolescent Capitalism: Contemporary Politics and Global Disorder*. Zed Books, London/New York.

Ashman, S., Fine, B. and Newman, S. (2011). Amnesty International? The Nature, Scale and Impact of Capital Flight from South Africa. *Journal of Modern African Studies,* 37(1) :6- 25.

Ashman, S. (2012). A New Growth Path for South Africa? *South African Labour Bulletin*, 35(5) :36-39.

Bertelsmann-Scott, T. (2010). SACU- One Hundred Not Out: What Future For the Customs Union? *South African Institute of International Affairs*, Occasional Paper No. 68:1-24.

Bischoff, P.H. (1990). *Swaziland's International Relations and Foreign Policy: A Study of a Small African State in International Relations*. Peter Lang, Frankfurt.

Blummenfeld, J. (1991). Economic Interdependence in Southern Africa: from Conflict to Cooperation. F. Pinter, London.

Cheru, F. (1997). Africa and the New World Order: Rethinking Development Planning in the Age of Globalization. *In:* Adebayo Adedeji (Ed.). *South Africa and Africa: Within or Apart?* Zed Books, London/New Jersey.

Crush, J. and Frayne, B. (2011). Supermarket Expansion and the Informal Food Economy in Southern African Cities: Implications for Urban Food Security. *Journal of Southern African Studies*, 37(4) :781-802.

Davies, R. (1990). Post-apartheid Scenarios for the Southern African Region. *Transformation*, II:12-39.

Davies, R. & Martin, W. (1992). Regional Prospects and Projects: What Futures for Southern Africa. *In* Vieira, S. Martin, W. and Wallerstein, I. (Eds.). *How Fast the Wind? Southern Africa and the World Economy, 1975-2000.* Africa World Press, Trenton, New Jersey.

Dos Santos, T. (1970), "The Structure of Dependence. *American Economic Review*, 60(2) :231-236.

Du Pisani, A. (2001). New Sites of Governance: Regimes and the Future of Southern Africa. *In* Vale P, Swatuk, L and Oden, B. (Eds.). *Theory, Change and Southern Africa's Future*. Palgrave, Hampshire.

Gelinas, J.B. (2003). *Juggernault Politics: Understanding Predatory Globalization*. Zed Books, London/New York.

Gibbs, R. (1997). Regional Integration in Post-Apartheid Southern Africa: the Case of Renegotiating the Southern Africa Customs Union. *Journal of Southern African Studies,* 23(1) :67-86.

Green, R. (1991). Economic Coordination, Liberation and Development: Botswana and Namibia Perspectives. *In* Harvey, C. (Ed.). *Papers on the Economy of Botswana*. Heinemann, London.

Hartzenberg, T. (2012) Economic Integration Matters for SADC. Paper delivered at the *SADC Think Tank Conference*. Maputo, Mozambique.

Hentz, J.J. (2005). South Africa and the Political Economy of Regional Cooperation in Southern Africa. *Journal of Modern African Studies*, 43(1) :21-51.

Hettne, B. and Soderbaum, F. (1998). The New Regionalism. Special Issue of *Politeia*, 17(3)

Hettne, B. (2001). Cooperation for Security and Development in Africa. *In*Vale P, Swatuk, L and Oden, B. (Eds.). *Theory, Change and Southern Africa's Future*. Palgrave, Hampshire.

Ho-Fung, H. (2009). America's Head Servant? The PRC's Dilemma in the Global Crisis. *New Left Review*, November-December.

Jourdan, P. (1995). *The Mining Sector in Southern Africa.* SAPES Trust, Harare.

Keohane, R.O. and Nye, J.S. (Eds.). (1989). *Power and Interdependence*. Harper Collins, San Francisco, California.

Leistener, G. (1981). Towards a Regional Development Strategy for Southern Africa. *South African Journal of Economics*, 49:349-364.

Leistner, G. (1985). Southern Africa: The Market of the Future. *Africa Insight*, 15:17-21.

Leith, J. (1992). The Static Welfare Economies of a Developing Country's Membership in a Customs Union: Botswana in the Southern African Customs Union. *World Development*, 20(7) :1021-1028.

Leysens, A. (2001). Critical Theory, Robert Cox and Southern Africa. *In* Vale P., Swatuk, L and Oden, B. (Eds.). *Theory, Change and Southern Africa's Future*. Palgrave, Hampshire.

Lipsey, R. (1960). The Theory of Customs Union: a General Survey. *The Economic Journal*, 70:496-513.

Lundahl, M and Petersson, L. (1991) *The Dependent Economy: Lesotho and the Southern African Customs Union.* Westview Press, Boulder.

Maasdorp, G. (1982). The Southern African Customs Union: An Assessment. *Journal of Contemporary African Studies*, 1:81-112.

Maasdorp, G. (1985) Squaring up to Economic Dominance. *In:* Rotberg, I. (Ed.). *South Africa and its Neighbours: Regional Security and Self-Interest*. Lexington Books, Lexington.

Maasdorp, G and Whiteside, A. (1993). *Rethinking Economic Cooperation in Southern Africa: Trade and Investment*. Occasional Paper. Konrad-Adenauer-Stiffung, Johannesburg.

Makgetlaneng, S. (2011). The Role of South Africa in African Continental Integration: the View of the Zimbabwean State, Capital and Civil Society. *Africa Insight*, 41(3) :80-98.

Malan, T. (1983). Regional Economic Cooperation in Southern Africa. *Africa Insight* 43-51.

Martin, W.G. (1991). The Future of Southern Africa: What Prospects after Majority Rule. *Review of African Political Economy,* 50:115-134.

Martin, W. (1992). Southern Africa and the World Economy: Regionality and Trade Regimes. *In*Vieira, S. Martin, W. and Wallerstein, I. (Eds.). *How Fast the Wind? Southern Africa and the World Economy, 1975-2000.* Africa World Press, Trenton, New Jersey.

Matsebula, M. and Simelane, V. (1996). Small Countries within Regional Integration. *In* Maasdorp, G. (Ed.). *Can South and Southern Africa Become Globally Competitive Economies*? St. Martin Press, New York.

Matthews, J. (1983). Perspectives of Economic Cooperation and Autonomous Development in Southern Africa. *In*: Amin, S. Chitala, D. and Mandoza, I. (Eds.). *SADCC: Prospects for Disengagement and Development in Southern Africa*. Zed Books, London.

Niemann, M. (2001). Unstated Places: Re-reading Southern Africa. In Vale, P, Swatuk, L and Oden, B. (Eds.). *Theory, Change and Southern Africa's Future*. Palgrave, Hampshire.

Oden, B. (2001). South African Benevolent Hegemony in Southern Africa. *In* Vale P, Swatuk, L and Oden, B. (Eds.). *Theory, Change and Southern Africa's Future*. Palgrave, Hampshire.

Qobo, M. (2010). Refocusing South Africa's Economic Diplomacy: the 'African Agenda' and the Emerging Powers. *South African Journal of International Affairs*, 17(1) :13-28.

Ravenhill, J. (2008). Regionalism. *In* Ravenhill J. (Ed.). *Global Political Economy*. Oxford University Press: Oxford.

Reu-Smit, C. and Snidal, D. (2010). Between Utopia and Reality: the Practical Discourses of International Relations. *In:* Reu-Smit, S. and Snidal, D. (Eds.). The Oxford Handbook of International Relations. Oxford University Press, Oxford.

Zondi, S. and Mulaudzi, C.(2010) SADC Integration and Poverty Eradication in Southern Africa: An Appraisal. *Africa Insight*, 39(4) 35-52.

Soderbaum, F. (2001). The Dynamics of Security and Development Regionalism in Southern Africa. *In* Poku, N. (Ed.). *Security and Development in Southern Africa*. Praeger, London.

Soderbaum, F. and Taylor, I. (2001). Transmission Belt for Transnational Capital of Facilitator for Development? – Problematizing the Role of the State in the Maputo Development Corridor. *Journal of Modern African Studies*, 39(4) : 675-95.

Soderbaum, F. and Taylor, I. (2003). *Regionalism and Uneven Development in Southern Africa: the Case of the Maputo development Corridor*. Ashgate, Aldershot.

Soderbaum, F. (2004). *The Political Economy of Regionalism: The Case of Southern Africa*. Palgrave, Hampshire.

Swatuk, L. (2001). "Southern Africa Through Green Lenses", in Vale P, Swatuk, L and Oden, B. (Eds.). *Theory, Change and Southern Africa's Future*. Palgrave, Hampshire.

Taylor I. (2010). A House Built Upon Sand: South African Imperialism in a Region without Regionalism. *Strategic Review for Southern Africa*, XXXII (2) :4-5

Tsie, B. (2001). International Political Economy and Southern Africa. *In*: Vale P, Swatuk, L and Oden, B. (Eds.). *Theory, Change and Southern Africa's Future*. Palgrave, Hampshire.

Vale, P. (2001). Dissenting Tale: Southern Africa's Search for Theory. *In*: Vale P, Swatuk, L and Oden, B. (Eds.). *Theory, Change and Southern Africa's Future*. Palgrave, Hampshire.

Wallerstein, I. (1992). *Geo-Politics and Geo-Culture: Essays on Changing World System*. Cambridge University Press, Cambridge.

BEYOND PARITY: GENDER IN THE CONTEXT OF EDUCATIONAL LEADERSHIP IN SWAZILAND

Sonene Nyawo[1] and Njabuliso Nsibande[2]

ABSTRACT

Gender mainstreaming especially in education is identified as a major strategy to facilitate growth in developing countries like Swaziland. The main purpose of this paper is to consider the different obstacles or self-limiting factors towards gender equality in accessing leadership positions in schools. Through a qualitative social inquiry approach 21 female school leaders from the Manzini and Hhohho Regions were interviewed. Findings reveal that women in Swaziland are still less keen to access leadership positions because of the resilient socio-cultural context. Recommendations include gender dialogue, women empowerment, and gender education programmes that will challenge the status quo even at school levels. The paper then suggests responsive interventions and entry points which will promote a supportive environment that will increase gender equality within the educational leadership sector in Swaziland

Keywords: Gender, equality, parity, educational leadership

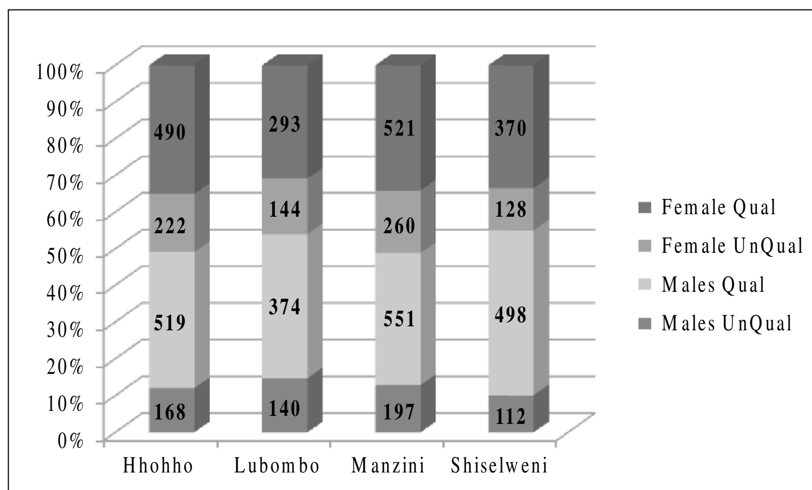
BACKGROUND

In the quest for achieving respect for human rights of all people, including women, international and regional instruments like conventions, declarations and treaties have been signed by state parties to denote acceptance of the enshrined provisions on gender equality. The 1997 Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), Article 10 (a), for example, specifically calls on state parties to ensure equal participation by women and men in all levels and areas of education. Hence, in 2008 the Southern Africa Development Community (SADC) Heads of States and Governments adopted a 50:50 target of women in politics and decision-making positions (SACMEQ, 2011). As part of furthering the global initiatives, Swaziland developed a gender policy in 2010, which amongst its thematic areas, lists equal opportunities in education and training. Swaziland has crafted the National Development Strategy (NDS), in which Article 10 (a) specifically calls on state parties to ensure equal participation by women and men. The NDS is also referred to as Vision 2022 and it maps out key macro-economic priorities for the country's progress in all sectors. Gender mainstreaming especially in education is identified as a major strategy to facilitate growth.

In recent years, Swaziland has made great strides in educating its citizenry as it is demonstrated by its high student enrolment rates of both genders. In the 2010 Education Management Information System (EMIS) Report, the enrolment in secondary schools increased from 57 100 in 2009 to 60 963 in 2010. Results indicated that Form 1 and 2 increased substantially for both boys and girl although enrolment by gender was slightly different (30

[1] *Department of Theology and religious Studies, University of Swaziland*
[2] *Department of Educational Foundations and Management, University of Swaziland*

313 for girls and 30 650 for boys) in 2010. Some reports provide comparative ratios of female-to-male gross enrolments in first (primary) and second (secondary) levels of education in Swaziland which indicate that 92 per cent of females are enrolled compared to 97 per cent of the males (World Bank Report, 2010; Daly, 2001). Daly further gives statistics that show that at secondary level more females are enrolled than males, with 101 females registered for each 100 males. These statistics generally demonstrate a high educational achievement for females. The 2010 EMIS report also presents statistics on qualified and unqualified teachers by gender in each region. As shown in Figure 1, a substantial number of Swazi women per region are more qualified than men.



Source: EMIS (2010:107)

Figure 1. Number of Teachers: Qualified vs. Unqualified Teachers by Gender and Region.

The educational system in Swaziland functions on a three-tier basis, with the primary level, secondary and tertiary levels being equivalent to elementary, secondary and college level education. Data drawn from 2011 records at the Teaching Service Commission (TSC) Information Office show that female head teachers at primary school level constitute 35%; at secondary/high school the same cadre of teachers makes up 17%; and only 1 female heads a tertiary institution. The bigger picture of the SADC region also confirms the low numbers of female teachers in educational leadership. According to SACMEQ (2011) primary school head teachers dropped from 40% in 2000 to 34% in 2007 and that was despite the observation that a majority of teachers at primary school level were female. Given these statistics, the paper argues that despite the gender oriented initiatives taken by the Swaziland government, leadership in schools exhibits patterns where managerial positions, such as head teachers, are largely occupied by men. Underscoring this argument, Neimanis (2001:40) maintained that "the result is a sector which is disproportionately dominated by women, except in those positions of leadership which have higher wages and prestige'.

The imbalances in equality in Swaziland were best captured by Cassandra Shaw, a journalist of the *Times of Swaziland*, in the 44th Independence supplement. She compiled interviews with women she termed, 'Swaziland's most powerful women' (*Times of Swaziland,*

Wednesday, September 5, 2012). According to one female interviewee, much still needed to be done in Swaziland on gender equality, as she claimed, "there is less representation of women in many sectors, and most women are in middle or low management, where there is less or no decision making." She asserted that even those who had made great strides in grabbing opportunities to match their male counterparts that did not make much of a difference because they were few. The second interviewee concurring with the first observed that more females were now educated, but very few made it to leadership positions; which in her words, 'the board room is still dominated by men, and Swaziland has not met the 30 per cent quota of women in parliament.' The third interviewee added that Swaziland would have national elections soon, and many women would vote for men, yet they were a majority. The reason was that 'as women we do not support each other.' The sentiments shared by the three Swazi women represented many voices that were concerned about the gender inequalities in government sectors in Swaziland. The education sector is no exception. The education system is structured around a hierarchical and bureaucratic style of management; that is, the control of schools and the decision making is centralised, and leadership is understood in terms of "position, status and authority" (Fenstermaker and West, 2002:18). Patriarchal attitudes thriving in the education sector debar women from intruding into the 'male territory' and those who take the courage to invade the territory are often ostracised, ridiculed and isolated.

The underlying assumption of this study, therefore, is that meaningful progress in education, which is the main social sector, tends to be derailed by the negative impacts of the socio-cultural context, which legitimizes inequality between women and men. It is further assumed that women's ability to climb the leadership ladder without discrimination or the ability to 'break the glass ceiling' continues to be a challenge due to the reality that Swaziland's long-standing patriarchal heritage persists and continues to define and structures gender relationships in all subsystems in the Swazi society. Gilbert and Gilbert (1998:47) noted in their observation that education is never neutral; it is an active supporter and faithful reflector of the status quo in the society. "If the status quo is predominantly unequal and unjust, and if it is increasingly so, education will be increasingly unequal and unjust too" Expressing similar sentiments, Kaur (2012:43) adds that it is the structural, cultural and social consequences of patriarchal power together with its myths, that dictate that leadership is a 'male domain' because men are perceived to be strong, and being a leader needs a 'strong man.' This thinking has resulted to women being under-represented in leadership in the schools, yet they numerically dominate the profession. The main purpose of this paper therefore is to consider the different kinds of obstacles or self-limiting factors towards gender equality in terms of whether or not leadership opportunities are equally available to both men and women in schools in Swaziland.

STATEMENT OF THE PROBLEM

Women in Swaziland have historically experienced unequal treatment in the political, economic, social, legal and cultural spheres because of systematic gender discrimination. In schools in particular, women constitute the majority but only a few get promoted to senior leadership positions.

OBJECTIVES OF THE STUDY

The objectives of the study are to:

1. examine the impact of socio-cultural constructs on women leaders in schools;
2. discuss women's experiences in their attempts to access leadership positions in schools in Swaziland;
3. explore the reasons that inspire or dissuade professional female teachers to assume leadership positions in the schools; and
4. investigate the attitudes of female teachers towards female leaders.

MAIN RESEARCH QUESTIONS

The intended main focus of this research study, which the research objectives specified (Creswell, 2007), was achieved through data generated from the following main research question:

How do socio-cultural constructs impact women in leadership in the education sector?

The sub-questions were:

- What is the representation of women in educational leadership in Swaziland?
- What inspires or dissuades professional female teachers to be leaders in the schools?
- How are the attitudes of female teachers towards female leaders?

LITERATURE REVIEW

The literature below demonstrates how social gender constructs shape women identities. Premised by the gender theory the study seeks to stretch further the arguments in the literature review to interrogate the implications these constructs have on women leadership specifically in the education sector within the Swaziland context.

Gender theory

There is a general awareness that the term 'gender' means different things to different people. For the purposes of this study, we use the term to refer to the socially constructed roles, responsibilities, identities and expectations assigned to men and women (Neimanis, 2005). For many, gender is always thought about in binary terms: man/woman; masculine/ feminine.Notably, expectations of women and men are limited by these binaries, and are communicated through sex role stereotyping. These stereotypes limit gender appropriate behaviour to a range of rigid roles which are assigned to women and men on the basis of their gender; for example, 'women are nurturers' and 'men are aggressors'. These role expectations are subtle and deeply ingrained in people's attitudes.

However, the emergence of new thinking on the social sciences challenges societal perceptions on gender. The 20th century saw the birth of the feminist theory which sought for women the same opportunities and privileges society gives to men (Mwanje, 2001). The theory has gone through various phases since 1960, resulting to its being explained in terms of waves. The first wave, also referred to as the 'liberal' wave, began with the US Presidential Commission of 1960. It focused on developments centred on issues of equality in general, and it sought equality in the sense of sameness or 'androgyny' (Mwanje, 2001:28). Mwanje adds that another wave known as 'early radical equality' emerged, which in his words "consists of a rejection of hierarchy and oppression in all its forms… women and children are the most basic (2001:29).Put differently, during the 1960s, second wave feminism started to critique essentialist assumptions about gender, and in the academy feminist scholars started to develop feminist theory based on a theoretical or philosophical analysis of women's liberation politics.

Subsequent to the second wave, a field of study called women's studies emerged. Feminist politics and women's studies put a spotlight on the inequalities between women and men in almost all societies. However, in this focus on inequalities between women and men, the term 'gender' somehow became synonymous with 'women,' yet in actual fact it seeks to examine cultural representations and lived experiences of being female or male. The field of masculinity studies which emerged in the 1980's in academia used the feminist theory to analyse gender and power relations between women and men. These studies helped to interrogate the phenomenon widely, taking into consideration the experiences of both sexes.

The gender theory therefore provides the framework for the paper in that it argues that through cultural formations that differ markedly and are ever changing, as reflected in everyday life and discourses, females and males learn 'appropriate' gendered behaviour from the moment of birth. This behaviour embodies deeply held ideologies, which are substantiated by religious texts, cultural practices and other means' (Wolpe *et al.,* 1997). Gender equality is therefore concerned with equal treatment of both women and men in all spheres of life, including schooling and competition in the informal and formal labour market without feeling discriminated against because of their gender.

Gender categorization in leadership

Extensive research as claimed by Dahlrig and Longman, cited in Connell (2005), has identified prejudice toward female leadership and gender stereotyping as likely explanations for the continued barriers that women experience in the workforce. According to Young (1993) the designation of tasks as being particularly suitable for men and women has more to do with socially constructed ideas about masculinity and femininity; hence men and women should do tasks to which they are 'naturally' suited. Elson and Pearson (1980) observe that in fact gender definitions are never absent; even if a woman escapes one particular set of gender ascriptive relations by not getting married, she cannot escape the way in which gender prejudicially defines all other aspects of her life. Eagly and Karan (2002) have used the role-congruity theory to explain prejudice and discrimination against women in leadership. They describe this theory to refer to human behaviours being consistent with socially acceptable gender roles.

With the role-congruity theory, features ascribed to leaders are viewed as incongruent with female characteristics; and this works at the disadvantage of women because being perceived as having less leadership ability than men thwarts their potentials (Eagly and Johannesen-Schmidt, 2001). Echoing the sentiments about the role-congruity theory, Kaur (2012) notes that throughout human history, leadership has been closely associated with masculinity; resulting in the king, the father, the boss, the Lord, being depicted as typical stereotypical images of leadership. As observed by Carli and Eagly (2001), whilst it is true that the beginning of the 20th Century has seen a rise in the improvement of women status in many societies, including developing countries like Swaziland, women continue to lack access to power and leadership compared with men; more than a decade later, major gender differences at different levels of education are still not tackled. Wolpe *et.al.* (1997) observed that the lack of adequate ECD provision was a gender issue based on the assumption that women are traditionally carers of children.

There are certain human qualities that are associated with masculinity and femininity. Notably, these qualities are important as they are not generally viewed as being equivalent in value by the society. "Men and masculine characteristics are more highly valued than women and feminine characteristics," (Unger, 1979:48). On the one hand, males are seen as

aggressive, assertive, unemotional, competent, dominant, analytical and more independently inclined. On the other hand, feminine characteristics revolve around an affective dimension (Unger, 1979). The feminine characteristics reflect warmth, tolerance, sacrifice, intuitiveness, gentleness, caring and being emotional. These feminine characteristics are deemed to be important for supporting the one who leads; hence women cannot lead, but only back up leadership. It is for this reason therefore that female teachers who courageously trespass in the man's domain and become head teachers, in the words of Kneel (1994:69), "have to work much harder than their male counterparts to get respect and support from colleagues." More so, many women have internalized beliefs about leadership roles that they are solely for men, and that hinders their ambition to pursue leadership.

GENDER AND THE DEVELOPMENT OF THE HUMAN CAPITAL

Any economy depends mainly on the effectiveness of human capital which is equally drawn from men and women. Although practices differ from context to context and organization to organization, there is a drive, especially in industrialized countries, to ensure that there are equal opportunities for men and women even in the way they are recruited in the leadership position. However, the aggregate statistics on labour force participation suggests gender inequality because even though women in most societies are supposed to have equal opportunities but the challenge is in their employability, especially into positions of influence. Morrison *et al.*(1987) define glass ceiling as 'a "transparent" barrier that keeps women from rising above a certain level in corporations' (p.13). Moran (1992) ; Carli and Eagly (2001) note that although women account for a larger population of the work force, fewer of them are in leadership positions. As much as there are changes in women status, there is very little change in the upper echelons of power in organizations, and women do not often question their subordinated roles in organizations. Morrison and Von Glinow (1990) maintain that the presence of what is termed 'the glass ceiling' is said to have inhibited women from advancing to the highest level of management in most organizations. They further see the so-called glass ceiling as 'an invisible barrier that prevents ambitious women from moving up the organizational hierarchy.' However it cannot be disputed that some women have occupied positions of power and leadership in their homes, churches and their communities at large. Therefore, part of the research focus in this study is on how women have struggled to attain high positions of power in organizations which, in turn, affect their behaviour patterns and still subjecting them to lower status.

RESEARCH METHODOLOGY

The study seeks to collect information of personal experiences and observations on women leadership in schools; thus making it qualitative. Qualitative research can be defined as a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live (Atkinson *et al.,* 2001). We selected this technique because it offers advantages of focusing on specific experiences and perceptions of individuals engaged in the area of interest (Fraenkel and Warren, 2000). The study focused on 3 primary and 3 secondary schools headed by female leaders in the Manzini and Hhohho regions respectively. Within the 6 schools, female deputies, female HODs and female senior teachers were selected. The respondents were expected to provide background information, including their qualifications, the positions they hold; how they got into these positions; factors

contributing to their successes and failures; the extent to which their leadership is accepted or rejected as women in such positions; their leadership styles, in general; and challenges they face in their day-to-day duties and how they have managed to overcome them. Three focus groups in each school that included women principals, heads of departments and senior teachers were conducted in the Manzini and Hhohho regions. The choice of the regions was based on statistics from the Ministry of Education which showed a higher number of female leaders in the schools.

The researchers gathered qualitative primary data from these participants using two techniques as their key data collection methods: semi-structured face-to-face interviews and focus group discussions. The two techniques were used because they allowed the researchers to discover the depths and nuances of the various opinions on women leadership, as the people on the ground shared their experiences. Also, some data were collected through analysing documents on gender and leadership. The participants were chosen through purposive sampling precisely because, as people on the ground, they had some meaningful insights into the topic of the study. Also they were selected on the basis of gender, age and experience in the teaching profession. The collected data was analysed through qualitative analysis techniques, based on an inductive methodology that found patterns in the data in the form of thematic codes. "Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis" (Patton, 1980: 64).

FINDINGS

This section presents findings categorised into four emergent themes in line with the objectives. The samplefor this study comprised female teachers whose age range was between 35 and 60. Out of the 21 respondents, 15 (71%) were between 45 and 60, and the remaining 6 (29%) were between 26 and 35. All 6 female head teachers were given questionnaires, followed by structured interviews. The remaining 15 female leaders participated in 3 focus group discussions, each comprising 5 respondents.

Achieving academic and professional qualifications

As stated earlier, current data from the Information Office in the Ministry of Education have shown that female head teachers at primary level constitute 35 per cent; at secondary/high school they are 17 per cent; and only 1 female heads a tertiary institution. The demographic information of the sample for this study revealed that women had not significantly advanced in their careers. Despite a substantial number of years in leadership positions, all the 21 respondents only had first degrees, diplomas or primary teaching certificates. Most of these respondents had very few opportunities for in-service education and professional advancement in leadership development. However, it was gathered from the interviews that there were many female teachers, especially younger ones, who had acquired higher qualifications with a leadership component, but they do not adequately access leadership positions despite their academic achievements. A majority of young female teachers with high qualifications were just ordinary teachers either at secondary or high schools.

Successes and failures in their leadership years

Participants were asked what they considered to be the successes and failures in their leadership years in schools. Good and bad examination results were used as a measure for

successes and failures, especially the external examinations at Grade Seven and Form Five (Grade12). They cited many reasons for their failures, which included negative attitudes towards them, being posted to remote areas, lack of confidence in their abilities, being too conscious about how society views them. Those that excelled in their schools' performance attributed their success to hard work and dedication of the staff members, especially the male teachers. One participant who attached her success to the support she receives from male teachers had this to say,

> Men are just good and some of the women are just spoilt and gossiping (sic). Every morning I pray before facing the duty (sic) I find it difficult in the people I am facing (sic).

Again, in one of the three focus groups, there was a general consensus that women fail because they were problematic; once they assumed leadership positions they did not often support their fellow women in junior positions. One of the focus group members even said:

> As women we fight over petty things, we compete in terms of asserts, children, marriage… for example, a female head teacher would be jealous that a junior female teacher is driving a better car than hers. Female teachers are also an easier target than the males. So, the female teachers feel undermined and abused because the female head teacher is afraid of the male teachers…. This leads to an imbalanced leadership.

When this point was explored further, participants in another focus group expressed that female head teachers always felt that they owed the male teachers 'apologies' that they usurped their jobs, and they therefore felt obliged to be extra nice to the male teachers. '*This is the influence of our male dominating culture,'* claimed another participant.

The data also showed that women leaders attributed their failures in the schools to antagonistic attitudes towards them. The respondents observed that some women could not function properly when criticized. However, there were those that claimed to have developed coping strategies that had helped them succeed in their leadership. It was the same thing one respondent said when she was asked about her style of leadership as she carries her day-to-day duties:

> First of all I pray, that the Lord makes me to be clever and be able to handle negative attitudes from colleagues and other stakeholders. I have also learnt to share all the difficulties that I come across with people who care and they give me good pieces of advice.

Interest in climbing the glass ceiling

Because of the negative connotations associated with women in leadership positions, the participants were initially reluctant to take up a leadership position when approached, as some of them were quoted saying:

> Initially I had no interest because I had been raised to believe that leadership positions are solely for males. But when the opportunity availed itself, I felt I had all it takes to be a leader.

Similarly, another one said,

> Honestly, I have never had an interest in administration. I was just appointed by my pastor. Actually, initially I declined the appointment but my pastor persuaded me to give it a try and it worked.

The above statements were supported by participants in the focus groups who maintained that women, who are in leadership positionsin mission schools, were often appointed by ‘grantees’ or church superintendents. One of the participants in the focus groups further observed that qualifications were not considered in the appointments; it was the church that determined whether one was a deserving candidate or not. When asked why they lacked the zeal to assume leadership positions, they stated that leadership was a male domain. They pointed out that culture dictates that a woman is a subordinate, and her place is ‘at the kitchen.’ Another participant added that traditionally, women are seen as lacking the necessary attributes for leadership. They are believed to be submissive, easily moved or emotional. They are also perceived as having great difficulty in making choices, as it involves being decisive, is one important quality that every leader must possess. Women therefore opt for softer jobs like being ordinary teachers, nurses, old-age home attendants and handicraft artists

Leadership styles

The data revealed that the women leaders used different leadership styles. Some preferred the participative type as reflected in the following statements:

> I think my leadership style is the consultative type. It is neither the democratic nor the autocratic one. I say so because I always seek the teachers’ ideas before taking decisions. I also solicit their opinions on innovations that I plan to introduce in the school.

Others claimed to use the situational type. A response from a high school principal was:

> Mine is situational, which is a combination of the democratic and authoritative. There are times when I have to put my foot down and come up with the final decision…

She highlighted that there were situations where she felt that her administrative decisions would not be carried out due to culture influence that:

> ‘What would a woman tell us, after all there are male teachers in the school who by right, are supposed to occupy that high seat.’

So, she had to prove to everyone that she was the one in authority.

Leadership, gender and women empowerment

Empowerment has become such a buzzword in gender and leadership circles. Participants were asked what could be done to empower women leaders. Responses were:

> Women leaders need to be empowered to boost their self-esteem and leadership skills. This can be done by organizing seminars and workshops where formal leaders would be equipped with the necessary skills. Employers should give/avail equal opportunities to females and males when hiring them. The hiring should be based on merits not on gender.

Another respondent downheartedly said:

> I don’t know what can be done but I strongly believe that prayer is the answer for all things.

DISCUSSION OF FINDINGS

Based on the findings it can be concluded that socio-cultural influences have placed women at a minority position such that they cannot even aspire for leadership positions in education.

Swazi culture continues to socialize females to believe in the leadership skills of males. As a result of the socio-cultural challenges faced by women, most of them even in education are reluctant to take up leadership positions. A majority of female head teachers in the study have no confidence in their leadership abilities. They seem to have regrets why they trespassed in a wrong domain that is male dominated. That is why most expressed that they had no interest in leadership position until they were coerced by other people into it. Culture has taught them that the man is the ruler in social units and women as subordinates must support male leadership at all cost. It is for that reason that those who find themselves in leadership positions either by choice or by default experience antagonism especially from other women. Other female staff members, where a woman is in a senior position, are a constant reminder that such a woman is a misfit in man's world. This pervasive ideology of male superiority, as noted by Whitehead (1993) shapes women's views about themselves and their capabilities.

Culturally, a woman must remain a minor throughout her life. She is always under the guardianship of a male; from childhood she is attached to her father, at marriage to her husband, when widowed to her late husband's brother or a close agnate, and at work to her male boss. Connell (2000) refers to this stereotypical mentality as 'hegemonic masculinity.' He defines it as a cultural dynamic by which a particular gender claims and sustains a leading position in social life. It is clear from the data that women in leadership positions are victims of the hegemonic masculinity discourse which constructs gender identities in settings such as schools, families, friendships and work. Unless the impacts of this culturally induced discourse are manifested and critiqued, women will not reach full realization of their potentialities.

Cultural backgrounds, high dependency in personality, contemporary leadership trends are in a tension as the awareness grows that there is a need to move beyond gender parity in the educational arena. The concept of 'leaders are born than made' still persists as women find themselves in the cold as they maneuver in the leadership arena dominated by men in higher positions. The antagonism and mistrust between women school leaders and women subordinates continue. Women tend not to support one another and they lack confidence towards their female counterparts when promoted to higher positions. Because of the challenges of women leaders competing with a type of leadership characterized by masculinity, it is easier for some to depend on their individual qualities, colleagues who are mainly male or even 'a Higher Power' than to develop and apply scientific knowledge of leadership and management. Considering the information boom and information networks, gender parity, especially at education leadership and management level will also depend on the willingness of women to be equipped more with relevant knowledge that will improve their leadership competencies. There is need for creating space for women to deliberate on leadership issues in order to develop their own meaning of leadership rather than what society defines for them.

CONCLUSIONS

The key findings revealed that no matter how effective and qualified women leaders can be, they cannot be fully trusted with leadership positions in the schools in Swaziland Gendered attitudes and perceptions birthed by the socio-cultural landscape, which does not favour aspiring women leaders, discourage women from aspirations for senior positions. Even those women who are brave enough to invade the male territory, and become leaders are not supported by their fellow women. It became evident from the participants' responses that social 'enculturation' shapes the women's thought patterns to believe that social norms and values

prohibit them from assuming leadership positions in the schools. Such perceptions about themselves are bred and perpetuated by social agents like family to ensure their continuity down the generations. Hence the participants of the study, though educated, could not stand up to question the patriarchal traits that have become synonymous with school leadership in Swaziland. The dominant male culture which also permeates the school system, distorts the women's knowledge of social reality by concealing its damaging values, whilst dismissing the positive contributions of females. Subsequently, the women leaders find themselves frustrated, ineffective and misplaced. However, some participants did find the need for Swazi women to be empowered in assertiveness and self-esteem. This will probably be the first step towards a new orientation of the female-male axis which recognizes dynamism that both feminine and masculine traits can contribute towards educational leadership.

Swaziland is a signatory to numerous international conventions and declarations which seek to avail equal opportunities to both women and men in employment. As shown in the background, she has also enacted national laws and policies on equal treatment of all citizens. For example, there is the National Development Strategy (NDS), otherwise known as Vision 2022, which is a development plan that maps out key sectors of the economy, of which gender equality is one of the priorities. Even the newly adopted 2005 Swaziland Constitution has enshrined a clause on equality amongst citizens in Section 28(i). It is therefore important to conclude this study with recommendations on how the country can best address gender imbalances in school leadership.

Introduction of gender awareness from childhood

Gender equity problems start from childhood. The family unit provides a rigorous early training in sex roles, and it continues to pressurize women and men throughout their lives to conform to the set or socially prescribed roles. The pressure further permeates the market world; hence occupations have also become sex stereotyped. Women have been concentrated in jobs that are identified primarily in terms of 'feminine' traits of nurturance, empathy and helpfulness, whilst men are in occupations that have 'masculine' traits of aggression and independence. It is therefore recommended that social institutional locations should reorient their perceptions on parcelled up roles to eradicate sex stereotypes. That means that education policy makers, curriculum designers, school management, teachers and parents need new forms of socialization to the issues to move beyond just being aware that such problems exist. Gender awareness at childhood must further be reinforced by gender education programmes which are aligned to the current Swaziland Education and Training Sector Policy that challenges the status quo even at school levels.

Women empowerment

Leadership that is required in times of change cannot be innate, and for a society to move beyond gender parity, the conception that leaders are born will become irrelevant. Research has shown that some women leadership styles emulate those of men; women tend to move towards authoritarian leadership instead of ensuring that all members of the organization work towards realisation of a shared vision. If women are not considered to be born with leadership qualities, it means they must be empowered to attain them. Then they will inspire and mentor one another to demonstrate qualities of being visionary leaders.

Moving beyond traditional roles

The traditional roles that women occupy in society do not make them feel like leaders; as a result, when they are in high-visibility positions of leadership, they have a hard time appreciating that exposure. This means that in order for them to see their leadership in the traditional sense, they require spaces where their individual strengths will be celebrated. Also, women should be allowed to bring their diversity as women and not necessarily be expected to do things like men do when they are in leadership positions. This also calls for mentorship programs exclusively made for women aspiring to be leaders or those already occupying leadership positions.

Engaging in a discourse of the 'over-advantaged' and the 'under-advantaged'

Senge (1995) in his famous Fifth Discipline, argues that the best way to understand what the other person is thinking or to understand the way people behave in a particular way, is to bring to the fore their assumptions and this cannot be achieved without dialogue. For example, societies need to be engaged on why men are 'over-advantaged' while women continue to be 'under-advantaged' when it comes to occupying the highest positions. Unless such issues are addressed, gender inequality will continue to haunt us. We therefore recommend that more gender awareness and dialogue be carried out for the country to realize parity.

REFERENCES

Atkinson, P., Coffey, A. and Delamout, S. (2001). *A debate about our canon: Qualitative Research*, (2nd Ed). Sage, Thousand Oaks.

Carli, L.L and Eagly, A.H. (2001). Gender, Hierarchy, and Leadership: An Introduction. *Journal of Social issues.* 57(4) : 629-636.

Carrigan, T., Connell, R.W. and Lee, J. (1985). Toward a new sociology of masculinity. *Theory and Society* 14(5) : 551-604.

CEDAW (2011), Gender, Leadership and Advocacy for Members of Parliament, Training Manual. Swaziland 2011-2014.

Creswell, J. (2007). Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. Third Edition. SAGE Publications, Inc.,

Daly, J. (March, 2001). Gender equality rights versus traditional practices: struggles for control and change in Swaziland. *Development Southern Africa*18(1). Available from http://www.econpapers.repec.org/article/tafdeveza/v-3a18-2ay%202001-3ai-3a1 30/05/2012.

Eagly, A.H. and Johnston, B.T. (1990). Gender and Leadership Styles: A Meta-Analysis. *Psychological Bulletin,* 108(2) : 233-256.

Fenstermaker, S. and West, C. (2002). *Doing Gender, Doing Difference: Inequality Power and Institutional Change*. Routledge, NewYork.

Fraenkel, J. and Warren N. (2000). *How to Design and Evaluate Research in Education* (4th edition). McGraw-Hill, Boston.

Gilbert, R. and Gilbert, P. (1998). Masculinity Goes to School. Routledge, London.

Kaur, G. (2012). Gender as a Social Construct. Available from http://www.slideshare.net/gurkirat.kaur80 30/05/2012

Kneel, H. (1981). A Survey of the attitudes and experiences of a sample of men working in management positions in South Africa. Unpublished M.A. Thesis, University of Natal. Pietermaritzburg.

Kotter, J.P. (1984). *Power and Influence: Beyond Formal Authority*. Free Press, New York.

LincolnConnell, R.W. (2005). *Masculinities.* Second Edition. University of California Press, Berkeley, CA.

Moran, B.B. (1992). Gender Differences in Leadership Styles. *Library Trends* 40(3) : 475-91. The Board of Trustees: University of Illinois.

Morrison, A. M., White R. P., Van Velso, E., and The Centre for Creative Leadership (1987). *Breaking the glass ceiling: Can women reach the top America's largest corporations?.*: Addison Wesley, Reading, M.A.

Mwanje, J. (2001). Issues in Social Science Research. Module 1. Organization for Social Science Research in Eastern and Southern Africa, Ethiopia.

Neimanis, A. (2005). *Gender Mainstreaming in Practice: A Handbook.* UNDP Regional Centre for Europe and CIS, Bratislava.

Report on the 2010 Swaziland Education Management Information System (EMIS), Ministry of Education and Training: Swaziland Government

SACMEQ. (2011). Progress in Gender Equality in Education: Swaziland. *Policy Brief* No.6, September 2011.

SADC. (2009). *Framework for Achieving Gender Parity in Political and Decision Making Positions by 2015*. SADC Secretariat.

Scrivens, C. (2002). Constructions of leadership: Does gender make a difference? – Perspectives from an English speaking country http://herkules.oulu.fi/isbn9514268539/html/b358.html 21/08/2012

Senge, P. (1990). *The Fifth Discipline: The Art and Practice of Learning Organizations.* Random House:New York.

Swaziland Education Management Systems (EMIS) (2010). Swaziland Ministry of Education and Training: Swaziland. Available from: http://www.unicef.org/about/annualreport/files/Swaziland_COAR_2011.pdf

8/11/ 2013.

Swaziland SACMEQ Report. Available from: http://www.unicef.org/about/annualreport/files/Swaziland_COAR_2011.pdf 8/11/2013.

Times of Swaziland, 'Swaziland's most powerful women' Wednesday, September 5, 2012. Mbabane.

Unger, R. (1979). *Female and Male:Psychological Perspectives*. Harper & Ron Publishers, New York.

Wang, L., Bruce, C., and Hughes, H. (2011). Sociocultural theories and their application in information literacy research and education. Australian Academic & Research Libraries, 42(4) : 296-308 http://www.alia.org.au/publishing/aarl. 27/10/2012.

Whetton, D.A. and Cameron, K.S. (1985). *Developing Managerial Skills.* Free Press, New York.

Whitehead, A. (2013). Gender Ideology and Religion: Does a Masculine Image of God Matter? http://www.academia.edu/1240291/2/09/2013

Wolpe, A., Quinlan, O. and Martinez, L. (1997). *Gender Equity in Education. Report of the Gender Equity Task Team*. Department of Education: South Africa

World Bank Report. (2010). *The Education System in Swaziland. Training and Skills Development for Shared Growth and Competitiveness*. World Bank, Washington.

Young, K. (1993). *Planning Development with Women: Making a World of Difference*, The Macmillan Press Ltd, London.

THE IMPACT OF ANTIRETROVIRAL THERAPY SCALE-UP IN SWAZILAND

Muhle Nimrod Dlamini[1]

ABSTRACT

Swaziland has a hyper HIV-epidemic. About 72, 000 people are enrolled on antiretroviral therapy (ART) in Swaziland, yet not much research has been done to examine its impact. This study, conducted in July 2012, aimed at exploring the impact of the use of ARVs. It also describes how a symptom based classification known as clinical staging is used to determine the eligibility to start ARVs. This qualitative study was conducted using in-depth face-to-face interviews. The study concluded that ARVs prevented severe illness which could lead to death.

Keywords: HIV and AIDS, Antiretroviral therapy, CD4 cell count, Health status, Swaziland

INTRODUCTION

Over 34 million people are living with HIV globally. According to the Joint United Nations Programme on HIV/AIDS annually, there are 1.76 million AIDS related deaths, 2.67 million new infections and 390 thousand new infections in children (UNAIDS, 2010). By 2006, 2.2 million were estimated to be on treatment with antiretroviral drugs (ARVs). Sub-Saharan Africa, the hardest hit region, is home to 22.9 million people living with HIV, 1.2 million of AIDS-related deaths and 1.9 million new HIV infections (UNAIDS, 2010). With a high HIV prevalence in Swaziland, it is important to examine the extent to which the use of ART has contributed towards prolonging the lives of people living with HIV (PLHIV). This study therefore aims at exploring the impact of the use of ARVs in Swaziland. It focuses on the use of ARVs with the objective of providing information on the ARVs used and their impact on people's health. It also describes how a symptom based classification known as clinical staging is used to determine the eligibility to start ARVs without the need to use CD4 count.

CONTEXTUAL BACKGROUND

Swaziland is one of the countries in the Sub-Saharan region which is hardest hit by this epidemic. HIV prevalence has steadily increased from 3.9 % in 1992, to 41.1 % in 2010 [Ministry of Health (MOH), 2010]. The graph below shows the HIV prevalence among pregnant mothers from 1992 to 2010.

These national surveillance statistics point to a serious epidemic. It has been observed that in Swaziland not everyone who needs ARVs gets them [World HealthOrganisation (WHO), 2010]. In the country People Living with HIV (PLHIV) were estimated to be 190, 000 and 87, 534 were on treatment with ARVs by December 2012 (Kingdom of Swaziland, 2012).

Antiretroviral Therapy in Swaziland

In an attempt to fight HIV and AIDS, the Government of Swaziland introduced Antiretroviral

[1] *Muhle Nimrod Dlamini, Ministry of Health, Swaziland National AIDS Programme. Email:muhledlamini@gmail.com*

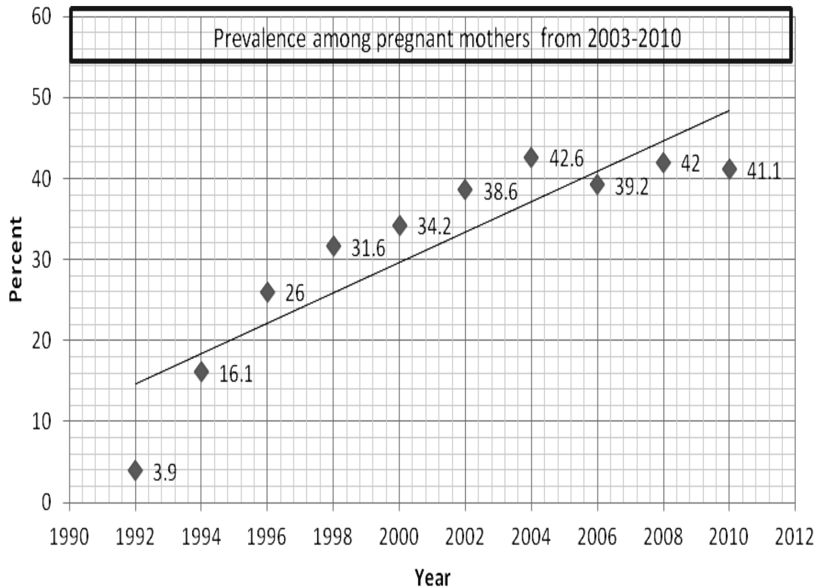


Figure 1. Trend of HIV prevalence in pregnant mothers from 2003 to 2010 (Source: MOH, 2010)

Therapy (ART) in 2003 [National Emergency Response on HIV/AIDS (NERCHA), 2005]. The introduction of ART came after His Majesty King Mswati III declared HIV as a national disaster (NERCHA, 2005). In 2003, there was only one health facility offering ART and two years later, in 2005, there were 17 health facilities [Ministry of Health and Social Welfare (MOHSW), 2005]. The Ministry of Health (MOH) for some time has been recommending offering treatment to asymptomatic patients with a CD4 threshold of 200. This has been increased to 350 in 2010 following a WHO recommendation (Kingdom of Swaziland, 2012). The WHO recommended the CD4 threshold of 350 because many studies established it as the best possible time to begin ART. Sabin and Phillips (2009) show that the recommendation was based on the results from analysing early cohort studies of patients with HIV. Wood *et a*l. (2005) agree with Sabin and Phillips (2009) by providing data from observational studies suggesting a longer term benefit when ART is begun well before the CD 4 cell count falls to 200 cells/μL.

A closer look at the trend in the demand of ARVs reveals that there has been a rapid increase in the number of people accessing ART services in the country. Due to this increase, the MOH adopted a clinical staging system of HIV infection and disease in adults and adolescents. The staging system is a symptom based classification. This staging system is used in many countries to determine eligibility for antiretroviral therapy. Clinical stages are categorized into four stages (1 through 4), progressing from primary HIV infection to advanced HIV and AIDS. These stages are defined by specific clinical conditions. For the purpose of the WHO staging system, adolescents and adults are defined as individuals aged = 15 years (WHO, 2005)

The clinical staging system prepares patients for ART initiation (MOH, 2010). This strategy was adopted from WHO clinical staging system. According to WHO (2005), the staging system was meant to assist poorly-resourced countries in the surveillance and

monitoring of HIV infection. Staging is based on clinical findings that guide the diagnosis, evaluation, and management of HIV and AIDS and does not require a CD4 cell count. The table below shows details of the staging system.

Table1. Clinical staging of HIV disease in adults and adolescents age 14 and above

Clinical stage 1
- Asymptomatic infection
- Persistent generalised lymphadenopathy (PGI)
- Acute retroviral infection

Clinical stage 2
- Unintentional weight loss (<10% of presumed or measured body weight)
- Minor mucocutaneous manifestations (e.g., seborrhoeic dermatitis, prurigo, fungal nail infection of fingers, recurrent oral ulcerations, angular cheilitis).
- Herpes zoster within the past five years
- Recurrent upper respiratory tract infections (RTIs; e.g. sinusitis, bronchitis, otitis media, pharyngitis).

Clinical stage 3
- Unintentional weight loss (>10% of presumed or measured body weight)
- Unexplained chronic diarrhoea for longer than one month
- Unexplained persistent fever, intermittent or constant, for longer than a month
- Oral candidiasis (erythematous or pseudomembranous)
- Oral hairy leukaemia
- Pulmonary tuberculosis, atypical or typical, within the previous year
- Severe bacterial infections (e.g., pneumonia, emphysema, pyomyositis, bone or joint infection, meningitis, bacteraemia)
- Valvovaginal candidiasis, chronic (i.e., longer than one month) or poorly responsive to therapy

Clinical stage 4
- HIV wasting syndrome
- Pneumocystis pneumonia
- Toxoplasmosis of the brain
- Cryptosporidiosis with diarrhoea, longer than a month
- Isospriasis with diarrhoea, for longer than a month
- Extrapulmonary cryptococcosis, including meningitis
- Cytomegalovirus (CMV) infection (retinitis or of an organ other than liver, spleen, or lymph nodes)
- Chronic herpes simplex infection mucocutaneous (longer than one month) or visceral (any duration)
- Progressive multifocal leukoencephallopathy (PML)
- Any disseminated mycosis (e.g., histoplasmosis, coccidiodomycosis, penicilliosis)
- Candidiasis of trachea, bronchi, lungs, or oesophagus
- Disseminated nontuberculouos mycobacteria infection
- Extrapulmonary TB
- Nontyphoidal salmonella septicaemia
- Lymphoma (cerebral or B cell non-Hodgkin's)
- Kaposi's sarcoma
- HIV encephalopathy

Source: National Guidelines on the Comprehensive HIV Package of Care for Adults and Adolescents in Swaziland, 2010.

Scaling up ARV Treatment in Swaziland

The aim of antiretroviral therapy is to suppress viral replication (Bailey and Fisher, 2008).

Swaziland has a significant ART programme which has set targets for rapid scale up of ART to 80 percent by 2013 (WHO, 2010). The programme has expanded enrolment of patients by increasing health facilities providing ARVs. A gradual scale up has been observed since 2003 where there were 2.3% patients enrolled on ART (WHO, 2010). The graph below shows the gradual scale up from 2003.

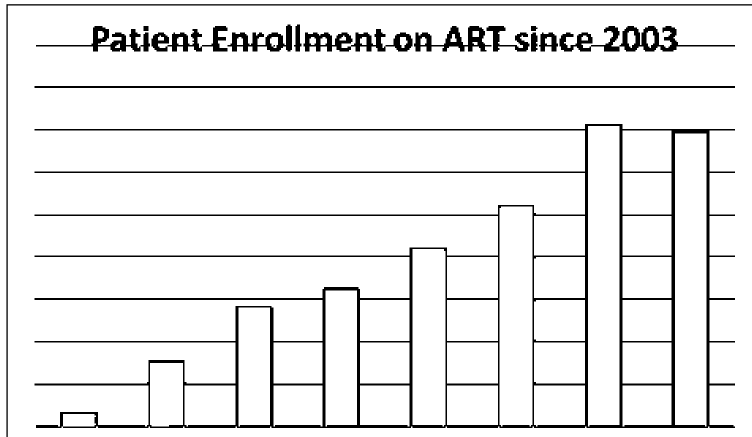


Figure 2. Scale-up of ARVs from 2003 to 2010. (Source, WHO, 2010)

ART initiation has only been available in the presence of a doctor either at the main health facility or at a primary care clinic on the day when the doctor is visiting with the mobile team (MSF, 2010). Given the acute shortage of doctors in Swaziland, doctor to patient ratio was 1: 23 in 2010 (Kingdom of Swaziland, 2010). Due to the shortage of doctors, scaling-up of treatment has been made possible by a model of delivery known as non-physician clinicians as a central provider of care. Recognising the need to increase the access to treatment, the MOH embraced the concept of nurse-initiated treatment (MSF, 2010). The ministry adopted a comprehensive HIV package of care (MOH, 2010) from WHO to improve guidance on treatment with ARVs. The comprehensive package provides a treatment guide of ARV. It considers that ART is based on two nucleoside reverse transcriptase inhibitors (NRTIs) and a protease inhibitor (PI) which requires the use of three drugs. The current treatment paradigm for those who are naive to ARVs is a triple drug regimen, usually two NRTIs and either a boosted PI or an NNRTI. The regimen includes two ARVs from among the nucleoside/ nucleotide analogy reverse transcriptase inhibitors (NRTIs), plus one nonnucleoside analogy reverse transcriptase inhibitor (NNRTI). The recommended first-line regimen is Tenofovir + Lamivudine + Efavirenz (tdf +3tc + efv). The package continues to give alternative first-line regimens in order of preference as Zidovudine+ Lamivudine+ Efavirenz (azt + 3tc + efv) or Stavudine+ Lamivudine+ Efavirenz (d4t + 3tc + efv). It also states that Efavirenz can be replaced with Nevirapine in patients who cannot tolerate it or for whom Efavirenz is contraindicated. This could be pregnant women during their first trimester or sexually active women who are not using reliable contraception.

According to Calmy *et al.* (2012), patients on ART achieve sustained virological suppression while some experience a treatment failure eventually necessitating change of treatment. The treatment changes to second–line ARV regimen. The decision to change to a

second-line regimen, as well as the specific choice of the regimen, is a collective decision to be made by the entire multidisciplinary team (MDT) (MOH, 2010). The package also states that at clinic level, the client is referred to an ART doctor to help make the decision to switch treatment. In cases where treatment failure has been identified and the switch is confirmed, the switch is to a second-line regimen. The second line drugs are: abacavir (ABC) + didanosine (DDI) + lopinavir/boosted with ritonavir (LPV/r) as indicated in comprehensive package.

METHODOLOGY

The study took place at a VCT/ART clinic in Mbabane Government Hospital. This VCT clinic was the first clinic in the country to offer ARVs in 2003. It is physically removed and separated from the rest of the hospital buildings but it is within the boundaries of the establishment. This is a qualitative study based on data collected by means of in-depth face-to-face interviews with a sample of 16 patients who came for refills of ARVs at the clinic. Respondents were aged between 23 to 52 years. The field work took place in July 2012. Due to technical difficulties in obtaining an accurate list of patients on ARVs, respondents were selected on the day of the interview while sitting in the clinic's waiting room. The choice was made randomly counting all patients at the time. Patients were approached for interview by the researcher who could communicate in an indigenous language. Ethical approval was sought from the management of the hospital and informed consent from all the patients participating in this study at the time of enrolment.

Patients were interviewed by the researcher and could communicate in both siSwati and English language. Once the patient was approached and confirmed participation in the study, the aim of the study and the purpose of the interview were explained clearly to the patient. A verbal consent was obtained. Both male and female patients participated in the study. Due to technical difficulties in obtaining an accurate list of patients coming to refill their ARVs, respondents were selected on the day of the interview while sitting in the clinic's waiting room. The choice was made randomly.

Interviews were conducted in one of the doctor's consulting rooms in the clinic. This provided private space to facilitate an open and confidential discussion with the respondents. The interviews used a semi-structured question plan as a guide. This was done to assist in getting more and detailed information. Even though there was a guide, the researcher probed in areas where information was not coming out clearly during interview sessions. Respondents were encouraged to openly talk about their status as people living with HIV. The interviews were transcribed by the researcher, coded and analysed using Microsoft Office Excel Software.

ANALYSIS OF FINDINGS

Of the 16 patients, 62.5 % were female. This is in line with Blandine and Marc (2009) who observed that more HIV positive women than HIV positive men are attending care facilities and accessing antiretroviral medicine. Respondents came from the four districts of the country including two patients who came from the Republic of South Africa. These two South Africans chose to use this clinic for their check-up. Of the 16 respondents, 68.75% were employed. Even though most of the patients stated that there were facilities providing ART near their residential areas, they continued to use the Mbabane VCT/ART clinic because they came there first when they were sick and they were initiated on ART.

Testing for HIV

Most of the interviewees stated that they tested because they were very sick. They also mentioned that they had TB infection and jaundice. Some of them were so sick such that they had difficulty in walking and were admitted in the Mbabane Government Hospital. Asked why they tested for HIV, one patient responded by saying, "I was very weak and fragile when I got admitted to the Mbabane Government Hospital. I had been sick for the past four months. I did not know what I was suffering from because I had never gone to a health facility. Instead, my husband had spent a lot of money paying traditional healers. The hospital was our last resort." Another one said, "I was very sick not knowing what I was suffering from. I visited many health facilities and traditional healers but got no help. I started coughing and when I went to Mbabane Government Hospital they discovered I had meningitis." From these responses it could be concluded that taking an HIV test is still a very difficult decision to make. People are compelled by their deteriorating health to take one. This is not a good sign in a country with a very high HIV prevalence. All it means is that Swazis begin taking the ART late.

Asked how they gathered the courage to take an HIV test, one of them said, "I was encouraged by my relative who works at a VCT centre to test". Another stated that his deteriorating health encouraged him to take the test. In his words, " I was very healthy until 2006 when I started becoming sickly. Every now and then I would catch flue and start coughing. This went on until 2007 when my wife succeeded in encouraging me to take an HIV test. From these responses, it can be deduced that respondents got to know their HIV status willingly even though most of them were forced by sickness.

Health condition before testing

Asked to describe their health condition at the time of admission to hospital, respondents stated that their health status was very bad. They maintained that they were very sick, very slim, and fragile and had no appetite and strength to walk. Others also mentioned that they had other diseases and conditions which led them to be admitted in hospital. According to Pasuthi, *et al.* (2008) cases of advanced immune deficiency are associated with CD4 cell depletion and striking opportunistic infections and malignancies which lead to recognition of AIDS in patients.

Adherence to treatment

In order for medications to have maximum beneficial therapeutic effects, adherence and proper patient prescriptions are key issues. This has been noted by Nsimba *et al.* (2010) who states that medications must be taken every day for the rest of the patient's life and the correct dose must be taken. According to Seema, *et al.* (2011) adherence is defined as a patient's ability to follow a treatment plan, take medications at prescribed times and frequencies. Once a person who tested positive and had sickness or was even failing to cope with normal life starts ARVs, they change his or her life to normal. All respondents agreed that ARVs brought them back to life. The diseases they had also stopped. One of them emphasised this when saying "There is life in ARVs and they have helped me to prevent other illnesses. I am healthy now and I am back to work". These responses demonstrate the power of ARVs in saving lives.

Considering that the drugs require routine administration and compliance in order for it to be effective, adherence is necessary for successful treatment (Safren *et al.*, 2001). Ability of the patients to consistently take the drugs without fail at exactly or approximately the same times of the day depends on the individuals' frame of mind, (Tessema *et al.,* 2010) his/her

family members' support, as well as people around them and the community at large (Sahay *et al*., 2011). Routinely taking ARVs can be cumbersome and also not easy to live with, follow or remember.

Taking ARVs goes with when to take them and at what time. Most respondents were informed during counselling sessions before ART initiation that they have to always take treatment at specific times. Most respondents would mention using cell phones to set an alarm to remind them of the time to take their ARVs, as one of them said, "I set an alarm to remind me to take my tablets". For those who have declared their status at home, they would ask their relatives or family members to remind them of the time to take their ARVs. This was made evident by the respondent's words saying, "I told my child to remind me to take my medication".

Health condition after ARV initiation

According to Kelly *et al.* (2009), a majority of patients who achieve and maintain an undetectable plasma HIV RNA level while receiving ART exhibit sustained increases in their peripheral CD4+ cell count. She observed that most patients exhibit a rapid increase in the CD4 cell count during the first 8-12 weeks of therapy and is followed by a more gradual increase until a normal CD4+ cell count is achieved. Atuyambe *et al*. (2008) also observed that the quality of life of patients who take ARVs as prescribed is improved. In the study, respondents' quality of life for those who were sick improved greatly after ARV's initiation. Most respondents would mention that they were back to work; they were feeling better. One of them among the unemployed said, "People also say I have improved and I work very hard." Another said, "I feel healthy and strong. I am back to work."

Effects of ARV Use

The respondents' period of taking ARVs ranged from three months to seven years. The patients' records of CD4 cell count showed a variable measure of response to ARVs treatment. This means immune reconstitution, as measured by increased CD4 cell count. According to Kelly, *et al*. (2009), when patients achieved a normal CD4+ cell count after being enrolled in ART, it usually remained normal. In this study only two patients did not have CD4 cell count records before being initiated to ARVs and the other did not have CD4 records during the study period as it can be seen on the graph below.

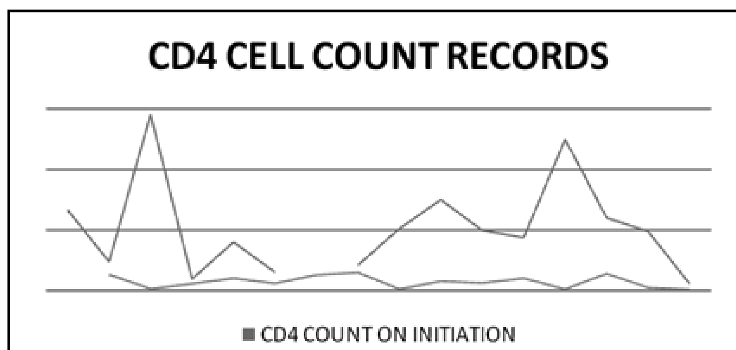


Figure 3. CD4 cell count records from respondents' patient records. (Source: Field work, July 2012)

Figure 3 shows that respondents' CD4 cell count improved from the time of ARV initiation to the time of latest recordings. It is only in the case of respondents who did not have proper records of CD4 count that we cannot tell whether there was improvement. In all the respondents with proper records, there was improvement of the CD4 cell count.

DISCUSSION

This research draws attention to the impact of the use of ARVs by people living with HIV. In many countries, especially the sub-Saharan countries, AIDS used to kill many people before the discovery of ARVs. Millions of lives have been sustained by providing antiretroviral therapy (UNAIDS, 2010). This remains a challenge to countries where there are people who do not want to enrol on ART or fail to access ART services.

In the context of the study, respondents clearly showed that they tested for HIV late and were compelled by forces like ill-health. Thepatients have continued to adhere to their treatment, as they mentioned the use of reminders to remind them when it is time for taking their ARVs. It became very clear that adherence plays a noteworthy role in ARVs treatment. We have noticed that ARVs improved the lives of respondents greatly in the form of increased CD4 cell count. The increase in CD4 cell count shows a reconstitution of the immune system. This confirms an earlier assertion in this study that ARVs are the saviour and restorer of millions of lives. This was also observed by Atuyambe *et al.* (2008) when saying ARVs do not cure HIV and AIDS, using them consistently tremendously improves the quality of life of most HIV-positive patients and helps them to live longer.

According to the findings of the study, ARVs appear to restore the lives of people living with HIV and prevent other infections, malignancies and death. This seems to confirm findings observed by others like Bailey and Fisher (2008). They observed that ART is an effective treatment for people living with HIV and has transformed their health. They further noted that ART for HIV infection has transformed HIV and AIDS from a terminal illness to a manageable chronic condition.

CONCLUSION

The limitation of the study includes the purposively selected facility-based sample of HIV positive patients from one site, which may not adequately reflect information from other health facilities now offering ARVs, including those in rural areas. In addition, our data reliability and validity may be compromised by that the interviews were conducted within the ART site which might have compelled the participants to become respondents due to the fear of negative repercussions that may result from reporting their candid opinions. Furthermore, the data collected from patientswho cameto refill ARVs may have excluded patients with different characteristics from those who are not adhering to ARVs treatment.

Despite these limitations, the policy implication of the study is clear – ARVs save and restore lives of people living with HIV. CD4 count of people living with HIV continues to improve after treatment initiation. This study has characterized the effect of ARV drugs in immune reconstitution shown by CD4 cell count increase due to treatment. This has also been observed by Granich *et al.* (2010). They asserted that the imperative of providing life-saving antiretroviral therapy (ART) is now undisputed. They further noted that ART dramatically lowers the viral load.

REFERENCES

Atuyambe, A., Neema, , S., Otolok-Tanga E., Wamuyu-Maina, G., Kasasa, S. and Wabwire-Mangen, F.(2008).The effects of enhanced access to antiretroviral therapy: a qualitative study of community perceptions in Kampala city, Uganda. *African Health Sciences*, 8(1) :13-19. *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2408540/.*30/07/ 2012.

Bailey, A. C. and Fisher, M. (2008). Current use of antiretroviral treatment. *British Medical Bulletin* 87:175–192 http://bmb.oxfordjournals.org/. 11/07/2012.

Blandine, B. and Marc, E. (2009). Gender asymmetry in healthcare-facility attendance of people living with HIV/AIDS in Burkina Faso.*Social Science & Medicine*, www.elsevier. 11/07/2012.

Calmy, A., Balestre, E., Bonnet, F., Boulle, A., Sprinz, E., Wood, R., Delaporte, E., Messou, E., McIntyre, J., El Filaili, K. M., Schechter, M., Kumarasamy, N., Bangsberg, D., McPhail, P., Van Der Borght, S., Zala, C., Egger, M., Thiebaut, R. and Dabis, F. (2012). Mean CD4 cell count changes in patients failing a first-line antiretroviral therapy in resource-limited settings.*BioMed Central journal (BMC) Infectious Diseases*, 12:147. http://www.biomedcentral.com/1471-2334/12/147. 27/08/2012.

Granich, R., Crowleya, S., Vitoria, M., Smytha, C., Kahnb, J. G., Bennett, R., Lo, Y.R., Souteyranda, Y. and Williams, B. (2010). Highly active antiretroviral treatment as prevention of HIV transmission: review of scientific evidence and update.*Current Opinion in HIV and AIDS* 5:298–304.

Granich, R., Lo, Y.R., Vitoria M., Kahn, J. G., Bennett, R., Smyth, C., Mahklouf-Obermeyer, C., Souteyrand, Y., Williams, B., Montaner, J., Schwartlander, B. and Hirnschall, G. (2010) Harnessing the Secondary Preventive Benefit of Antiretroviral Treatment. Treatment Strategies - Prevention and Control.*AIDS* 24 (5) :S70–S80

Ledergerber, B., Mocroft, A., Reiss, P. and Saag, M. (2009). Timing of initiation of antiretroviral therapy in AIDS-free HIV-1-infected patients: a collaborative analysis of 18 HIV cohort studies. *Lancet*, 373 (9672) :1352-63.

Kelley, C. F., Kitchen, C. M. R., Hunt, P. W., Rodriguez, B., Hecht, F. M., Kitahata M., Crane, H. M., Willig, J., Mugavero, M., Saag, M., Martin, J. N. and Deeks, S. G. (2009) Incomplete Peripheral CD4 Cell Count Restoration in HIV-Infected Patients Receiving Long-Term Antiretroviral Treatment.*Clinical Infectious Diseases* 48:787–94.

Kingdom of Swaziland, (2012). Swaziland Country Report on monitoring the political declaration on HIV and AIDS, Mbabane, Swaziland.

Kingdom of Swaziland, (2012). Ministry of Health ART program annual report, Mbabane, Swaziland.

Ministry of Health, (2010). 12th National HIV Serosurveillance among Women Attending Antenatal Care Services, Survey Report, Mbabane, Swaziland.

Ministry of Health, (2010). Service Availability Mapping, Mbabane , Swaziland.

Ministry of Health, (2010). Swaziland National Comprehensive HIV and AIDS Package of Care for Adults and Adolescents, Mbabane, Swaziland.

Ministry of Health and Social Welfare, (2005). HIV/AIDS Prevention and Care Programme (HAPAC) End of Project Report, Mbabane, Government of the Kingdom of Swaziland.

Medecins Sans Frontiers/Doctors without Borders (MSF), (2010). Fighting a Dual Epidemic, Treating TB in a High HIV prevalence setting in Swaziland, MSF, Mbabane. National Emergency Response Council on HIV/AIDS (NERCHA), (2005). Annual Report: A Nation at war, Mbabane, Swaziland.

National Emergency Response on HIV/AIDS (NERCHA), (2005). 2003-2005, UNGASS Indicator Country Report, Mbabane, Swaziland.

Nsimba, S. E. D., Irunde, H. and Comoro, C. (2010). Barriers to ARV Adherence among HIV/AIDS Positive Persons taking Anti-Retroviral Therapy in Two Tanzanian Regions 8-12 Months after Program Initiation.*Journal AIDS Clinic Research*, 1(3) : 1-9.

Pasuthi, P., Bakthavathsalan, G., Seravanan, G.and Devaray, A. (2008). Changes in CD4 cell count, Lipid profile and liver enzymes in HIV infection and AIDS patients.*Journal of Applied Biomedicines* 6:139-145. www.zsf.jcu.cz . 27/08/2012.

Sabin, C.A. and Phillips, A.N. (2009). Should HIV therapy be started at a CD4 cell count above 350 cells/µl in asymptomatic HIV-1-infected patients? [Special commentary] Current Opinion in Infectious Diseases: 22(2) :191-197. http://www.who.int/hiv/events/artprevention/sabine.pdf. Accessed 30/07/2012.

Safren, S. A., Otto, M.W., Worth, J. L., Salomon, E., Johnson, W., Mayer, K. and Boswell S. (2001). Two strategies to increase adherence to HIV antiretroviral medication: Life-Steps and medication monitoring. *Behaviour Research and Therapy* 39:1151–1162, www.elsevier.com. 11/07/2012.

Sahay, S., Reddy, K. S. and Dhayarkar, S. (2011). Optimizing adherence to antiretroviral therapy.*Indian Journal of Medical Research* 134(6) : 835–849. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3284093/ Accessed 29/07/2012.

Seema, S. K., Srikanth, R.and Dhayarkar, S. (2009). Optimizing adherence to antiretroviral therapy.*Indian Journal of Medical Research* 134:835-849.

Tessema, B., Biadglegne, F., Mulu, A., Getachew, A., Emmrich, F. and Sack, U. (2010). Magnitude and determinants of nonadherence and nonreadiness to highly active antiretroviral therapy among people living with HIV/AIDS in Northwest Ethiopia: a crosssectional study. *AIDS Research and Therapy*7:2. http://www.aidsrestherapy.com/content/7/1/2. 13/07/2012.

UNAIDS, (2010). Global report 2010, HIV treatment. Geneva , UNAIDS.

UNAIDS (2012) Report on The Global AIDS Epidemic, UNAIDS, Geneva.

Wood, E., Hogg, R. S., Harrigan, P. R. and Montaner, J. S. (2005). When to initiate antiretroviral therapy in HIV-1-infected adults: a review for clinicians and patients, *Lancet Infectious Diseases* 5(7) :407-14.

World Health Organization, (2005). Interim WHO Clinical Staging of HIV/AIDS and HIV/AIDS Case Definitions for Surveillance, WHO, Geneva..

World Health Organization, (2010). Swaziland country office, annual report. WHO, Mbabane.

"IN JESUS' NAME YOU ARE FREE": HIV, ARVS AND HEALING SPACE IN SELECTED AFRICAN INITIATED CHURCHES

Eliot Tofa[1]

ABSTRACT

In 2001, most African countries signed the Declaration of Commitment on HIV and AIDS at the United Nations General Assembly Special Session, expressing their deep commitment to combat HIV and AIDS through prevention, treatment, care and support. Consequently, anti-retroviral drugs are readily available to People Living with HIV and AIDS and the number of people receiving anti-retroviral therapy has significantly increased in the past decade. However, there has been a sad development: the explosion of churches convincing seropositive members to discontinue ARVs. Although ground-breaking scientific research has demonstrated, irrefutably, that ARVs prolong life: that seropositive people can live a healthy and productive life, miraculous "cures" of HIV are, today, a deep-seated dilemma in Africa. The paper therefore calls for the urgent need to re-think and counteract activities, teachings and practices that are contrary to scientific responses to HIV and AIDS diagnosis and treatment.

Keywords: African Initiated Churches; AIDS; ART; ARVs; faith healing; faith healers; HIV; televised healing; seronegative; seropositive and viral load

INTRODUCTION

In 2001, most African countries signed the Declaration of Commitment on HIV and AIDS at the United Nations General Assembly Special Session, expressing their deep commitment to combat HIV and AIDS through prevention, treatment, care and support. Consequently, anti-retroviral drugs are readily available to People Living with HIV and AIDS (PLWHA) and the number of people receiving anti-retroviral therapy has significantly increased in the past decades. However, there has been a sad development: the explosion of churches convincing seropositive members to discontinue ARVs. Although ground-breaking scientific research has demonstrated irrefutably that ARVs prolong life: that seropositive people can live a healthy and productive life, miraculous 'cures' of HIV are, today, a deep-seated dilemma in Africa. The article seeks to: (a) demonstrate the dark side of certain religious beliefs in the background of HIV; (b) demonstrate consequences that may arise out of those teachings and (c) raise an awareness of inimical activities in the fight against HIV and AIDS. The article is therefore critical of selected African Initiated Churches' message on HIV and AIDS in sub-Saharan Africa (SSA). In this article it is argued that informal communication about HIV and AIDS and, most importantly, HIV miracle 'cure' claims by some Pentecostal Charismatic Churches (PCCs) are not only inimical to the public health message but highly perilous. It is further argued that the PCCs' message about HIV and AIDS raises critical social and moral questions: What can be done to protect PLWHA from certain detrimental activities of some AICs? The

[1] *Eliot Tofa is a Senior Lecturer in the Department of Theology and Religious Studies at the University of Swaziland*

article further points out that though laws have been promulgated to curb social ills such as drug abuse, environmental degradation and so on, legislators have remained silent on PCCs' persuading followers to discontinue ARVs with full knowledge that miraculous cures of HIV are medically indefensible. Notwithstanding rock-solid medical initiatives to mitigate the impacts of HIV and AIDS, one of the greatest challenges of the 21st Century for most governments in the Global South, is that there is hardly any policy promulgated to address this sad development. Arguably, claims by some Christian faith-prophet healers that they can change the status of people from seropositive to seronegative as well as to cure people living with AIDS contradict known biomedical facts. Discontinuance of ARVs reverses gains that have been made in the struggle against HIV and AIDS especially through the provision of anti-retroviral drugs. This article therefore calls for the need to re-think ways of counteracting the activities, teachings and practices of PCCs that are contrary to scientific protocols to HIV and AIDS treatment.

AN OVERVIEW OF SOME PCCS' THEOLOGICAL THINKING

For the past three decades, sub-Saharan Africa (SSA) has witnessed and continues to witness a proliferation of the so-named African Indigenous Churches (Appiah-Kupi in Meyer, 2004) or African Initiated Churches (Anderson, 2001) or African Independent Churches (Sundkler, 1961; Daneel, 1970, etc.) – Christian churches formed by Africans and controlled by Africans themselves (Cox, 1995; Poewe, 1994; Jules-Rosette, 1997). The focus of this paper is on the so-named Pentecostal Charismatic Churches (PCCs) and HIV and AIDS in Africa. PCCs are the primary focus of this paper because of the following reasons. First, unlike "mainline churches", they are distinct in that they put emphasis on the Prosperity Gospel also known as the health and wealth gospel: the teaching that God gives abundant blessings of sound health, wealth and power to the obedient and the faithful ones (Marshall-Fratani 2001 in Meyer, 2004; Dube, 1989). Second, they "represent an extensive reconfiguration of public discourse on heath and treatment-seeking among the poor" (Pfeiffer, 2002:176-177). Third, they incorporate some central tenets of Pentecostalism: the prominence of the Holy Spirit; glossolalia; "and ceremonies of baptism, which are then combined with the continued acceptance of local African spiritual explanations of misfortunes and illness" (Pfeiffer, 2002:178 cf Cox, 1975). Fourth, with the advent of globalisation, the majority of PCCs have quickly adapted to a changing religious landscape. They broadcast "the message through flashy TV and radio programmes" (Meyer, 2004; Marshall-Fratani, 2001 cited in Meyer, 2004) as a strategy to reach a wider audience (Hackett, 1998). Today, the vast majority of PCCs have gone digital and the cyberspace, radio and television channels are awash with free twenty-four hour running programmes: call-ins; donation portals; on-line prayer sessions; on-line anointing through the screen programmes; live prayer broadcasts; testimonies of miraculous cures; and so on. *"In Jesus' name, you are free"* is the key catchphrase in their healing space. Health seeking individuals visit the man [woman] of God seeking complementary or alternative [spiritual] healing. Those who may not afford to visit the prophet-faith healer are persuaded to receive their anointing by touching the television screen in their houses or by going on the Internet (Kwabena Asamoah-Gyadu, 2005, 2007). Every Sunday (and at times during other days of the week) some people view live broadcasts of people in long and winding queues desperate for healing. More often, we see the indisposed holding placards displaying their medical conditions pleading, "Please man [woman] of God, help me or help my [*relative*],

I am [he/she is] suffering from …." (See some channels on DSTV such as Love the World, EmmanuelTV, Ernest Angley Ministries, Christ Embassy, etc.). The healing sessions are punctuated with testimonies of miraculous healings, conceptions, exorcisms, election victories, and promotion at work and so on. Arguably, African Initiated Churches (AICs), especially PCCs, have gone berserk and have succumbed to the forces of globalisation.

Theoretical framework of Religion and self-mastery

Scholars have observed that religion has a greater influence on an individual's control of the self and other psycho-social competencies (Exline, 2002; Pargament, 2007; Ellison, 2012; Schieman, 2003, 2010). Religion may undermine or bolster the mastery of the self. In line with Freud and Fromm, the paper hypothesises that "religious worldviews – especially those that are dogmatic and absolutist – may serve as illusory psychological crutches" (Ellison, 2012:3 see also Freud, 1961 and Fromm, 1960). The belief in the inerrancy and scriptural authority in some AICs may foster "cognitive rigidity, and may deter individuals from using reason and intellect to navigate daily life and resolve personal problems, thereby eroding one's sense of personal control" (Ellison, 2013:3 see also Adorno *et al.* 1950; Rokeach, 1960). The catchphrase in those AICS that 'Jesus heals' [including HIV and AIDS] may inhibit co-religionists to "build a sense of confidence in one's own capabilities" (Ellison, 2012:3 see also Ellis, 1962; Holland, 1968) by relinquishing their health status in Jesus Christ. In the face of HIV and AIDS, the article takes views by some thinkers that "religion could have particular harmful consequences for those facing difficult events or conditions, by shaping the repertoire of tools via which they cope with problems" (Ellison, 2012:4; Ellis, 1983; Freud, 1961). Thus religion may promote what other writers have described as "deferring" styles of coping: "religion channels coping efforts to more passive approaches, such as prayer, faith, or heightened religious practice, presumably at the expense of more appropriate or "rational" strategies" (Ellison, 2012:4; see also Pargament, 1988). By so doing "using faith or prayer to surrender control and responsibility for problems to God – tends to report negative mental and physical health outcomes, including lower levels of mastery" (Ellison, 2012:4; see also Pargament, 1988). The teaching that "Christ is able" or "God is my co-pilot" does not only undermine self-mastery (Pargament, 1997; Ellison, 2012; Ano and Vasconcelles, 2005) but fosters false authenticity in People Living with HIV and AIDS. While it is true that religion bolsters self-mastery "by: (1) reducing structural inconsistencies; (2) supplying material and emotional assistance to members; and (3) providing opportunities of skills and competencies" (Ellison, 2012: 5), the article contends that religion diminishes the sense of control of the self and makes co-religionists susceptible to teachings harmful to their health and well-being. The article argues that by dissuading people to continue taking ARVs, some Christian communities are prime impediments in AIDS prevention.

LITERATURE REVIEW

Previous research on religion and HIV and AIDS has described religion as a double-edged sword in HIV prevention - a barrier to HIV transmission (Elifson, *et al.*, 2003; Garner, 2000; etc.) and/or aid to HIV transmission (Trinitapoli and Regnerus, 2006; Pfeiffer, 2004, etc.). This is because, as much as religious institutions play a titanic role in HIV and AIDS prevention, care and support (e.g. Pisani, 1999; Green, 2003(a)), the same institutions may – in some cases - promote risky [sexual] behaviours (Trinitapoli, 2006; Pfeiffer, 2004; Farley, 2007; Dube, 2007; Messer, 2004; etc). Denis, for example, observes that religious institutions were the first

to institute HIV and AIDS programmes especially in providing care for Orphaned and Vulnerable Children in South Africa (Denis 2009). In the same vein, Prince and others point out that this was true for mainline churches, Pentecostal churches "refused to engage with HIV until 2000" (Prince, *et al*., 2009; see also Burchardt, 2009; Epistein, 2007; Nguyen, 2009). By the turn of the millennium, religious institutions, most scholars point out, became actively engaged with HIV and AIDS especially in education, counselling and support of People Affected and Living with HIV and AIDS (Prince, *et al*., 2009; Kalofonos, 2008). As Kalofonos rightly points out, some churches in central Mozambique claim that prayer is medicinal; prayer heals [including HIV and AIDS].

This paper contributes to existing studies by exploring harmful religious beliefs, teaching and practices in the backdrop of HIV and AIDS - dissuading desperate people on ARVs to take prescribed medication on the belief that their faith in Jesus Christ would cure them of HIV and AIDS. The paper makes a critical reflection on the understanding of health and well-being against the background of HIV, that is, the position of selected Pentecostal Charismatic Churches (PCCs) against that of Medical Science. As Giddens and Stutton (2013) rightly put, "illness is experienced and interpreted by the sick person and those with whom she or he comes into contact. The patterns of everyday life are temporarily modified by illness and interactions with others become transformed" (Giddens and Stutton, 2013:452). For this reason, people construct various meanings on health problems; they make meaning of their situation differently (Giddens and Stutton, 2013). Previous research has established that, when people fall sick, they assume the sick role: abdicate their daily chores; concentrate on their healing and seek professional practitioners to accelerate their recovery (Parsons in Giddens and Stutton, 2013). In order to expedite quick recovery, researchers have observed that compliance, adherence and concordance on the part of the patient are critical (Pratt, 2003). In the same vein, most recent studies point out that the role of the patient is also critical in achieving maximum therapeutic outcomes (Pratt, 2003). The traditional thinking that the patient has to "blindly" follow [medical] instructions to expedite healing is generally rejected. This is also true in spiritual healing; the patient has to fight for his or her recovery. However, in the case of some PCCs, patients devote all their trust and confidence in the clinician, the prophet-healer to the point that they passively participate in their healing process. As Agadjanian and Menjívar rightly point out, "relations of trust and co-operation between individuals in a group not individuals in themselves" (2008:302) determine attitudes and behaviours. Leaders of PCCs wield much authority over their followers and their informal communication about HIV and AIDS plays a very significant role in reinforcing or weakening the individual member's capacity to negotiate his/her struggle with HIV and AIDS.

Charismatic founders of PCCs in question wield much authority over their followers. As Agadjanian and Menjívar rightly point out:

> Thus, social relationships within generally larger and more diverse but less cohesive mainline congregations have more of a weak and bridging nature; in contrast, social ties in smaller yet tightly-knit peripheral churches [AICs] are typically strong, bonding congregation members both through faith and organizational loyalty. Differences in the social fabric of the two types of churches are paralleled by ideological differences: mainline churches tend to be both more ideologically flexible and more socially liberal, whereas peripheral churches are typically more ideologically rigid and socially conservative. Importantly, then, membership in a church may affect health and related psychosocial outcomes not only through formal church teachings but also through the ideological and

> social atmosphere in which individuals are placed by virtue of their church membership. Thus, membership in congregations belonging to mainline denominations may allow for a more reflective and even critical assessment of official church teachings on morally problematic matters such as HIV/AIDS and greater openness to secular interpretations of these issues than does membership in congregations of peripheral churches (2008:302).

HIV and AIDS are some of the most dreaded health conditions and people are inclined to seek complementary and/or alternative solutions. The author strongly agrees with Macilionis and Plummer's submission that people with AIDS [and HIV] contend with fear and sometimes outright bigotry that have no basis in medical fact (2012). For this and other reasons PLWHA seek alternative solutions to HIV. The message of PCCs – that of instant healing attracts desperate People Affected and Living with HIV and AIDS.

METHODOLOGY

The article is based on the consultation of selected PCCs' official websites, electronic media and desktop research. In addition, publications by and on AICs have been consulted as well. It, however, must be pointed from the outset that the article is not concerned about the authenticity of HIV and AIDS miracle 'cure' claims but impacts of those claims on public health. The article discusses such claims within the HIV and AIDS discourse from a biomedical perspective and relentless efforts by governments and other players in combating HIV and AIDS. The few PCCs cited in this article are a few of the many other AICs. The following testimonies are good examples of activities of PCCs under discussion.

Testimony I: Ernest Angley Ministries

> Greetings to you and to all your wonderful prayer warriors. I want to thank you, Reverend, because when you came to South Africa, me and my family came on the last day of your miracle crusade. My son was very ill for some time. I took him to different clinics, but he always got worse.
>
> When you were praying for people to receive the Holy Ghost, my son was on my back; and he began to cry very hard, jumping and doing all kinds of disturbing things, and I just thought he was hungry.
>
> After the crusade, we went home and slept; and since then, he is a different child. He has no more illness. I will cherish that moment at your crusade for the rest of my life. He is so fat and a joyful little boy. He is so exciting to be with, and he is alive today because of Jesus.
>
> This year, I found out that I had the AIDS virus; but praise God, He spared my life. One Sunday, I was watching your program; and when you were praying for the people, I put my hand on the television. Suddenly, my body was hot, and it felt like something was washing over it. When you finished praying, from my neck to my thighs, I remained hot for the rest of the day.
>
> I've claimed the victory over the disease; and I have no more pain in my body, no more AIDS in my life and no more worries or depression. I can't thank you enough for your prayers. A Rejoicing Mother, Gauteng, South Africa (see https://www.ernestangley.org/testimonies accessed 20/02/2013)

Testimony II: Rebirth Family Centre

> The Bishop of Rebirth Family Centre in Umbilo, KwaZulu Natal, South Africa claimed that

he can heal HIV and AIDS with his holy water. The water which was sold between R15 and R30 was believed to reverse seropositivity to seronegativity. Phakamani bemoans that the Bishop claims: "Some have even stopped taking their antiretroviral (ARV) treatment because they say that they have been 'cured' of Aids" (Phakamani, http://drum.co.za/news/kzn-bishop-claims-to-heal-aids-with-holy-water/accessed 20/02/2013).

Testimony III: Christ Embassy International

The 'Healing School' of Christ Embassy broadcast on eTV at 0730 a.m. of every Sunday of 2010 claimed that the founder can heal heart disease, cancer and arthritis. The South African Medical Journal reports that, "At least two HIV-positive people died last year [2009] after attending Christ Embassy 'healing' services in Johannesburg, 'faithfully' stopping their ARV treatment, one of them also infecting family members with multidrug-resistant TB." After going on ARV for two and a half years, gaining 22kgs more and tuberculosis cleared, she discontinued ARVs after attending a 'curing ceremony' by the Christ Embassy. Her health deteriorated and when she restarted ARVs, it was too late, she passed on (Bateman, 2010).

Testimony IV: Synagogue Church of All Nations

In a ten minute video posted by the church on You-tube, a 36-year woman - Nkachukwu Orakwue Odele – claims that she was healed by one of the Wise Men from HIV after living with the virus for two years (see video on http://www.youtube.com/watch?v=2P4L6ohE-u4 accessed 20/02/2010)

Testimonies of this content are common in the PCCs' live broadcast services as well. In following paragraphs, the article discusses such claim in the light of the public health message.

AICs, HIV prevalence and the public health message

The focus of this paper is on HIV, ARVs and healing in AICs in the Global South. The paper seeks to: (a) describe informal communication of AICs about HIV and AIDS; (b) unravel ways in which that communication invalidates the public health (PH) message on HIV and AIDS prevention, treatment, care and support; (c) explain how religious involvement shapes the individual member's response to the AIDS crisis and to (d) suggest possible replies to the clash between informal communication in AICs about HIV and AIDS and PH messages. In other words, the paper interrogates the role of religion in shaping the thinking and attitudes of congregants towards HIV and AIDS and pilots possible answers to attendant moral dilemmas. SSA has been selected on the reason that (a) it is one of the regions that have been devastated by HIV and AIDS and (b) records an ever ballooning of the number of AICs (Gifford, 1998; Jenkins, 2002). It is, for example, estimated that 15% of the total population of Zimbabwe are HIV-positive (Zimbabwe National Statistics Agent, *Zimbabwe demographic and health survey 2010 -11*) ; 17.8% of the total population in South Africa is HIV-positive (UNAIDS, 2012), "HIV prevalence increased significantly and among persons aged 15-49, it rose to 16.2% in 1999, before coming down and stabilising at around 12% since 2005" in Malawi (Malawi Government, 2010 -2012 NAF Report:11) and that Botswana had an HIV prevalence rate of 24.8% for ages between 15 and 49 in 2009 (AVERT, 2012). The fact is that HIV and AIDS have posed a serious menace in SSA compared to other parts of the globe. The UNAIDS Global Report of 2013 reveals that, "In 2011, there were an estimated 1.8 million [1.6 million–2 million] new HIV infections in sub-Saharan Africa … Between 2005 and 2011, the number

of people dying from AIDS-related causes in sub-Saharan Africa declined by 32%, from 1.8 million [1.6 million–1.9 million] to 1.2 million [1.1 million–1.3 million]) " (UNAIDS, Regional Fact Sheet, 2012:1). These figures argue that the HIV and AIDS pandemic in SSA is one of the greatest challenges of the millennium.

In spite of the fact that in 2001 most countries in southern Africa signed the Declaration of Commitment on HIV and AIDS at the United Nations General Assembly Special Session expressing their deep commitment to combat HIV and AIDS through prevention, treatment, care and support, HIV and AIDS are high in the region, jeopardizing regional attempts to meet development goals (Barrett and Whiteside, 2006). The health sector is financially overburdened as governments relentlessly attempt to combat HIV and AIDS, malaria and other diseases. The number of people on ART has ballooned to eight million globally and a great number of AIDS-related deaths are from SSA (UNAIDS, 2012:6; Jackson and Lee, 2002). SSA continues to witness the mushrooming of AICs claiming to 'cure' people of HIV and AIDS. Quoting from selected verses from the Bible such as Mark 5:34, 10:52; Romans 10:9-13; Ephesians 2:8; Matthew 8:17; Isaiah 53:4-6, just to cite a few, these churches teach that all conditions, including HIV and AIDS, can be cured through faith in Jesus Christ. Both electronic and print media are swamped with testimonies of miraculous 'cures' from HIV and AIDS, e.g. SCOAN on DSTV, Christ Embassy, to name a few. People seeking alternative healing are persuaded to discontinue medical treatment, including ARVs, on the strong belief that their faith in Jesus Christ would heal them. The Bishop of Rebirth Family Centre of Bishop Nala in KwaZulu-Natal, for example, claimed that his holy water 'cures' HIV and AIDS (Phakamani, 2013). The Bishop claimed that holy water could miraculous cure people of HIV and this attracted a huge controversy with the Treatment and Action Campaign of South Africa (Madlala and Dzanibe, 2013). Such claims do not only negate governments' initiatives of rolling ARVs to people living with the HIV virus but is not in tandem with the public health message – ART, as the answer to seropositivity.

HIV and the body: Faith healing and biomedical perspectives

Advanced research has established how HIV operates and destroys the immune system of the human body. Clinical research has established that once a person contracts HIV, the virus attaches itself on the walls of lymphocytes known as CD4 cells – T-helper type 2 cell and eventually gains entry into the targeted cell (Barnett & Whiteside, 2006; Bartlett and Finkbeiner, 1998). The CD4 cell is a cell that protects the body from foreign bodies and other infectious diseases. Once inside the cell, the virus (consisting of only the ribonucleic acid (RNA), "a molecule which is actually the mirror image of the deoxyribonucleic acid (DNA) but which cannot produce new viruses" (Bartlett and Finkbeiner, 1998:65), attacks and destroys the cell: "Reverse transcriptase allows the viral RNA to turn into a mirror image of itself; that is, it allows the viral RNA to turn into viral DNA" (Bartlett and Finkbeiner, 1998:65). The viral DNA, in turn, instructs the host and infected cell "to produce, not new CD4 cells but new HIVs instead" (Bartlett and Finkbeiner, 1998). The affected cell is destroyed and the produced new HIVs invade the next cells and in so doing the virus replicates in the body at alarming levels. When the body realises the presence of HIV in the next few days, antibodies to combat HIV are produced. This marks the beginning of the seroconversion stage but the rate at which HIV multiplies in the receptor cell is much faster than the rate at which antibodies are produced. Barnett and Whiteside submit that during this window and incubation period, "… up to 5% of the body's CD4 cells (about 2, 000 million cells) may be destroyed by the

approximately 10 billion new virus particles produced daily" (Barnett & Whiteside, 2006: 33-34). And yet, in a healthy person there are about 1, 200 CD4 cell per milliliter of blood (Bingham, 1987; Barnett and Whiteside, 2006). In the end, the immune system is compromised and when the viral load is high to the extent that CD4 cells fall below +/- 100 or +/- 300 copies per millilitre of blood, depending on the strength of the individual's immune system, the infected person becomes prone to HIV related viral, bacterial and fungal opportunistic infections. Once HIV is at an advanced stage and the person living with the virus is not on ARVs, the health condition deteriorates to full-blown AIDS, a disease that accounts for most of the preventable deaths in SSA. ARVs suppress the multiplication of the virus and boost the production of CD4 cells and reverse HIV infection symptoms. ARVs also help reduce chances of transmission of HIV from an infected to an uninfected person and the mother to the unborn child. With the advent of highly active antiretroviral therapy (HAART) in the late 1990s, HIV has become manageable like any other chronic diseases such as diabetes, cutting drastically HIV-induced deaths. The United Nations Report of 2012, for example, reveals that:

> In South Africa, 100 000 fewer deaths occurred, followed by nearly 90 000 in Zimbabwe, 71 000 in Kenya, 59 000 in Ethiopia and 48 000 in the United Republic of Tanzania. A number of the region's countries with smaller populations but high HIV prevalence have also made significant gains in averting deaths related to AIDS. Botswana cut AIDS-related deaths by 71%, Rwanda by 68%, Namibia by 60%, Zambia by 56% and Burundi and Côte d'Ivoire by 51%. Benin, Burkina Faso, Eritrea, Guinea (sic), Lesotho, Malawi and Mali all reduced AIDS related deaths by one third. The countries of the Caribbean experienced a 48% decline in AIDS-related deaths while in Oceania the drop was 41% (UNAIDS 2012:15).

Today, there are many testimonies of hope by PLWHA. The Treatment Action Campaign (TAC) of South Africa, for example, reveals some of the many touching life stories of benefits of ARVs:

> 'After the TB I got pneumonia. I was losing weight and getting tired. After treatment, I gained weight. So, yes, the pills are working,' John Vollenhoven (TAC, 2006: 6).
>
> 'When I started ARVs my CD4 count was 178 and my viral load was 240 000. I was very weak and I was losing weight and when I would eat I would vomit,' Thobani Ncapayi (TAC, 2006: 6).
>
> 'When I was advised to go on treatment my weight was 48kg, 20kg less than my normal body weight. By the fifth day of ARVs I felt I had a bigger appetite and strength and started to gain weight,' Zoliswa Magwentshu (TAC, 2006: 6).
>
> 'I talk to many men in my work. I say that we should not forget about our medicines when we feel better. Males, males, males can be irresponsible. Someone gets back on his feet and then he forgets about the past. Then he makes the same mistakes – he goes back to drinking, smoking, unsafe sex; and then you get drug resistance. And, after a time, the drugs don't work for him anymore. Then he will blame the drugs,' Phumzile Nyhwagi (TAC, 2006:58).

Although ARVs do not eradicate HIV but ARV regimens have, arguably, transformed the lives of PLWHA and prolonged lives. By inhibiting the replication of HIV, ARVs boost the immune system, reduce HIV to undetectable levels and prevent unwarranted AIDS related deaths. However, the success of ARVs depends on strict adherence to medication; non- adherence may, among other complications, lead to: development of resistant HIV strains; regimen

failure; cross-resistance to other medications; toxicity; increased costs and psychosocial harms (UNAIDS, 2006).

From the biomedical perspective, HIV, to the present, has not cure. In this respective "miraculous cures" of HIV tend to promote delusion of being HIV negative. People taking ARVs may have "the quantitative plasma HIV RNA" reduced to undetectable levels and yet the virus is present in the body. Instant eradication of HIV as claimed by faith-healers is not in tandem with biomedical knowledge about HIV management and prognosis. The teaching of some AICs about HIV and AIDS presentsthe greatest challenge in the Millennium.

Discussion on AICs, ARVs and the Politics of HIV

With the advent of HIV and AIDS, AICs have grown to become alternative and/or complementary 'hospitals' for PLWHA; a place to feel at home! When people's health and well-being are compromised, they do not only try alternative and complementary remedies but they also try to make meaning of their condition(s). As Dyk (2008:201) rightly points out, "In an attempt to understand illness, *traditional* Africans will ask the questions: 'Why?' and 'Who?' There are beliefs that mental as well as physical illness can be caused by disharmony between a person and the ancestors, by a god or spirits, by witches and sorcerers, by natural causes, or by a breakdown in human relationships." However, with regard to HIV, Dyk is quick to point out that, "There is no indication in the literature that *traditional* Africans attribute AIDS to the anger of ancestors or to God's punishment. However, the influence of Christianity can, however, be traced through some African Christians who believe that AIDS is God's punishment, for immorality and sins," (2008:202). This thinking explains why HIV and AIDS have been misunderstood in some AICs, fostering the belief that HIV can be eradicated from the body through prayer and faith or the myth that believers could be insulated from HIV by appeasing the spiritual world (cf Dyk, 2008).

To date, there is no known cure for HIV; ARVs only suppress the replication of HIV in the body and in so doing inhibit progression towards full-blown AIDS. However, some AICs, on the contrary, declare that believers can be instantly 'cured' of HIV and AIDS if they profess unwavering faith in Jesus Christ of Nazareth. This explains why these churches have grown to become hospitals for people experiencing anguish, distress, anxiety and deprivation (Krakauer and Newbery, 2007). In addition, the prosperity gospel - a teaching that promises abundant blessing-enormously contributes to the attractiveness of these churches to those in a state of bankruptcy. The observation that they teach that salvation is holistic and, that, they promise total redemption of not only the individual, but the community as a whole, has made these AICs a home for the homeless, a soul for the soulless. AIDS is one of the most dreaded health conditions and people and communities hanker for insulation from HIV and AIDS. In fact, when an individual is infected with HIV, the individual and his or her family go through, among other periods, traumatising stages of shock, fear, denial, anger, bargaining and finally, acceptance. It is under such circumstances that AICs are an immediate alternative for People Living and Affected with HIV and AIDS as they claim to provide palliative care and a new life, a fresh journey with Christ. In the same vein, perceived complications of biomedical therapies possibly 'coerce' PLWHA to seek alternative and complementary remedies in AICs. For these and other reasons not mentioned in this paper, some AICs have grown to become 'hospitals' for PLWHA. It is also arguable that advanced marketing strategies in the print and electronic media promote their teachings and practices related to HIV and AIDS treatment, care and support. However, their teachings of non-adherence do not only endanger lives but are an

impediment to government efforts to meet Millennium Development Goals (MDGs).

In line with MDGs developed by the United Nations Development programme, governments in SSA have committed to combat HIV/AIDS, malaria and other diseases. In this regard, conventions, ratifications and policies have been developed with the aim of meeting those developmental goals. In the case of HIV and AIDS, governments have developed National Strategies Frameworks designed to accelerate prevention, treatment, care and support of PLWHA. Following the UNGASS declaration, governments in SSA have not only made ARVs readily available but have also embarked on nation-wide HIV and AIDS campaigns; providing people with accurate information about HIV and AIDS prevention, treatment, care and support. Sadly, SSA is witnessing the proliferation of AICs claiming to eradicate HIV and cure people from AIDS through faith healing. The cited few AICS are good examples and representative of what happens in most of PCCs in SSA. The Treatment Action Campaign of South Africa, for example, in August 2010 complained of faith healing campaigns which were aired by the eTV of South Africa arguing that they were frustrating its efforts to combat HIV and AIDS (TAC, 2010). Notably, earlier on in 2007, the South African Standards Authority (ASA), to no avail, had passed the ruling that miracle crusades claiming to heal HIV violated ASA's code of ethics and misleading (News24 24/4/2007). This, admittedly, is a social problem that calls for an immediate social action. Governments allocate and spend colossal budgets in HIV and AIDS prevention, treatment, care and support and, on the other hand, some churches convince members to relinquish ART on the pretext that their faith would heal them. This presents an enormous challenge for governments in Southern Africa in combating HIV and AIDS and meeting the sixth goal of the MDGs. This article therefore calls on governments and other players to consider developing a social policy that counteracts such deceptive teachings and practices in some AICs.

A social policy is, by definition, a combined approach meant to curb and correct social problems (Cheyne, *et al.,* 2005). The activities of some AICs – encouraging members on ARVs to discontinue medical- treatment presents a social problem in SSA and calls for a strategy to curtail this development. This is not only contrary to the governments' efforts to improve the quality of the lives of PLWHA, but is also detrimental and hazardous to the individual's health and public health as well. PLWHA are susceptible to opportunistic infections and communicable diseases such as tuberculosis, one of the killer diseases in SSA. In this regard, governments deploy a large amount of resources in order to combat HIV and AIDS but, on the other hand, some AICs convince immuno-suppressed people seeking alternative and/or complementary remedies to discontinue ART; convincing them that unwavering faith could 'cure' them of HIV and AIDS. This is a serious challenge given that there is no known cure for HIV and AIDS to the present.

First, it is hazardous in that this belief could promote not only inattentive sexual behaviours but also the transmission of HIV in discordant sexual partners. The church has not been spared from HIV and AIDS either. Second, this may lead to the development of multi-drug resistant infections as Nyhwagi says in her life story quoted above. Discontinuing ARVs may lead to further complications and deaths. Third, some AIDS-related opportunistic diseases are highly contagious and chances that the concerned individual may pass the disease to the next person are great. Fourth, it is against the governments' position as far as HIV and AIDS prevention, treatment, care and support is concerned. In essence, such teachings and practices are not in tandem with the public policy of governments in SSA and the world over. The biggest dilemma is what to do to curb these harmful activities prevalent in communities of faith in SSA.

In view of the United Nations Universal Declaration of Human Rights, from which constitutions in SSA have been developed, faith healing claims constitute freedom of thought, conscience, religion, opinion and expression – a constitutional right of the people. This is within the ambit of Articles 18 and 19 on Human Rights:

Article 18.

> *Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.*

Article 19.

> *Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.*

On grounds of freedom of religion and expression, attempts to criminalize activities of AICs which convince members to discontinue ARVs may have serious legal implications - just to claim that one can cure HIV and AIDS through prayer is not criminal in itself. It is just a belief, freedom of expression and of religious belief. The criminal element only arises if any misrepresentation is employed to induce another person to act resulting in his or her injury or damage - and at the benefit of the impostor or charlatan. But, in the context of faith healing, it is very difficult to prove in the affirmative or negative; believers act out of their own volition [but at times it could be out of desperation] and in the process of exercising their constitutional right. For the believer, faith heals HIV and AIDS but for the government such claims are not supported by scientific and medical proof as research has shown that AIDS has no known cure to date. The activities of some AICs in the backdrop of HIV and AIDS present a contentious debate. Even if one suffers injury and damage from such beliefs and practices and decides to institute civil suit against the fraudster, it is a difficult and insurmountable route to claim damages in light of the constitutional rights and privileges. This possibly explains why governments in SSA have watched helplessly people dying of otherwise preventable deaths. It is all about freedom of expression and freedom of religion; a deep-seated challenge in HIV and AIDS prevention, care and treatment.

CONCLUSION

Under present circumstances, governments are caught up in a catch twenty–two situation. It is 'difficult' for governments to criminalize such activities; hence they can only watch and wait. After all, some legal experts can argue in the courts of law that the people are not coerced; they act out of their conscience and strong religious beliefs in seeking alternative and complementary remedies. However, not everyone who acts out of their own volition is healed; not all people are healed! The teachings and practices of these churches are therefore a threat to the individual and public health, which pose a deep seated challenge of the millennium (Krakauer and Newbery, 2007). ARVs have saved lives and ignited hope in people living and affected with HIV and AIDS, hoping that a new drug will eventually be discovered. In fact, triple combination therapies have made the taking of ARVs much more convenient and much

friendlier. Most importantly, ARVs are readily available at a minimal or no cost in nearly all health institutions. As indicated in the life stories of PLWHA above, not only are significant benefits for taking ARVs but also "there is a positive moral factor – the feeling of 'doing something' which will give the patient some hope of a cure. Moreover, the affected individual can be followed up, lead a more regular and healthier life (style) (Manuel, 2002:65). Therefore, the activities of some AICs, dissuading members from taking ARVs raise critical moral questions. In view of the fact that we have now reached a stage in which much is known about HIV; these contrary messages touted by the AICs are a cause for concern. The vast majority of people are aware that HIV has no cure. However, the psycho-social, and, to some extent, economic stressors related to HIV infection pushes PLWHA to extremes by relinquishing their lives to Christ. PLWHA, under such an environment, are convinced to abdicate their own responsibility and subsequently withdraw their control of the self and rest their lives in the hands of Jesus Christ. Previous studies have, however, shown that a large percentage of people receiving little support from related institutions and taking many medication at once hardly consistently adhere to ARV treatment (Pratt, 2003). The advent of HAART and the combining of two or more pills taken once or twice a day have reduced HIV and AIDS to innocuous conditions. More importantly, the virological consequences of discontinuing ARVs are known; PLWHA receive counselling before going on ART but it is deplorable to learn that, in spite of sufficient knowledge, some people living with HIV and AIDS discontinue ARVs and embark on seeking alternative [spiritual] healing. As an answer to this mammoth challenge of the 21st century, I call for governments in SSA to re-think and consider the promulgation of a social policy that counteracts the AICs teachings and intensifies civic education on HIV and AIDS prevention, treatment, care and support. Lastly and equally importantly, I call for the urgent development of legal frameworks that inhibit certain activities marketed by religious institutions masquerading under the disguise of freedom of religion or belief, opinion and expression. Otherwise, without such a framework, efforts to combat HIV and AIDS in SSA will remain futile and elusive as the HIV itself.

REFERENCES

Adorno, T. (1950). *The Authoritarian Personality*. Harper and Brothers, New York.

Agadjanian, V. and Menjívar, C. (2008). Talking About the "Epidemic of the Millennium": Religion, Informal Communication, and HIV/AIDS. *Sub-Saharan Africa Social Problems* 55(3) :301-321.

Anderson, A. H. (2001). Types and Butterflies: African Initiated Churches and European Typologies. *International Bulletin of Missionary Research* 25: 107-13.

Ano, G. G. and Vasconcelles, E. B. (2005). Religious Coping and Psychological Adjustment to Stress: A Meta-Analysis. *Journal of Clinical Psychology* 61:461-480

Avert, HIV and AIDS in Botswana http://www.avert.org/aids-botswana.htm, accessed 30/08/2013.

Barlett, J . G. and Finkbeiner, A. K. (1998). The guide to living with HIV infection. John Hopkins University Press, Baltimore.

Barnett, T. and Whiteside, A. (2006). AIDS in the 21st Century. Macmillan, Palgrave

Bateman, C. (2010). eTV's Faith healing Advertorial. *South African Medical Journal* 100(10) :630-632.

Bingham, J. (1978). "HIV, AIDS and ARC: The Virus and the Disease". *In:* Cosstick, V. (Ed.). AIDS: Meeting the Community Challenge. St Paul Publications, England.

Burchardt, M. (2009). Subject to Counseling: Religion, HIV/AIDS and the Management of Everyday Life in South Africa. *In*: Beker, F. and Geissler, P. W. (Eds.). AIDS and Religious Practice in Africa, Brill, Leiden.

Cheyne, C., O'Brien, M. and Belgrave, M. (2005). Social Policy in Aotearoa New Zealand: A Critical Introduction. Oxford University Press, Oxford.

Cox, H. (1995). Fire from Heaven: The Rise of Pentecostal Spirituality and the Reshaping of Religion in the Twenty-First Century. Addison-Wesley, Massachusetts.

Daneel, I. (1970). Zionism and Faith-healing in Rhodesia: Aspects of African Independent Churches. Mouton, The Hague.

Denis, P. (2009) The Church's Impact on HIV/AIDS Prevention and Mitigation in South Africa.*Journal of Theology for Southern Africa* 134:66-81.

Dube, D. (1989). A Search for Abundant Life: Health, Healing and Wholeness in the Zionist Churches. *In* Gerhardus, C. and Oosthuizen, S. D. (Eds.). Afro-Christian Religion and Healing in Southern Africa. Edwin Mellen, Lewiston, New York.

Dube, M. W. (2007). Who do you say I am? *Feminist Theology* 15(3) : 346–67.

Dyk, A. V. (2008). HIV/AIDS Care and Counseling: A Multi-disciplinary Approach. Pearson, South Africa.

Elifson, K. W.; Klein. H.; and Sterk, C. (2003). Religiosity and HIV Risk Behavior Involvement among 'At Risk' Women. *Journal of Religion and Health* 42(1) :47–66

Ellis, E. (1962). *Reason and Emotion in Pyschotherapy.* Lyle Stuart, New Jersey.

Epistein, H. (2007). *The Invisible Cure: Africa, the West and the Fight Against AIDS.* Farrar, Straus and Giroux, New York.

Exline, J. J. (2002). Stumbling Blocks on the Religious Road: Fractured Relationships, Nagging Voices, and the Inner Struggle to Believe. *Psychological Inquiry* 13:182-189

Farley, A. M. (2007). The Yale Divinity School Women's Initiative on AIDS. *In:* Gill, R. (Ed.). Reflecting Theologically on AIDS: A Global Challenge. SCM, London.

Freud, S. (1961). The Future of Illusion. W. W. Norton, New York.

Fromm, E. (1960). Psychoanalysis and Religion. Rinehart and Winston, New York.

Garner, R. C. (2000). Safe Sects? Dynamic Religion and AIDS in South Africa. *The Journal of Modern African Studies* 38:41–69.

Gifford, P. (1998). African Christianity: Its Public Role. Indiana University Press, Bloomington and Indianapolis.

Green, E. C. (2003a). Faith-Based Organizations: Contributions to HIV Prevention. USAID/Washington and The Synergy Project, TVT Associates, Washington DC.

Hackett R. I. J. (1998). Charismatic/Pentecostal Appropriation of Media Technologies in Nigeria and Ghana.*Journal of Religion in Africa* 28(3) : 1-19.

Holland, G. A. (1968). Deliverance from Sin: Ellis Vs Mowrer. *Rational Living* 3: 20-23

http://www.youtube.com/watch?v=2P4L6ohE-u420/02/2013. https://www.ernestangley.org/testimonies 20/02/2013.

Jackson, H. and Lee, T. (2002). "Sub-Saharan Africa". In McElrath HIV and AIDS: A Global Overview. Greenhood Press, London.

Jenkins, P. (2002). The Next Christendom: The Coming of Global Christianity. Oxford University Press, Oxford.

Jules-Rosette, B. (1997). At the Threshold of the Millennium: Prophetic Movements and Independent Churches in Central and Southern Africa. *Archives de Sociales des Religions*. 99:153-167.

Kalofonos, I. Prayer is Medicine: HIV Evangelization in Central Mozambique.Working paper presented at the Religious Engagements with Disease Past and Present, Copenhagen. 28th April 2009.

Krakauer, M. and Newbery, J. (2007). Churches' Responses to HIV/AIDS in Two South African Communities, Journal of the International Association of Physicians in AIDS Care. Mount Sinai School of Medicine, New York.

Kwabena Asamoah-Gyadu, K. (2005). *African Charismatics*. Brill, Leiden.

Kwabena Asamoah-Gyadu, K. (2007). "Get on the Internet!" Says the Lord.' *Religion, Cyberspace and Christianity in Contemporary Africa in Studies in World Christianity* 13:225-242.

Macilionis, J. J. and Plummer, K. (2012). *Sociology: A Global Introduction* 5th edition, Pearson Education Limited, England.

Madlala, M. and Dzanibe, S. (2013). "Bishop's AIDS 'cure' draws fire" http://www.iol.co.za/news/south-africa/kwazulu-natal/bishop-s-aids-cure-draws-fire-1.1606618 accessed 07/02/ 2014.

Manuel, C. (2002). "HIV Screening: Benefits and Harms for the Individual and the Community". *In:*Bennett, B. and Erin, C. A. (2002). HIV and AIDS: Testing, Screening and Confidentiality. Oxford University Press, Oxford.

Malawi Government, Malawi HIV and AIDS Extended National Action Framework (NAF), 2010-2012, DRAFT, p.11 accessed 30/08/2013.

Marshall-Fratani, R. (2001). Prospérité Miraculeuse: Les Pasteurs Pentecôtistes et Làrgent de dieu au Nigeria. Politique Africaine. 82:24-44. *In:* Meyer, B. Christianity in Africa: From African Independent to Pentecostal-Charismatic Churches Annual Review of Anthropology 33:448.

Messer, D. E. (2004). *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS crisis.* Fortress Press, Minneapolis.

NEWS24. (2007). 'No proof Jesus heals Aids' http://www.news24.com/SouthAfrica/News/No-proof-Jesus-heals-Aids-20070424 30/08/2013.

Pargament, K. I (et. al.) (1988). Religion and the Problem-Solving Process: Three Styles of Religious Coping. *Journal of the Scientific Study of Religion* 27: 90-104.

Pargament, K. I. (1997). *The Psychology of Religion and Coping.* Guilford Press, New York

Pargament, K. I. (2002). The Better and the Sweet: An Evaluation of the Costs and Benefits of Religiousness. *Psychological Inquiry* 13:168-181.

Phakamani, M. (2013). KZN Bishop claims to heal aids with "holy" water. http://www.drum.co.za/news/kzn-bishop-claims-to-heal-aids-with-holy-water/ 20/02/2013.

Pisani, E. (1999). Acting Early to Prevent AIDS: The Case of Senegal. Joint United National Program for HIV/AIDS, Geneva.

Pfeiffer, J. (2002). African Independent Churches in Mozambique: Healing the afflictions of Inequality.*Medical Anthropology Quarterly*16(2) :176-199.

Pfeiffer, J. (2004). Condom Social Marketing, Pentecostalism, and Structural Adjustment in Mozambique: A clash of AIDS prevention messages. *Medical Anthropology Quarterly* 18(1) :77-103.

Poewe, K. (Ed.). (1994). *Charismatic Christianity as a Global Culture*. University of South Carolina Press, Columbia.

Pratt, R. F. (2003).*HIV and AIDS: A Foundation for Nursing and Healthcare Practice*. Arnold: London.

Prince, R.; Denis, P and Dijk R. (2009). *Engaging Christianities: Health and Social Relations in Eastern and central Africa.* Indiana University Press, USA.

Rokeach, M. (1960). *The Open and Closed Mind: Investigations into the Nature of Beliefs Systems and Personality Systems*. Basic: New York.

Schieman, S. (in full) (2003). Religious, socioeconomic status, and the sense of mastery.*Social Psychology Quarterly* 66: 201-221.

Schieman, S. (2010). Religious Beliefs and Mental Health: Applications and Extension of Stress Process Model. In Pilgrim, D. in full (Eds.).*The Sage Handbook of Mental Health and Illness.* Thousand Oaks, California.

Sundkler, B. (1961). *Bantu Prophets in South Africa*. Oxford University Press, London.

TAC. (2006). *ARVs in Our Lives: A Handbook for People Living with HIV and Treatment Advocates in Support Groups, Clinics and Communities.* TAC, South Africa.

Trinitapoli, J. (2006). Religious Responses to AIDS in Sub-Saharan Africa: An Examination of Religious Congregations in Rural Malawi. *Review of Religious Research* 47(3) :253-270.

UNAIDS. (2006). The Foundation for Professional Development: HIV/AIDS Management for Professional Nurses. SA: Foundation for Professional Development

UNAIDS. (2012). World AIDS Day Report. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/jc2434_worldaidsday_results_en.pdf accessed 30/08/2013.

UNDP. (2000). Millennium Development Goals http://www.undp.org/content/undp/en/home/mdgoverview.html accessed 30/08/2013.

Zimbabwe National Statistics Agent, Zimbabwe Demographic and Health Survey 2010 - 11, the Zimbabwe National Statistics Agency, P.O. Box CY 342, Causeway, Harare, Zimbabwe.

THE IMPLEMENTATION OF ICT EDUCATIONAL POLICY IN SELECTED SCHOOLS IN SWAZILAND

Nokuthula Vilakati[1]

ABSTRACT

This paper sets out to explore gender awareness as a research issue pertaining to gender and ICT educational policy implementation. The study's methodological approach is mainly qualitative. A conclusion reached is that within the schools under study, effort made seems to be mainly concentrated upon meeting practical gender needs through compulsory ICT skills for boys and girls rather than also on meeting strategic gender needs. The study population segment in three purposively selected schools included ICT programme coordinators, school managers or principals and other members of the emerging ICT Programme Community of Practice (CoP).

Keywords: Information and Communication Technology (ICT) programme, gender-based equality, gender equity, gender mainstreaming, policy implementation, gender empowerment

INTRODUCTION

Information and Communication Technology (ICT) is increasingly shaping the nature of global economic, social and political life. As such societies may need to provide equal opportunities to ICT access, creative and innovative use for all learners. Such provision is in line with the Education for All (EFA) Goal 5 which is to achieve gender equality in education by 2015, by ensuring girls' full and equal access to and achievement in basic education of good quality. Policy makers perceive that perhaps ICT can be one of the means of achieving gender equality because of its potential role to provide increased flexibility, easy communication and immediate access to global resources that are needed by learners and educators alike. Therefore this research study probes the extent to which ICT educational policy implementation at the secondary school level has been gender responsive, in a bid to address ICT and gender inequality concerns.

The term 'ICT' as it is used in this study refers to a national curriculum foundational subject of Information and Communication Technology. The study also regards ICT to encompass technological innovation and convergence in information and communication that can lead to the development of so-called information or knowledge societies, with resulting changes in education (United Nations, 2005). However, the study acknowledges the complexity in defining ICT due to the dynamic nature of information and communication technological developments. Another key concept is 'gender equality' which Nyaruwata and Chideya (2013:9) understand to encompass policy guidelines and actions in favour of the advancement of girls and women alongside that of boys and men. The definition incorporates boys and men, as their involvement and attitude change are essential in the process of creating social relations in which both sexes are equally represented. Therefore, for purposes of this study gender

[1] *Nokuthula Vilakati, Coordinator for Instructional Design and Development, Institute for Distance Education, University of Swaziland*

equality refers to a state where new policy directions encompass the advancement of girls and women alongside that of boys and men.

Another term, 'gender empowerment,' is used in this study to refer to the process or processes whereby people become aware of their own interests and the power dynamics that constrain them. As a result of such awareness, they are able to develop the capacity and the means to take greater control of their lives, without infringing on the rights of others. This entails developing a critical understanding of one's circumstances and social environment that can lead to action. Such a perspective is in line with that of Ogato (2013) who regards empowerment as the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them. Therefore, the study used gender equality and empowerment as the guiding principles for a critical analysis of ICT educational policy implementation within the secondary school sub-sector in Swaziland.

SITUATIONAL ANALYSIS

The Swaziland Government has underscored the critical role of the Education, Training and Skills Development Sector (ETSDS) in contributing towards shared growth and enhanced quality of life for all. The acceleration of Swaziland's growth and global competitiveness will most likely be knowledge and technology driven. However, the adequacy of the ETSDS in playing this expected role has hitherto not been fully analysed. One of the contributing factors as observed by the World Bank (2010) is that the current ETSDS is inadequate to supply the quality, mix and threshold of skills required to effectively spearhead knowledge and technology-driven shared growth. Nevertheless, the World Bank (2010) notes that Swaziland's recognition of human capital as a key driver of growth is laudable because this is consistent with the view that human capital or skills, technology, absorptive capacity or innovation and the investment climate are among the critical determinants of productivity and self-sustaining economic growth.

Like most developing countries, Swaziland does not have adequate resources, in terms of the technological infrastructure or an adequate pool of skilled educators necessary to make ICT education available on a wide scale across the education sector. A major challenge at school level has been the non-availability of qualified ICT teachers, in part due to that until recently there were no teaching posts that were allocated to schools for the ICT programme. As a result, some secondary schools tended to heavily depend upon companies which offered them hardware and software packages, as well as a "teacher" who did not hold any teaching qualification. Out of the few qualified ICT teachers, most were redeployed to teach Mathematics and Science instead of ICT. Another challenge is that students tend to be required to pay high fees for the ICT programme in some public secondary schools. Yet the Ministry of Education and Training (MoET) has a mandate to provide relevant, good quality and affordable education to all learners of school-going age, irrespective of their socio-economic backgrounds as encapsulated in the Education Sector Strategic Plan (2010-2022).

There is disparity between boys and girls in participation and performance in Science, Mathematics and Technology (SMT). For example Obanya (2004) attributes such disparity to too deeply entrenched cultural norms, values and beliefs that can influence subject choice among students such that some subjects are considered to be strictly for girls while others are for boys. However, Obanya (2004) acknowledges the key role played by the Forum for African Women Educationalists (FAWESWA) in addressing such a concern. For example, some

projects which were planned through FAWESWA in Swaziland have developed targeted approaches to the gendered education of girls and women, alongside that of boys and men. Such projects were a response to the challenge that some girls tended to either shun SMT or among those girls who opted for SMT at secondary school level- a high proportion of them generally underperformed in those subjects (2011). In response, FAWESWA has attempted to promote gender equity and equality in Swaziland by fostering positive policies, practices and attitudes towards girls' education. For example, FAWESWA has implemented a Science, Mathematics and Technology career challenge project, to motivate a high number of girls to participate and enhance their performance in these content areas.

POLICY ISSUES

The Swaziland Government launched a National Information and Communication Infrastructure (NICI) Policy in 2007. Through the policy, the Government of Swaziland declared its commitment towards ensuring that ICT is deployed and taught at all levels of the formal education system. The NICI Policy outlines that the main aims of ICT within the education sector are to facilitate learning and also to create an information based society. The policy further makes specific reference to gender equity and the empowerment of girls and women. There is a specific policy pronouncement that conscious interventions will be put into place to promote gender equity, women and girls' empowerment in a bid to raise awareness, build capacity among girls and women, alongside boys and men.

In the National Education Policy, provision is made through the Education Sector Strategic Plan (2010-2022) for the development of an all-embracing education sector ICT policy. Some of the outlined strategic objectives include using the computer in the classroom for self-paced learning, after a few initial lessons on Internet access or the basics of a software programme. Another objective is that more creative educational ways for the use of computers should be devised. Further, teachers are to integrate the use of computers into their regular teaching. It is for this reason that one of the main targets and indicators is that by 2015, all secondary schools with ICT facilities should have at least a qualified ICT subject teacher.

A follow-up initiative was a draft ICT Educational Policy (2010) which was inspired by the potential of ICT to enhance and improve the quality of education across sub-sectors of the education system. The rationale for a dedicated education sector policy has been to provide guidelines to assist the MoET to optimize the use of ICT within the education system. One of the policy directions is that schools in rural communities will receive special attention in the provision of basic ICT infrastructure for the introduction of the ICT programme. The MoET will also support the development of a gender responsive ICT programme to be offered in all schools. A concerted effort will also be made to prioritise a gender responsive in-service training for male and female educators to become computer literate. The policy further lays more emphasis on the intention to develop gender responsive ICT programmes and the use of ICT to target learners with special needs.

Reference to ICT is also included as one of the school curriculum development policy objectives as outlined in the Swaziland Education and Training Sector Policy (2011). One of the objectives is to periodically review emerging developmental issues that include, but are not limited to ICT, gender and other emergent developmental issues. In the medium term, one of the programme development strategic framework deliverables is to develop and offer ICT as one of the primary and secondary school subjects. In the long term, effort will be made to

integrate ICT into the secondary school curriculum.

PURPOSE OF THE STUDY

The main objectives that guided the study were as follows:

- To critically analyse the 'problem' of gender inequality in relation to ICT educational policy implementation in the selected schools.
- To examine the extent to which gender is mainstreamed during ICT educational policy implementation in the selected schools.
- To explore the implications of ICT educational policy implementation in transforming gendered practices in the schools under study and potentially in the wider society.

REVIEW OF LITERATURE

An enabling ICT educational policy framework

According to Zlotnikova and Weide (2011) despite the many challenges faced by most countries of sub-Saharan Africa, there are significant attempts to implement ICT educational policies. They acknowledge that almost all the countries in sub-Saharan Africa have either national ICT policies or ICT educational policies. One of the positions emerging from the literature is to extrapolate the benefits of an ICT policy. For example, Wild (2011) argues that a national ICT policy can position a country to better exploit ICT to further national, economic and social goals. Similarly, Bassi (2011) emphasises the importance of an ICT educational policy by postulating that such a policy can maximise the potential for countries to enhance the reach and quality of teaching and learning through the effective use of ICT. As a result, policy makers are implored to craft such policies in order to be more likely to tap into the benefits of ICT to leverage a country's education system. There appears to be consensus in some of the literature that a supportive policy environment and framework, developed at the national level, is a key to the successful integration of ICT into any education system. Likewise, Swarts (2006) draws a parallel on the importance of a clear policy framework to provide an enabling environment for technologies to be integrated, deployed and used to their full potential.

Some studies have been conducted on the implementation of ICT educational policies. In a needs analysis study by Kidombo, *et al.* (2012) they found low levels of ICT integration in the selected schools. The study recommended that the Ministry of Education in Kenya needed to develop an ICT policy to streamline this important area of learning. Consequently, the ministry will be guided by such a policy to provide ICT teachers to schools and reward those who had ICT skills and had integrated ICT into their teaching, in order to motivate them. The study also recommended that it might also help to include ICT integration as part of the school manager's annual performance appraisal criteria, to encourage the managers to embed ICT into school practice.

In the case of Tanzania, a situational analysis study was conducted by Swarts and Wachira (2010) to determine both challenges and opportunities towards the exploitation of ICT to address the identified key educational challenges of access, relevance, equity and quality. Their analysis of the ICT educational situation in Tanzania was that the government was committed to improve the state of education through ICT, which was evident in the various policy documents and national plans.

In a study by Madzima *et al.* (2012) the authors acknowledge effort by the Swaziland

government to craft a national ICT policy. They then recommend the need to establish a more well-structured policy to guide the introduction of ICT in schools such as to plan for all ICT related costs. They argue that it is such a policy that can corroborate the position taken by Swaziland, that of regarding ICT as a tool that will promote socio-economic, political, and sustainable development. The present study seeks to underscore the fact that the success of an ICT programme will depend largely on policy intervention level that is directed towards how ICT must be deployed in the school programmes. As a result, the study further recommends that Swaziland needs to go beyond policies that merely recognize the strategic role of ICT for growth and development to institutionalize concrete measures that support the ICT pedagogic initiatives.

Some research studies have examined the role of school level ICT policies in guiding ICT educational practice. In a study conducted by Tondeur *et al.* (in press) based on a developed country context, a school policy was formulated to guide ICT educational practice at the local school level. The study then examined the extent of ICT integration from both the teachers and principals' perceptions. The study concluded that school related policy components such as an ICT plan, ICT support and ICT training have a significant effect on class use of ICT. Such a conclusion was reached as a result of findings from the sampled schools that most of the school policies were often underdeveloped and underutilised. As a result, the study suggested that school principals had to develop a more collaborative approach when crafting such a policy. Nevertheless, the study underpins the importance of a shared and school-wide vision about ICT integration that reflects the opinions and beliefs of key stakeholders including the school manager, the ICT coordinator, and the teachers.

From the findings of the discussed research studies, it can be deduced that putting in place an ICT educational policy to build the necessary capacity for educational transformation and innovation through ICT integration is a complex task. ICT educational policy implementation calls for a concerted effort to translate vision and policy into implementable activities through enabling appropriate organizational structures, with the right human resources and skills sets. Therefore despite the consensus in the literature about the benefits of both a national ICT policy and even more specifically an ICT educational policy to inform and guide ICT educational practice, more evidence based studies are required on the actual implementation of such policies.

Key ICT educational policy components and parameters

Some of the reviewed literature identifies a number of ICT educational policy models in the African context. They also identify gaps in some of the existing models of ICT educational policies, which are likely to affect the way that the policy is implemented within the education sector. For example, one of the models is that of *Knowledge Maps* cited by Zlotnikova and Weide (2011). The model foregrounds four key components of an ICT educational policy which are *impact, costs, current implementations of ICT in education* and *planning*. Under the impact component, equity issues are considered and they include, among others; gender, special needs and marginalized groups. Another cited model of ICT in education is the *ICT in the School System* which is a representation of access and use of technologies in the school system. The latter model is more elaborate in that it specifies six core elements of an ICT educational policy as follows: *access to old and new ICT*; *formulation of a school policy*; *ICT training of teachers*; *teachers' usage of ICT across the curriculum*; *students' usage of ICT* and *enhancing both the quality of education and student outcomes*. However, even though the

models are helpful in identifying the core components that an ICT educational policy can include, the components cannot by themselves ensure success in the implementation of such a policy.

To augment the gaps in the models, Zlotnikova and Weide (2011) propose an extended model of any ICT educational policy. Not only does their model specify key components of an ICT educational policy but also the influential parameters that tend to make such a policy either succeed or fail. For example, the extended model allows for policy makers to identify core elements which are context-specific, such as *access to ICT infrastructure*; *teacher training on using ICT*; *gender issues*; and *ICT curricular*. Thereafter, the components are to be aligned to the parameters that are necessary for each of the ICT educational policy components to be operationalized. The outcome is a derived managerial framework that can enable a more comprehensive situational analysis as a precursor to ICT educational policy implementation. For example the extended model proposes a group of coherent demographic parameters, one of which is gender parity in education. As a result, such a parameter is more likely to guide the ICT educational policy pronouncement on gender issues.

Gender mainstreaming into an ICT programme

There are a number of compelling reasons for gender mainstreaming into an ICT educational policy implementation. The World Bank (2011) identifies a number of gender equality issues in ICT education in general, with access to ICT cited as the most basic gender equality issue, because it is linked to the availability of the necessary infrastructure. It is generally noted that girls and boys tend to have unequal access to ICT facilities. Another key issue relates to training in ICT skills which is also noted to be particularly gender insensitive. Then the main social and cultural concern is a gender bias in attitudes among males and females who study ICT, which tends to attract less females to science and technology subjects at the school level and beyond. However, Joyce (2009) argues that there is very little difference between boys and girls in terms of achievement in the ICT programme. Instead, there are marked differences in terms of self-perception, whereby males tend to be more confident than their female counterparts. Therefore, it appears that gender issues can be included as a legitimate component of an ICT educational policy to regulate ICT educational practice, as determined by the country specific coherent parameter on gender parity.

Gender needs analysis framework

The major issues on ICT, gender equality and gender empowerment drawn from the reviewed literature and case studies converge into a combined framework which is discussed in this section. The combined framework was used to undertake a situational analysis in the selected secondary schools in a bid to unpack the nature of gender dynamics in the way the ICT educational policy is implemented, as part of a broader national ICT policy implementation plan. The first component of the conceptual framework which relates to gender equality maintains that some of the gendered practices are experienced, maintained and reinforced in schools. The framework combined elements from Aikman *et al.* (2011), used to map four approaches to gender equitable ICT education. The intention is to weigh not only the strengths and limitations of ICT educational practices, but also to offer a framework for analysing gender equality in ICT educational policy implementation within the school setting. The first level was to determine whether or not boys and girls had equitable access to basic ICT resources. At the next level, analysis was guided by approaches of gender equality from a human rights

perspective, to expose ICT educational inequities in the structure and functioning of schools. The third level was concerned with delineating different gendered identities and epistemologies in education through recognising and valuing different forms of knowledge and pedagogies. Then at the fourth level there was consolidation of all findings from the other levels aimed at foregrounding specific conditions and issues in the school's environment, to indicate either gendered inequalities or none in the way the ICT educational policy was implemented.

To complement the Aikman et al. (2011) framework, the Longwe's empowerment framework cited by Leach (2003) was also used at another level of iteration as a lens to probe the extent to which the ICT programme can transform school practice towards gender equality and empowerment. The Longwe framework was adapted for this study to determine different levels of equality that can be factored into ICT educational policy implementation strategies. Such levels of equality are hierarchical, from a lower level of access, to an intermediate level of awareness then the highest conscientisation level. It is at the highest level that equality and empowerment are more likely to be achieved when there is achievement of equal participation by students and educators, in and equal control in, the way the ICT programme is rolled out. The perceived benefit of the combined framework is that it enabled the researcher to probe whether or not the way the ICT educational policy was implemented can meet strategic gender needs which include ability or none to raise awareness towards the benefits of and genuine participation in, the ICT programme. Yet at the same time the framework provides a lens to guard against narrow focus on only practical gender needs that were limited to mere access to ICT programme resources.

METHODOLOGY

The study's methodological approach is mainly qualitative. Data has been drawn from both primary and secondary sources. The researcher has used mixed data collection methods which include focus group discussions, a survey and analysis of books, journals and government documents. The survey instrument used was an extensive four (4) page questionnaire with a Likert-type scale that mainly contained statements of attitudes or beliefs towards gender mainstreaming into ICT in the education programme. With each statement, a five (5) point scale was used with options ranging from 'strongly agree' to 'not sure.' The overall study design followed an ICT educational policy situational analysis approach within the secondary school sub-sector. The primary task was to obtain various kinds and amounts of qualitative data that would allow the exposure of the experiences and situations of gender equality or none in the way the ICT educational policy was being implemented.

Data collection procedures

The questionnaire was sent to school ICT subject teacher leaders and school managers in the three selected schools. School A was an urban girls' only school; while Schools B and C were co-educational schools, located respectively in rural and peri-urban settings. School managers in two out of the three schools returned the questionnaires. Data collection was also through focus group discussions with school-based ICT Programme Coordinators and other teachers, who qualify to be regarded as members of emerging ICT subject Communities of Practice (CoP), as part of the targeted population segment. The purposively selected ICT teachers and other members shared their in-depth views on the potential role that ICT education can play in achieving gender equality by focusing upon improving the needs of dynamic learners.

The focus group discussions with ICT Programme Coordinators and other teachers further assisted in identifying how professional teacher development programmes could be reconceptualised or repurposed to address gender mainstreaming and potentially gender equality issues during ICT educational policy implementation. It is through such improved awareness that educators are more likely to be more participative in implementing the ICT educational policy objectives that address gender equality issues.

Data analysis

A qualitative approach to data analysis was used as guided by the combined gender analysis framework. The data was coded according to recurring themes guided by the main research questions, to determine levels of gender equality or none in terms of ICT leadership and management at the school level; other ICT programme related and pedagogical issues including assessment; professional development for teachers; availability of ICT resources and overall impact assessment.

STUDY FINDINGS AND DISCUSSION

The findings are reported under main themes as follows:

Gender equality analysis at the level of access to computers

In School A it was indicated that 38 computers were used by a total of 670 students, while in School B, a total of 27 computers were shared among 417 students. A comment made by the School A respondent was that:

> The school is working on establishing a second computer laboratory and the computers are already available.

It was also noted that in both schools, 3 computers were used for administrative functions while only 1 to 2 computers were reserved for use by teachers. It is perhaps for that reason that some teachers opted to use computers in the computer laboratories. However, it became apparent that even though in both schools effort was made to provide access to computers for an average class size of 40 pupils, there was room for improvement as indicated by the comment made by the teacher. It also became evident that teachers were not well considered in ICT educational policy implementation through a provision of ICT facilities for teacher use, yet it was the teachers who were to drive the implementation of an ICT policy by integrating ICT into their teaching. Since there was no mention by respondents of ICT access arrangements along gender considerations, it appears that in the selected schools, there was no strategy in place for gender differentiated access to ICT for both under-served groups of male and female students and teachers.

Analysis of gendered differences in ICT programme pedagogical approaches

In School B, three out of four respondents indicated that more girls than boys tended to use ICT to enhance their learning, while more boys than girls often used ICT to play popular computer games. Predictably, it was found that more respondents tended to associate computer games with male rather than female students. A rather more specific finding was gathered during the School B Focus Group Discussion, whereby differences in ICT use were cited to indicate that girls used ICT more frequently to browse the Internet for research purposes. However, boys did not use computers for research purposes. A possible explanation was that

boys thought that they knew more about computers and seemed to be less keen to use them for educational purposes.

On the issue of ICT enabled assessment, almost all respondents from the three schools disagreed that ICT was generally used to support and/or enhance formative learner assessment. Instead they referred to the summative ICT literacy assessment, whereby most respondents indicated that the students sat for the Future Kids examination, which was affiliated to Skills Pro, in South Africa. Before then students had followed the Institute for Computer Education in South Africa (ICESA) programmes but due to a tendency by some students to copy responses from previous examination questions, the school opted for an alternative ICT programme. Another cited compelling reason for opting out of the ICESA programme was that the Future Kids examination was more practically-oriented. It can be concluded that no attempt was made in the schools to implement a gender responsive pedagogy in the ICT programme. Gender responsive pedagogy as an objective is not even included in the overall Education Sector Strategic Plan for 2010-2022, which poses a challenge for the implementation of gender mainstreaming into the ICT programme.

Analysis of gendered ICT programme student outcomes

One of the statements posed related to how respondents regarded the ICT competency levels of male and female students. There was equal distribution of responses in favour of both boys and girls in both co-educational schools. Such a finding seemed to confirm the conclusion reached in the Joyce (2009) study where there was very little difference between boys and girls in terms of achievement in ICT. However, participants in the School B Focus Group Discussion tended to perceive girls to be generally more motivated in using ICT to enhance their academic work, with the result that girls were more represented in the Top 5 of highest performing pupils at the school. Despite this, the overall performance of girls in Mathematics and Science was found to be low in the senior grades, which confirmed the observation by FAWESWA (2011).

According to the respondents who participated during both Focus Group Discussions, differences were noted only in the choice of other subject areas which was according to gender orientation. For example, in School B most boys had previously tended to choose Design and Technology which was then perceived as a masculine subject while most girls tended to choose Home Economics, which was perceived to be feminine. However a recent development in the school was that some boys opted for Home Economics which they no longer perceived to be typically feminine. The differences in the choice of other subjects confirms what Obanya (2004) regards as a persistent culture and belief in many schools in Swaziland that some subjects are strictly for girls while others are for boys. Nevertheless, there is a notable potential role that the ICT programme can play in challenging such deeply entrenched gendered subject choice patterns.

Gender analysis in ICT programme leadership and management policy directions

Both schools A and B respondents indicated that each school had a vision for ICT, which was shared with staff as well as clear strategies for implementing the school vision. Further, the School A respondents strongly agreed that there was a budgetary allocation for ICT as well as regular upgrading of the ICT infrastructure. However, in School C, three out of the four respondents disagreed that there was a budget allocation for the ICT programme.

It was also noted by the respondents that school policies did not include any pronouncement towards ICT and gender mainstreaming. Instead only a regulatory mechanism was put in place

for students at senior levels of education. For example, according to respondents who participated during the School B Focus Group Discussion, their school-based draft policy only regulated the use of the Internet among students in senior grades, with a provision made for each student in the last two high school grades to browse the Internet for two hours per week. However, in practice some students were unable to utilise the time allocated due to restrictions in the opening hours of the ICT laboratory. The draft policy for the school also catered for local community use of computer and printing facilities, such that the computer laboratory was opened on Saturdays to benefit the community. It seems that even though in two out of the three schools there were policy guidelines to ensure that there was financial provision towards the ICT programme as well as operational guidelines to regulate ICT facility usage, none in all the three schools articulated leadership and management strategies that were directed towards ICT and gender mainstreaming.

Level of gendered ICT use by educators to transform educational practice

According to respondents in School A Focus Group Discussion, more female teachers were integrating technology into their teaching; with a distribution of about 6 female teachers and 4 male teachers. However, most of the teachers tended to limit their use of ICT only to word processing functionalities. In contrast, during the School B Focus Group Discussion, participants indicated that ICT integration into teaching was in the main common among young male teachers. They observed that such limited uptake of ICT by other teachers was despite measures taken by the ICT Task Team in School B to train any willing teacher. The respondents also indicated that some of the older teachers tended to resist change towards adopting ICT. However, some teachers indicated that to enable their teaching through ICT, they needed enabling ICT teaching resources. They also needed regular workshops to upgrade their basic ICT skills. It transpired from the discussions that most teachers in both schools were not keen on integrating ICT into their teaching despite that some had even attended professional development sessions for teachers facilitated by the University of Swaziland (UNISWA). Therefore, it is evident that not much ICT integration and gender mainstreaming can be realised unless ‘incentives’ are put in place for most teachers to be motivated.

Gender and ICT professional development for teachers

In an attempt to gauge the level of ICT teacher professional development (PD), one of the statements posed was, ‘I think there are systematic staff development programmes in ICT.’ In all three schools more respondents indicated that there were systematic staff development programmes in ICT which took into account teaching needs. However, all respondents strongly disagreed that there were regular audits to establish staff ICT training needs prior to the rolling out of staff development initiatives. None of the PD initiatives was specific to integrating gender into the ICT programme. It appears that despite the education sector ICT policy pronouncement on a gender responsive ICT programme, in practice no attempt has been made for professional development to foreground gender responsive ICT pedagogical approaches.

Analysis of the objectives of ICT programme in schools through a gender lens

Several objectives of the ICT programme in schools were outlined by the School A respondents, one of which was for students to learn about fundamentals of a Personal Computer. At lower secondary school level, the main purpose was for basic computer awareness while for more senior students the objective was hands-on practical skills on

Microsoft Office desktop applications including Word, Excel, Access and Power Point.

According to the respondents who were part of the Schools B and C Focus Group Discussions, old ICT such as video was also used during Literature in English lessons to study drama texts such as Macbeth. New ICT in the form of computers was used for conducting research using the intranet search engines, as well as to type and print projects. In contrast, junior classes tended to use ICT for computer literacy while senior students used the intranet for research purposes in a wide range of subjects including Agriculture, Design and Technology, History, Home Economics and Geography. A specific example that was cited was the use of intranet resources by senior students to conduct literature reviews in a project where they had to compare organic and inorganic fertilizers. It appears that it is only in senior grades that ICT is used for knowledge deepening in the selected schools. Therefore, even though such use indicates the potential for gender empowerment, there is room for improvement towards more innovative and creative uses.

Perceived impact of the ICT programme in transforming 'gendered' school practices

Participants in the School B Focus Group Discussion indicated that ICT could potentially contribute towards more gender equality when both boys and girls would use ICT to enhance their academic performance. They also reflected that the Swazi child tended to be socialised such that more boys than girls were perceived to be more inclined towards ICT. However, the respondents argued that gender equality could be promoted as a result of recent developments in the sampled co-educational schools through the requirement that both boys and girls follow the same ICT programme, with limited opportunity for divergence. Nevertheless, the transformative potential of the ICT programme can only be a result of collaboratively formulated strategies with clearly spelled out performance targets and indicators during the rolling out of the gender responsive ICT educational policy.

CONCLUSIONS

The main result of the study is that in all the schools under study, gender mainstreaming into the ICT programme tended to be limited to the level of access to ICT literacy skills through a gender neutral approach. For example, in the sampled schools, practical gender needs were to some extent met through the provision of infrastructure for compulsory ICT literacy skills for both male and female students. However, even such access was limited by the number of ICT work stations and restricted computer laboratory opening times. Most respondents also indicated restricted Internet connectivity for students. Yet for advanced digital literacy there is need for ICT skills acquisition beyond basic literacy and mere access to the ICT infrastructure. Therefore, effort to implement the ICT educational policy in the schools under study seemed to be limited to the provision of access to technology and basic ICT literacy but not on the requisite skills development, knowledge and attitudes that could, in the long run, empower both male and female educators and ultimately the students.

Further, it was also established that the provision of basic ICT literacy was ad-hoc because it was not guided by any Ministry of Education and Training syllabus. For example, in the sampled schools, students followed an ICT literacy programme that was not validated by the MoET, yet empowerment and gender equality can be achieved through well-articulated programme objectives, guided by an educational policy framework and implementation plan. As a result, the extent to which ICT can meet structural gender needs seemed not to have been adequately realized.

Further, it can be concluded that there was limited teacher access to computers at the schools under study which can undermine the use of computers as a tool for advanced digital literacy skills acquisition by the teachers. This in turn can negatively affect the skills learned by the students with the help of their teachers. There was also inadequate opportunity for professional teacher development for advanced digital literacy that would in time promote gender equality among students. No attempt has been made either for capacity building among the teachers in gender responsive pedagogy enabled through ICT. Another challenge has been that in the selected schools the school-based ICT policies tended to be gender neutral with no objectives for gender mainstreaming despite the inclusion of the national ICT educational policy objective of implementing a gender responsive ICT programme.

RECOMMENDATIONS

The proposed extended ICT educational policy managerial framework can be helpful for both policy makers and implementers to ensure that, for each policy component, there is a parameter to ensure how it will be operationalized. Even though such a framework will differ from school to school depending on the applicable contextual factors, it can ensure that both policy makers and implementers are able to articulate achievable gender responsive ICT educational policy implementation plans. In particular, the study highlights that there is need for key stakeholders to deliberately strategize on how to mainstream gender into the ICT educational programme. Such ICT policy directions can then be translated into a school's ICT educational policy implementation plan and strategy. The strategy can also incorporate how the ICT programme will systematically integrate ICT literacy alongside ICT for knowledge deepening and for knowledge creation in a bid to achieve gender empowerment for both teachers and students. Equal access to ICT infrastructure and basic ICT literacy is inadequate to empower but rather it only merely creates awareness of the need for change in attitudes through ICT, and genuine participation in learning ICT skills beyond literacy.

There is also need to address the concern that schools tend to overlook investing in teachers and pupils but narrowly focus only on technology in terms of budget allocation. Schools need to engage teachers in crafting PD interventions because teachers constitute a critical factor in implementing the ICT programme. The teachers must be comfortable and acquainted with the array of technologies in order to gain greatest benefit from their use. Therefore, some proportion of the budgetary allocation for the ICT subject may be channelled towards the training of teachers, provision of technical support, changing of the curricula and teaching approaches in order to take greatest advantage of the dynamics of the ICT programme. Subsequently, to meet the continuing professional development needs of teachers, teacher education institutions may also craft different PD programmes, particularly those that strongly advocate the use of ICT to facilitate the processes of knowledge construction and knowledge creation among students, as a strategy towards gender equality.

Another means of improving the ICT programme is by widening access to the ICT facilities and e-resources such as open educational resources, as indicated by the expressed need for teaching resources by the respondents. As a result, the ICT programme will be more likely to be responsive towards gender equality and empowerment. Finally, the paper points to a need for an expanded concept of gender equality to be articulated through the preferred ICT educational policy model, both at national and school levels. For example, all stakeholders need to be involved not only to point out new insights into the contextual issues within the

school, but also for such insights to bring about change beyond the school's context in the future.

SIGNIFICANCE

The main contribution of the paper is to reassert that the problem of gender and ICT is not a numerical problem about the number of girls and boys in an ICT programme. Further, that gender equality is not merely reducible to equal numbers of students who go through the ICT programme, but calls for a concerted effort to avail a greater range of opportunities for being gendered. There is need to explore how gender equality, in the way the ICT educational policy is implemented, can also enable greater levels of self-determination for all students through the purposeful, meaningful and productive application of ICT, in ways which are more likely to enhance both individual and collective well-being. Therefore, the paper provided an opportunity to reflect upon ICT policy implementation issues within the school setting while also pointing to the possibility for simultaneously exploiting gender mainstreaming opportunities, situated within the context and culture in which the education occurs. As a result, a follow up study can probe the likelihood that gendered differences among male and female pupils can also be represented in teachers through the differences on how the teachers view the way the ICT educational policy is implemented in the school.

REFERENCES

Aikman, S., Halai, A. and Rubagiza, J. (2011).Conceptualising gender equality in research on education quality, *Comparative Education*, 47(1) : 45-60.Bassi, R. (2011). ICTs in education (ICT4E) Policies and Plans Worldwide. Retrieved on 12 January, 2014 at: http://www.gesci.org/assets/files/Knowledge/country-policies.pdf

Forum for African Women Educationalists. Swaziland Chapter.http://ngogateway.com/organization/forum-for-african-women-educationalistsswaziland-chapterfaweswa/.10/09/2011

Government of Swaziland. (April, 2011). Ministry of Education and Training. The Swaziland Education and Training Sector Policy. Mbabane.

Government of Swaziland. (November, 2010). Ministry of Education and Training. Education Sector Strategic Plan: 2010-2022. Mbabane.

Government of Swaziland. (2011). National Information and Communication Infrastructure (NICI) Policy. Ministry of Information, Communication and Technology. Mbabane

Joyce, A. (2009). Are girls excluded from ICT or just perceived so? https://www.edutechdebate.org/gender-equality-in-ict-education/are-girls-excluded-from-ict/. 4/09/2012

Kidombo, H.J., Gakuu, C.M. and Ndiritu, A.W. (2012). Institutional Management and Integration of ICT in Teaching and Learning in Selected Kenyan Schools. *Journal of Continuing Open and Distance Education*, 2(1) :151-174 http://distance-education.uonbi.ac.ke/node/2379

Leach. F. (2003). *Practising gender analysis in education*. Oxfam, Oxford.

Madzima, K., Dube, E. L. and Mashwama, P. M. (2012). ICT Education in Swaziland Secondary Schools: Opportunities and Challenges. http://www.appropriatetech.net/files/Papers_Knowledge_Transfer.pdf. 19/08/2013

Nyaruwata, L.T. and Chideya, T.N. (2013). Gender issues in economic growth and poverty reduction. Training Manual for Training on Gender Mainstreaming in the economic and political arenas, May 22-1 June 2013 , Rider Hotel, Seeta, Kampala, Uganda: Organization for Social Science Research in Eastern and Southern Africa (OSSREA).

Obanya, P. (2004). Promoting basic education for women and girls. Four African case studies. United Nations Educational, Scientific and Cultural Organization, (UNESCO), Paris.

Ogato, G.S. (2013). The quest for gender equality and women's empowerment in least developed countries: Policy and strategy implications for achieving millennium development goals in Ethiopia. *Academic Journals*5(9) : 358-372

Swarts, P. (2006). ICT and the third revolution in educational policy. Retrieved on 12 January, 2014 at: http://www.digitallearning.eletsonline.com/2006/09/ict-the-third-revolution-in-education-policy-2/

Swarts, P. and Wachira, E.M. (July, 2010). Tanzania: ICT in Education Situational Analysis. http://www.tanzania.go.tz/egov_uploads/documents/Situational_Analysis_Tanzania_sw.pdf.31/01/2014

Tondeur, J., Van Keer, H., Valcke, M. and van Braak, J. (in press). ICT Integration in the Classroom: Challenging the Potential of a School Policy

Wild, K. (2011). What is ICT policy? Retrieved on 12 January, 2014 at http://www.old.apc.org/english/capacity/policy/mmtk_ictpol_intro_handout.doc

World Bank. (2010). The Education System in Swaziland: Training and Skills Development for Shared Growth and Competitiveness. Africa Human Development Series, World Bank Working Paper 188. World Bank, Washington, DC.

World Bank. (2011). ICT and Education Projects. http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTEDUCATION/0, , print:Y~isCURL:Y~contentMDK:20533886~menuPK:617610~pagePK:148956~piPK:216618~theSitePK 15/09/2012

Zlotnikova, I., and Weide, van der T.P. (2011). An approach to modelling ICT educational policies in African countries. *International journal of Education and Development using Information and Communication Technology (IJEDICT),* 7(3) : 50-73

CONVERGENCE AND ASYMMETRIES IN THE COMMON MONETARY AREA IN SOUTHERN AFRICA

Dumsile F. Dlamini [1]

ABSTRACT

This paper examines the extent of macroeconomic convergence and asymmetric adjustments to aggregate shocks in the economies of the common monetary area in Southern Africa. These are vital in the discussions on the creation of a fully-fledged monetary union in the area. The study finds strong co-movement in inflation and interest rates which confirms nominal convergence in the area. The slight narrowing in per capita income dispersions indicates some real convergence. However, differences in the composition of exports as well as low correlation of growth rates shows that countries in the area are more likely to face asymmetric shocks. Based on optimum currency area theory, the existence of these shocks can complicate the functioning and stability of the monetary union, which means that there has to be well planned gradual step by step creation of the union as well as putting in place other adjustment mechanisms to cushion member countries in the face of asymmetric shocks.

Key Words: Convergence, asymmetry, aggregate shocks, monetary union, optimum currency area

INTRODUCTION

One of the principles of the New Economic Partnership for Africa's Development (NEPAD), the operational arm of the African Union (AU), is acceleration of regional and continental integration. This integration is seen as a way to generate economies of scale found in larger markets and ensures solidarity in Africa. It is true that most African countries are small judging by their per capita incomes and population sizes. As a result, they fail to provide potential investors with enough variety in investment opportunities and attractive returns. The United Nations Economic Commission for Africa (UNECA) (2004) report states that NEPAD was set up to provide a development framework premised on regional integration, among other things. The report further stipulates that given the challenges posed by regionalism and globalisation, African countries stand a better chance to reduce marginalisation in the global economy if they act collectively.

According to Masson and Pattillo (2004), motivations for creating currency unions, especially in Africa, go beyond the benefits identified under optimum currency area (OCA) framework. Initially this framework was developed by Mundell (1961) and Mckinnon (1964). They believe that it can create central bank independence by providing an agency of restraint which would create commitment and credibility of monetary authorities. Furthermore, besides being able to effectively deal with external challenges, Maruping (2005) points out that African governments believe that by joining forces they will be better able to create stable macroeconomic environments that will effectively stimulate economic activity and sustainable development of their economies.

In the same light, the AU continues to stress the importance of ensuring that all the existing

[1] *Department of Economics, University of Swaziland*

regional economic communities in all four regions of the continent are supported and enhanced. As stated by the Central Bank of Swaziland (2006), the AU envisages eventually having a common currency and central bank by 2025. This means that regional integrations can be seen as springboards for a united Africa.

In the Common Monetary Area (CMA), smaller members enjoy benefits such as relatively stable inflation, elimination of uncertainty concerning exchange rate fluctuations which lower costs and boosts investor confidence, restraints on government expenditure, constrains on monetary expansion as these must be in line with CMA guidelines. However, smaller members face constrained monetary and exchange rate policies such that they cannot use these to effectively deal with domestic or idiosyncratic shocks. Mihov (2001) points out that to the extent that such shocks are significant, a common monetary policy may worsen cyclical misalignments as it will only deal with common shocks. The smaller members are also unable to effectively participate in the monetary policy formulation process in the area.

This study focuses on the extent of convergence and the existence of asymmetric shocks in the CMA which comprises Lesotho, Namibia, Swaziland and South Africa. These countries are also members of the Southern African Customs Union (SACU), which allows for free trade among members and a common external tariff on goods from outside the Union. Botswana is also a member of this union. This study is therefore a useful input in the on-going discussions by central bank governors in the CMA on moving towards a fully-fledged monetary union. Such discussions are a stepping stone to the AU's dream of a common currency and central bank for the African continent.

The subsequent sections of this paper are as follows: Section 2 presents the literature review followed by the methodology in section 3. The empirical analysis is in section 4 and section 5 presents the conclusion and recommendations.

LITERATURE REVIEW

Benefits and Challenges of Monetary Integration

Discussion on monetary integration, according to Jefferis (2007), has been at the forefront in economic policy discussion agendas mainly because of the European Monetary Union (EMU). When countries form a currency union, according to literature on OCA theory, they anticipate a number of benefits. First, there is a reduced transaction cost as they no longer need to convert currencies and hedge against exchange risk in transactions. Gains from trade rise as trade volumes rise and there is increased market access through the creation of a larger regional market. Also as trade rises business cycles are more synchronised. And countries gain economic competitiveness due to increased specialization. There is elimination of nominal exchange rate volatility; hence, lower interest rates, lower real exchange rate volatility, deeper financial integration, and wider acceptability of currency. Countries experience low inflation as monetary expansion is constrained and governments restrain excessive spending. Countries also gain from increased asset values as currency risk and interest rates decrease and costs of operating and maintaining a separate monetary system are reduced. Above all, countries expect to enjoy more stable macroeconomic environments;characterised by high economic activity, low unemployment rates, and higher investment emanating from coordination and harmonisation of macroeconomic policy in the region.

However, monetary integration also poses serious challenges. Beetsma and Bovenberg (2001) identify the loss of control over monetary and exchange rate policies as tools that can

be used to deal with domestic or idiosyncratic external shocks. According to Bean (1992), countries also lose the privilege of seigniorage revenue because monetary unification calls for convergence of inflation rates and maintenance of low budget deficits which cannot be monetised. Concomitantly, there is fear of negative consequences from being associated with less successful economies, and how this tends to drag down more successful economies, resulting in lost credibility in the international economy. They fear negative consequences due to adverse selection and moral hazard as they could be painted in the same brush. Corsetti, *et al.*(1999), Hughes-Hallett and Weymark (2001) ; and Dellas and Tavlas (2005) note that, existing asymmetries in terms of shocks and monetary policy transmission mechanism among countries may be exacerbated if costs and benefits emanating from a monetary union are unfairly distributed.

Further, Dellas and Tavlas (2005) note that, costs will rise due to the nature of existing nominal rigidities. For example, they indicate that if countries have the same kind of labour market rigidities they will benefit more from forming a monetary union. Feldstein (2005) identifies the inherent conflict between using a single currency and operating independent fiscal policies. Governments, he argues, as a result tend to run large budget deficits so long as there is no market feedback to discipline for such. Bordo and Jonung (1999) identify the challenge of ensuring that institutions set up to oversee operation of the area have clear and non-overlapping mandates in order to avoid conflicts and also be able to resolve them smoothly, should they occur.

The main features of the CMA

Historically the CMA has undergone various stages and is one of the oldest arrangements to have survived together with the financial cooperation in Central Africa (CFA) franc zone. Originally, the pound, under British rule, followed by the South African rand circulated in Botswana, Lesotho and Swaziland before these countries gained independence from Britain. According to Wang, *et al.* (2007), flows of funds among these countries were not restricted and all external transactions were effected by South African banks subject to their domestic exchange controls. In 1972 negotiations to formalize the already existing monetary relationships began after successful renegotiation of SACU in 1969. In 1974 the Rand Monetary Area (RMA) agreement was signed. However, later in 1975 Botswana pulled out to pursue an independent monetary policy. According to Grandes (2003), Botswana has kept the pula linked to the rand via a currency basket, in which the rand weighs 60-70%.

Following major economic events in South Africa, which included the depreciation of the rand in 1986, Swaziland renegotiated the RMA. It was then replaced by the CMA. Namibia joined in 1992 after gaining independence from South Africa in 1990. The main thrust of the CMA is to foster and sustain economic development in member countries, with special emphasis on the smaller members, by means of coordinating monetary and exchange rate arrangements. Nielsen, *et al.*(2005) assert that the main goal of monetary policy in the CMA is to sustain the pegged exchange rate by upholding enough foreign exchange reserves and keeping interest rates at levels that will not result in alteration of the peg.

In the CMA, currencies of smaller members are pegged one to one to the South African rand. and the exchange rates are not irrevocably fixed. It allows members to issue their own currency and currencies of smaller members are not legal tender in SA but circulate in the border areas. There is free flow of funds for current and capital account transactions within the area except where the smaller members require funds for prescribed financial institutions

investment or liquidity purposes. Smaller members have access to South African capital and money markets via prescribed investments or approved securities that South African financial institutions can hold. The arrangement allows independent authorisation of gold and foreign exchange transactions and dealers by individual members, in line with set regulations within CMA. There are bilateral agreements between South Africa and the smaller members that govern the latter‘s access to South African foreign exchange markets. Furthermore, there are compensatory payments for seigniorage forgone by using the rand, apportioned using an established formula stipulated in the CMA agreement. Lastly there is reconciliation of monetary and foreign exchange policies through a CMA commission consultative process. The commission meets annually, but can also meet at the request of any member.

Wang *et al*. (2007), assert that certain features of the CMA are notable when compared to those of other monetary integrations as shown in table 1, in the following ways: First and foremost, the CMA is dominated by South Africa, which accounts for over 90% of the whole area’s GDP, trade and population. Secondly, the CMA is not a fully-fledged monetary union as there is no common central bank, pool of reserves, and regional surveillance of domestic fiscal and structural policies. The rand is a de facto common currency in the area and conversion from one currency to the other is at zero cost, making the currencies perfect substitutes. Thirdly, the existing exchange rate arrangement of smaller countries resembles that of a currency board even though there are no prohibitions on smaller countries holding domestic assets as would be the case under a currency board. Further, the parity is not irrevocable and there exists no provision for mutual support of the exchange rate peg should it come under strain.Fourthly, the CMA is based on SACU, a free trade area that entails high capital mobility making it similar to the Euro area. Finally, there exist no fiscal transfers among countries to assist them deal with asymmetric shocks, should they arise. Grandes (2003) and Masson and Pattillo (2004), support this comparison and mention that the CMA is eclectic and highly adaptable, factors that are likely to have contributed to its survival over the years.

Table 1. Features of monetary unions

	WAEMU	CAEMC	Euro Area	CMA
Membership	8	6	12	4
Single currency?	Yes	Yes	Yes	No, but de facto common currency
Common central bank?	Yes	Yes	Yes	No, but SARB has immense influence
Common pool of reserves?	Yes	Yes	Yes	No
Regional surveillance of fiscal policy?	Yes	Yes	Yes	No
Free trade area?	No	No	Yes	Yes
Degree of capital mobility within region?	Low	Low	High	High
External exchange rate anchor?	Yes, peg Euro	Yes, peg Euro	No	No

Note: WAEMU=West African Economic and Monetary Union
CAEMU=Central African Economic and Monetary Union
SARB= South African Reserve Bank

Monetary Policy in the CMA

The primary focus of the monetary policy in South Africa is to stabilise the value of the rand in an effort to promote balanced and sustainable growth of the economy. The SARB follows an inflation-targeting framework introduced in the year 2000. According to Aron and Muellbauer (2006), adoption of this framework was intended to improve its policy so that it is more predictable, transparent and policymakers are more accountable. Under the framework, the target for the consumer price index (CPIX), excluding the mortgage interest rate, is between 3 and 6 per cent per year. The main instruments of the monetary policy include the repurchase rate (repo rate) and open market operations.

Monetary policy in the rest of the CMA centres on protecting the pegged exchange rate by preserving adequate foreign exchange reserves. The smaller members have to back all domestic currency issued with these reserves. Interest rates are also kept in line with those pertaining in South Africa to avoid any distortions to the fixed exchange rate. Nevertheless the smaller members have set up various ways that they use, to a limited extent, to direct monetary policy in their countries. The bank of Namibia uses the bank rate to influence commercial banks' reserves. It also uses the call rate, defined as the rate paid to commercial banks on funds kept on a short-term basis with the central bank. The reserve requirement is used, but its use is limited because most of the commercial banks in the country are owned by South African banks.

The Central Bank of Swaziland uses the discount rate, reserve and liquidity requirements, open market operations, and moral suasion, an unofficial monetary policy tool used to persuade, as opposed to compel, by law, financial institutions in following suggested guidelines on availability and cost of credit. The bank ensures that interest rate differentials with South Africa are at their lowest. This helps to manage capital flows and shield the economy from any negative consequences from monetary policy instituted by South Africa. The Central Bank of Lesotho (CBL) 's principal mandate is price stability followed by anchoring monetary policy to that of South Africa through the rand-loti peg. The CBL utilises open market operations to regulate domestic banking sector liquidity and maintain adequate reserves to support the peg.

THE STUDY METHODOLOGY

Convergence and Asymmetric Adjustments to Aggregate Shocks

The study examines the extent to which there is convergence and asymmetric adjustments to aggregate shocks in the economies of the Common Monetary Area (CMA). Macroeconomic convergence and asymmetric adjustments are crucial issues if the CMA is to evolve into a fully-fledged monetary union. Frankel and Rose (1996a), Calderon, *et al.*(2003), Masson and Pattillo (2004), and Cheung and Yuen (2004), among others, indicate that standard literature on Optimum Currency Areas (OCA) identifies some key criteria in determining if countries are suitable candidates for a monetary union. Countries must exhibit close international trade links, their business cycles must be synchronised and they must also have flexible labour and capital markets. The OCA criteria are treated as exogenous in the traditional OCA literature. However, studies such as Frankel and Rose (1996a and 1996b) argue that these criteria are endogenous. They are reinforced by the creation of a monetary union implying that candidates of a monetary union can satisfy the OCA criteria ex-post rather than ex-ante as economic structures are expected to be transformed in the monetary union.Adams (2005) highlights

political factors as key in determining the formation and success of currency unions

To measure convergence and asymmetry of business cycles among members, studies such as those of Anthony and Hughes-Hallett (2000), Wang *et al.* (2007), Kocenda, *et al.*(2006), and Eichengreen and Bayoumi (1996) focus on GDP growth rates, inflation rates and interest rates. In this study I assess the behaviour of these variables to identify if there is any convergence and asymmetry within the CMA. First, I measure convergence using an error-correction model premised on the assumption that variables in the smaller countries follow those of the larger country in the area. This model is an extension of the model by Wang *et al.* (2007). I also measure β–convergence to gauge if the smaller countries tend to catch up with the larger country overtime as in Kocenda *et al.* (2006). Furthermore, I apply univariate modelling to assess if overtime the variables of interest in the member countries tend to move towards the same long-run equilibrium values. I measure asymmetry using the correlation of individual countries' GDP growth rates to that of the area as a whole. I also consider the composition of the countries' exports as a proxy for the likely presence of asymmetric shocks in the CMA.

Measures of Convergence

In this study I use two measures of convergence. Firstly, I use an error correction model, which is a modification of Wang *et al.* (2007). It assumes that key macroeconomic variables of smaller members are affected by those of the larger country in any monetary grouping. Given the hegemonic role of the larger country, there is no feedback effect expected from smaller economies to the larger country. Furthermore, in the short run, should there be any deviation of the smaller country's variables from those of the larger country, an adjustment process is triggered until they equalize. The adjustment speed varies across smaller countries depending on a variety of factors, such as differences in economic and institutional structures.

The model is specified as follows:

$$\Delta X_t = \alpha + \sum_j \theta_j \Delta X_{t-j} + \beta \Delta X_t^* + \gamma (X_{t-1} - X^*_{t-1}) \tag{1}$$

X_t represents either inflation, GDP or interest rates and X^*_t represents the relevant variable for the larger economy, β captures short term response of X_t in each of the smaller members to changes in the larger country variable, X^*_t. The convergence speed to long-run equilibrium values for each variable is captured by γ and θ measures the presence of persistence in each of the variables. Persistence gives an indication of differences in economic and institutional structures among countries. The convergence speed variable must be negative to support that smaller countries adjust their variables should they deviate from those of the larger country. If it happens to be zero this would indicate that there is no relationship among these economies. A positive convergence speed coefficient would indicate that if divergences occur they would be persistent.

In eq. (1) variables of the smaller member countries are assumed to be linear functions of the larger country in the long run. For example, this means that interest rates in the smaller countries follow those of the dominant partner. There is no feedback effect expected given the hegemonic role played by the dominant partner in the area. In this case interest rates adjust to the long-run equilibrium rate should there be any disturbance to the linear relationship. The same reasoning applies to inflation rates and GDP growth rates in the area.

I assume that the variables for the larger country are driven by the following process:

$$X_t^* = \delta + \sum_j \theta_j X^*_{t-j} + \varepsilon_t \tag{2}$$

Eq. (2) presents the larger country equation which captures internal persistence.

The second measure is based on Kocenda *et al.* (2006). It captures the extent to which smaller countries catch-up with the larger country overtime. It measures convergence towards a benchmark. They argue that this measure has recently been used on time series methods to capture a second dimension to β-convergence. This is because most cross-sectional tests used tended to over-reject the null hypothesis of no convergence. The model is given as:

$$x_t = \delta + \alpha t + u_t \tag{3}$$

where; X_t is the percentage deviation of a small country variable from that of a large country variable, δ captures the original deviations in the variable of interest between two countries, t is a time trend and u_t is a random error. In this setting β–convergence occurs if first, on the onset δ is negative and statistically significant. This would indicate that the small country is lagging behind the larger country. Second, the time-trend coefficient α should be positive and statistically significant, indicating that overtime the lagging country catches up with the leader. In this study X_t is the percentage deviation of real per capita GDP of the smaller countries from that of the larger country.

Measures of Asymmetry

The first asymmetry measure used in this study is based on Anthony and Hughes-Hallett's (2000) study on the Caribbean monetary union. It examines the correlation between annual GDP growth of each member country and GDP growth of the whole area. This measure captures the extent to which member countries will be subject to the same shocks given the observed differences in their economies. These include differences in size, cultures, economic, and institutional structures. In Mihov (2001) and Demyanyk and Volosovych (2005), this measure is identified as a conventional way of measuring synchronization of economic activity. Low correlation is interpreted to mean that countries could be subject to asymmetric shocks. Kalemli-Ozcan, *et al.*(2004) and Eichengreen and Bayoumi (1996), also stress that if economies face asymmetric shocks it means that they show asymmetry in GDP. They argue that to the extent that large GDP asymmetries exist, the monetary union may reduce welfare because individual countries lose monetary policy autonomy. In such a situation, it is only if there exist risks sharing mechanisms such as fiscal transfers that the costs of adjusting to shocks will be reduced.

The other measure used in the study is based on Eichengreen and Bayoumi (1996) and Wang *et al.* (2007). It uses differences in the composition of exports among union members as a proxy for the asymmetry of shocks. The argument is that when member countries export the same products, industry specific shocks will be more symmetric. As countries face symmetric shocks, such as terms of trade shocks, their business cycles would tend to become more and more symmetric, making them good candidates for a monetary union.

EMPIRICAL ANALYSIS

Data Description and Sources

Annual data obtained from the International Finance Statistics (IFS) and World Development Indicators (WDI) was used. Interest rate data for Namibia begins in 1993 as the country gained

independence in 1990. I estimate eq. (1) to (4) using Ordinary Least Squares (OLS). The lag length is chosen using the Akaike Information Criteria (AIC). Using the results from the error-correction model I carry out simulations to observe how CMA country variables under study behave when subjected to a shock. I also run Granger-causality tests and observe how they compare with the results from the error-correction model.

Table 2. Data description

Sample	Variables	Description
1980-2007	Interest rate	Lending rate
1980-2012	Inflation rate	Consumer Price Annual % change
1980-2012	Growth rate	Real GDP annual % growth
1980-2011	Real GDP per Capita	GDP constant 2000 US $ divided by population

Note: Standard errors are reported in parenthesis r_t = Interest rate. π_t = Inflation rate. y_t = growth rates.

Empirical Evidence on Convergence in the CMA

Error-correction model results

Estimating eqs. (1) and (2) for each of the variables yields the results presented in table 3. The appropriate lag length for eqs. (1) and (2) is chosen using the AIC.

Table 3. Error-correction model results for selected macro-variables

	Lesotho			Namibia			Swaziland		
	Δr_t	$\Delta \pi_t$	Δy_t	Δr_t	$\Delta \pi_t$	Δy_t	Δr_t	$\Delta \pi_t$	Δy_t
β	0.7	0.71	0.74	0.73	0.72	0.91	0.85	1.03	0.7
γ	(0.07)	(0.22)	(0.19)	(0.10)	(0.20)	(0.45)	(0.11)	(0.38)	(0.31)
	-0.23	-0.97	-0.3	-0.57	-0.52	-1.33	-0.25	-1.11	-0.67
θ_1	(0.11)	(0.18)	(0.16)	(0.23)	(0.18)	(0.28)	(0.17)	(0.20)	(0.17)
	0.2					-0.04	-0.24		
θ_2	(0.08)					(0.19)	(0.11)		
	-0.17								
	(0.08)								
R^2 S.E.	0.9	0.58	0.56	0.83	0.51	0.89	0.72	0.53	0.46
AIC	0.82	2.7	2.34	0.72	2.25	1.69	1.42	4.35	4.17
	2.64	4.91	4.65	2.37	4.57	4.13	3.66	5.87	5.8

Note: Standard errors are reported in parenthesis r_t = Interest rate. π_t = Inflation rate. y_t = growth rates.

The results indicate that interest rates in the smaller countries are highly influenced by those of the larger country, South Africa. This is shown by the coefficient β which is large and significant with the correct sign for all the smaller members. The coefficient γ, which captures the speed of convergence in interest rates in the long run, ranges between -0.23 to -0.57. For Swaziland, though the convergence coefficient has the right sign, it is not significant. Lesotho has the lowest convergence coefficient, though not significantly different from that of Swaziland. This could be due to the underdevelopment of the financial sector in Lesotho.

The results also show that inflation rates in South Africa affect those of the smaller countries as captured by β. This coefficient has the right sign and is statistically significant for all countries. It is much higher for Swaziland at 1.03 and very similar for Namibia and Lesotho

at 0.71 and 0.72 respectively. The convergence speed is higher for Swaziland at -1.11 followed by Lesotho at -0.97 and Namibia at -0.52. For all the countries there is no evidence of persistence in inflation. This is shown by the insignificance of the coefficients. These results are reasonable given that smaller countries rely heavily on imports from South Africa. Further, the currencies of member countries are pegged one-to-one to the rand. This makes the inflation targeting framework being pursued by South Africa applicable to the whole area.

The GDP growth in Swaziland, Lesotho and Namibia is positively related to growth in South Africa as captured by the β coefficients. The γ coefficients show that there is convergence in the long run. This is shown by the significance of the coefficients, which also carry the correct signs. The convergence speed for Swaziland, Lesotho, and Namibia is -0.67, -0.30 and -1.33 respectively. For Namibia, the reported persistence is insignificant. It is however important to note that the model does not include other factors, such as structure of economies, and level of quality of production factors that influence economic activity in each economy. However, the results obtained are useful in that they bring out that growth in South Africa does influence that of the smaller countries.

In general, these results are consistent with those found by Wang *et al.* (2007). Slight differences reflect the inclusion of persistence parameters and the use of annual data. For Lesotho and Swaziland, there is persistence in interest rates, which indicates that adjustment following any disturbance will be gradual rather than fast and immediate. As a result, current lending rates in Lesotho and Swaziland will be affected by their past two and one year values respectively.

Using the results shown in table 2, simulation of the behaviour of the economies of the CMA when faced with a 1% shock from South Africa yields the responses in figure 1. The graphs show that following the shock, in the very short run economies may react differently. However, they tend to behave the same way as they approach long-run equilibrium together. This indicates that there is convergence in the CMA in terms of inflation, interest and GDP growth rates. This means that business cycles of these economies should be fairly synchronised.

The behaviour of inflation in the CMA is further supported by evidence from running Granger-causality tests. These tests are based on the assumption that causality in inflation is unidirectional from South Africa to the smaller members. This assumption is based on the hegemonic role South Africa plays in the area. The results presented in table 4 show that inflation in the smaller countries is Granger-caused by inflation in South Africa.

Table 4. Pairwise Granger-Causality Tests: Inflation in the CMA

Null Hypothesis	F-Stat	Prob
South Africa inflation does not Granger-cause Swaziland inflation	7.00	0.00
Swaziland inflation does not Granger-cause South Africa inflation	2.42	0.13
South Africa inflation does not Granger-cause Lesotho inflation	16.52	0.00
Lesotho inflation does not Granger-cause South Africa	0.29	0.59
South Africa inflation does not Granger-cause Namibia inflation**	10.03	0.00
Namibia inflation does not Granger-cause South Africa inflation	1.45	0.24

Note: F-Stat = F-Statistic and Prob = probability.

The close co-movement of inflation in the CMA supports a finding by Tenreyro and Barro (2003) that a common currency increases price co-movements as shown in figure 2. Since inception of the inflation targeting framework in South Africa inflation rates in the area move even closer.

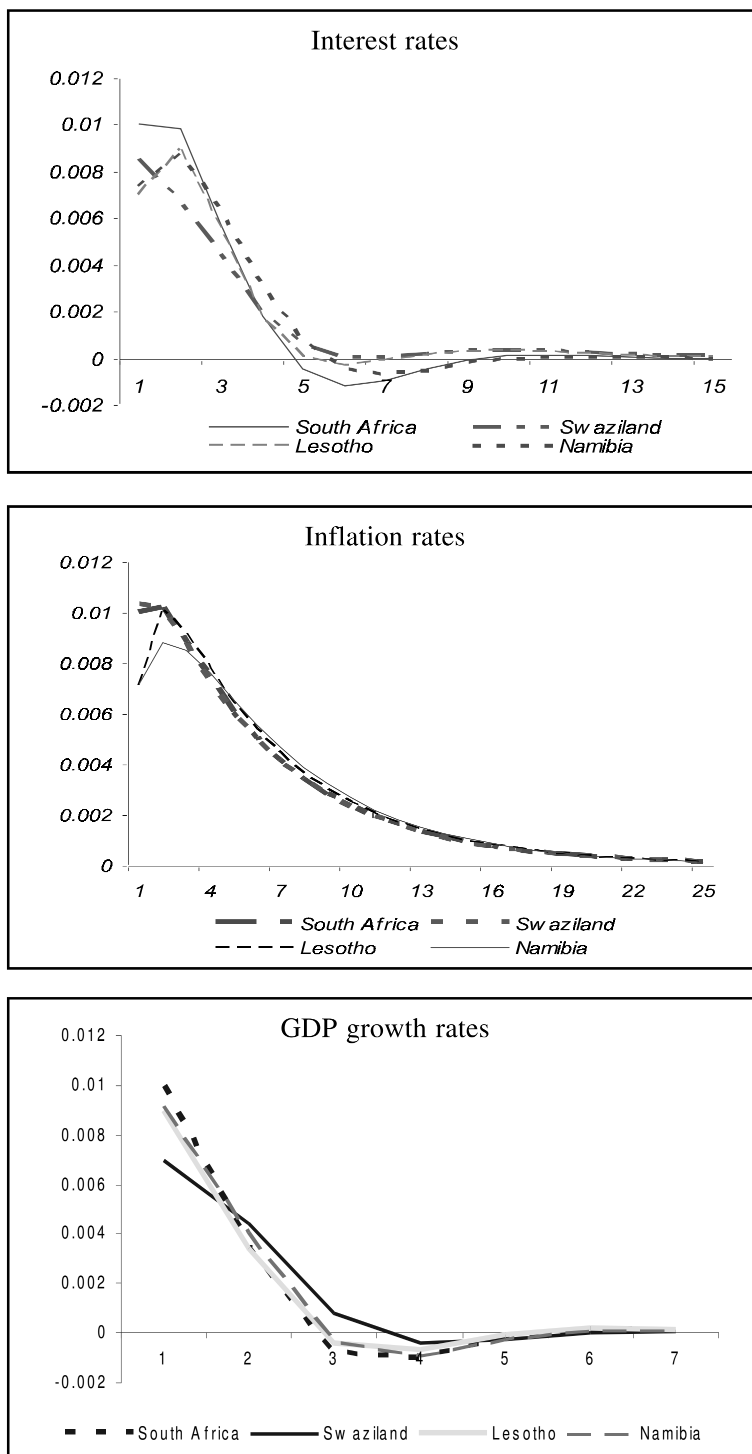
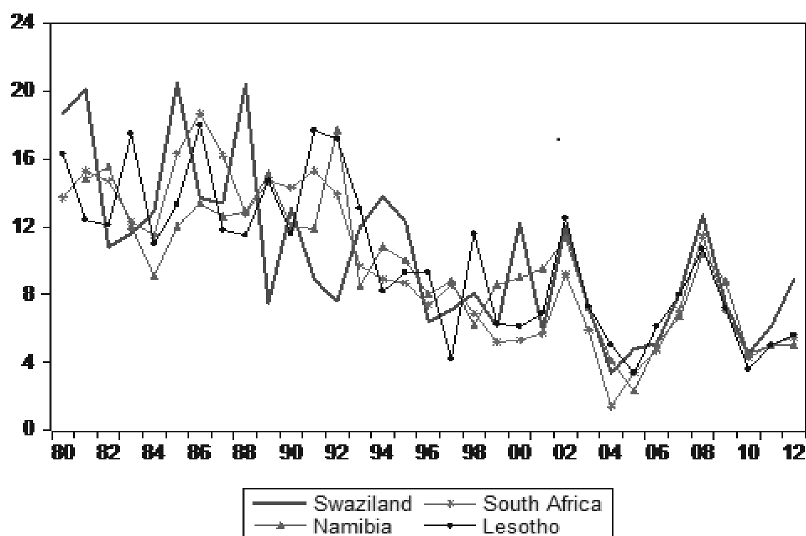


Figure 1. Error-Correction Model results simulations



Source: World Development indicators, 2011 and African Development Indicators 2012/2013

Figure 2. Inflation in the CMA

In the literature on OCA trade integration is one of the key criteria used to determine if countries are suitable candidates for a currency union. This is because as trade integration intensifies business cycles tend to be more synchronised. However, Frankel and Rose (1996a) point out that from a theoretical point of view, as trade intensifies among countries; it could lead to either synchronous or asynchronous business cycles. This is because countries could become more specialised in their production, leading to idiosyncratic cycles as noted by, among others, Eichengreen (1992) and Krugman (1993). On the other hand, business cycles could become more synchronised if intra-industry trade intensifies, demand shocks preponderate, and when countries face common shocks.

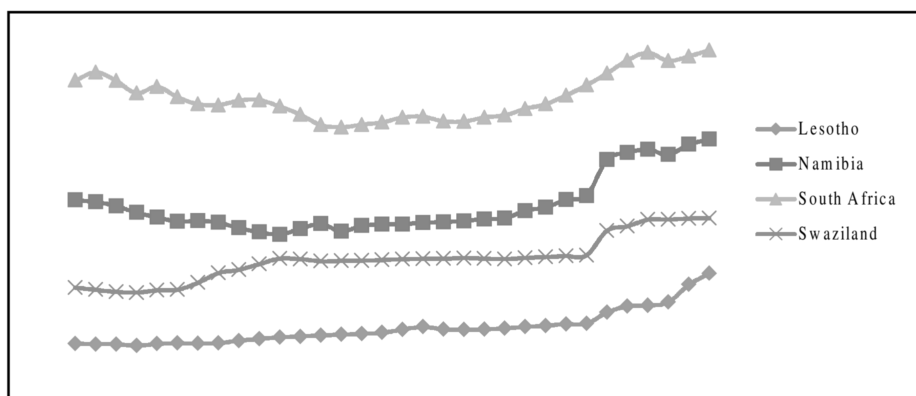
Table 5. CMA Direction of trade, 2011

Trade direction	Lesotho	Namibia	South Africa	Swaziland
Exports to:				
South Africa	16.6	21.4		58.2
Europe	26.4	20.4	11.5	1.1
United States	55.1	7.8	8.9	1.4
Rest of world	1.9	50.4	79.6	39.0
Exports/GDP*	46.8	44.7	29.3	57.5
Imports from:				
South Africa	73.0	76.1		87.0
Europe		7.4	8.7	1.2
United States		1.3	6.4	1.7
Rest of world	27.0	15.2	84.9	10.1
Imports/GDP*	105.9	52.4	29.9	68.3

Source: African Statistical Yearbook, 2013

From table 5, it emerges that the smaller members are more open, especially Lesotho and Swaziland, judging from the exports and imports to GDP ratios. They are also highly dependent on imports from South Africa, which account for over 80% of total imports. For Lesotho and Namibia, most of their exports are destined for the US, about 80%; and Europe about 50%. Swaziland on the other hand, exports over 68% to South Africa which is much higher compared to what the other smaller members export to South Africa. South Africa on the other hand is engaged in trade with countries outside the CMA. According to Grandes (2003), intra-industry trade does not seem to have intensified in the area. Hence, member countries are likely to face asymmetric shocks leading to divergences in business cycles.

Figure 3 plots GDP per capita for countries in the CMA. It depicts the extent to which income gaps have fallen over the years among members.



Source: World Development indicators, 2011; and African Development indicators 2012/2013

Figure 3. GDP per capita for CMA countries (in thousands constant 2000 US$)

The graph shows that there has been some convergence within these countries in the last two decades as evidenced by a slight narrowing of income dispersions, σ-convergence. This supports the conclusion made by Masson and Pattillo (2004), Jefferis (2007), and Wang *et al.* (2007), that the CMA forms a core convergence club or group. From figure 3, the gap in per capita incomes between South Africa, the richest member, and the poorest country in per capita terms, Lesotho, has continued to decrease over the years. From the late nineties, Swaziland has been faced with a serious slowdown in economic activity while growth in South Africa has been robust. Should this pattern continue, per capita income dispersions are likely to grow larger.

β-Convergence Model in the CMA

In this subsection I measure the extent to which the smaller countries in the CMA catch up with the dominant partner, South Africa. For β-convergence to occur, the country lagging behind initially must catch up with the per capita income of the larger country. If convergence occurs, then countries are better candidates for a monetary union. I measure β-convergence by simulating a model based on Kocenda *et al.* (2006) specified in eq. (4), which yields the results in table 6 below:

Table 6. β-convergence results

Parameters	Lesotho	Namibia	Swaziland
δ	-3.26	-1.30	-3.13
	(0.05)	(0.04)	(0.03)
α	0.04	0.01	0.02
	(0.003)	(0.002)	(0.002)
R_2	0.88	0.67	0.94
Residua(-1)			0.99
			(0.07)

Note: Standard errors are in parenthesis. The results for Swaziland were corrected for serial correlation.

For all three countries, the initial deviation shows that they are all lagging behind South Africa. This is shown by the statistically significant and negative δ coefficients. The trend coefficient α is positive and statistically significant for all three countries. This shows that over time the smaller countries catch-up with South Africa. Hence, this confirms that there is β-convergence in the CMA. All the three measures of convergence show that there is evidence of convergence among these countries.

Empirical Evidence on Asymmetry in the CMA: Correlation of Growth Rates

Correlation of growth rates

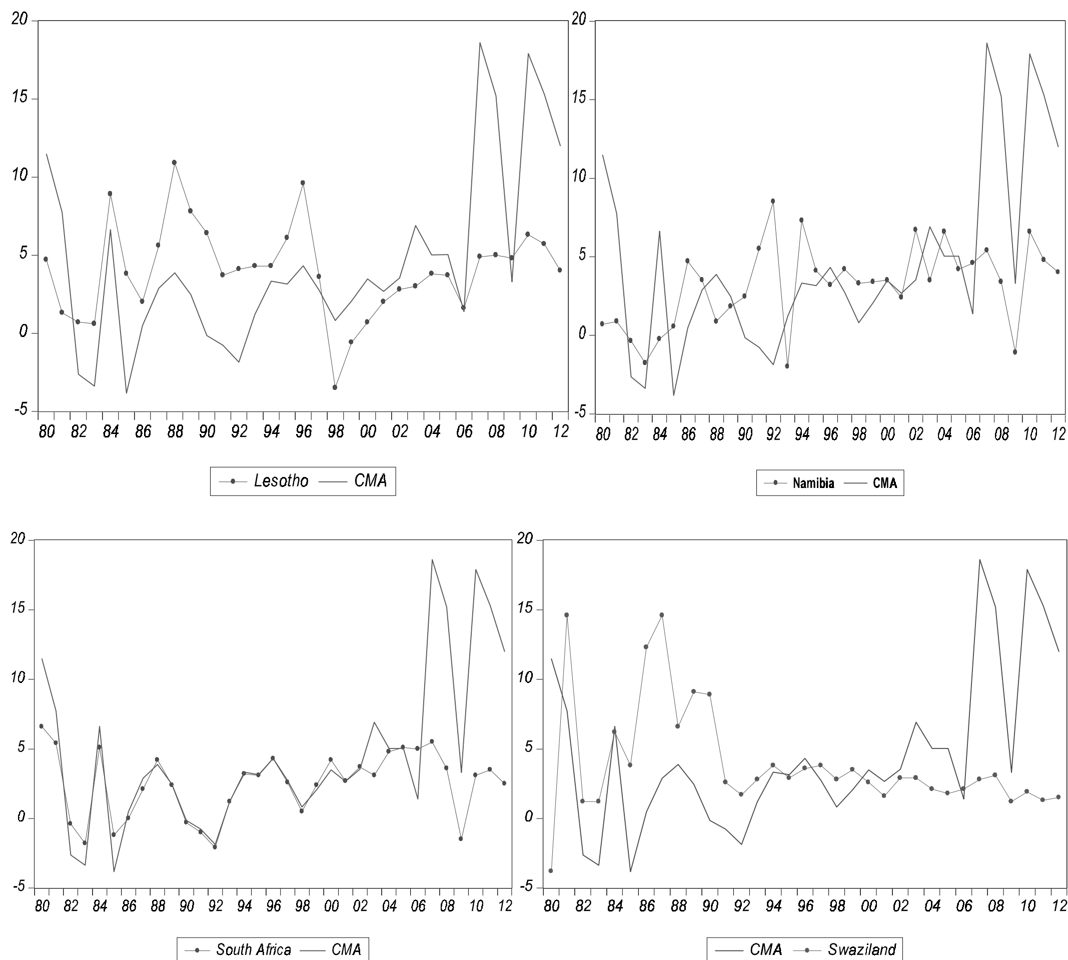
To measure asymmetry among CMA members I analyse the correlation of national annual real GDP growth with that of the whole area. Low or negative correlation is interpreted as an indication that member countries are not suitable candidates for a monetary union.

Table 7. Correlations of growth rates

Country	Correlation with CMA growth	Correlation with SA growth
Lesotho	0.25	0.24
Namibia	0.14	0.12
Swaziland	0.004	0.004
South Africa	0.99	-

Table 7 shows that the correlation between South Africa's growth and that of the whole area is higher, very close to one, which is to be expected given that South Africa contributes approximately 90% of GDP for the whole area. Lesotho has the second highest correlation followed by Namibia. However, the correlation for Swaziland is extremely low at 0.004. These differences could possibly reflect differences in economic and industrial structures. They also indicate that CMA members are likely to face asymmetric shocks. The correlations of growth rates between the smaller members and South Africa are not significantly different from that with the whole area for Lesotho and Namibia. For Swaziland the correlation of growth rates with that of South Africa is actually negative. It is likely that this is due to the fact that Swaziland exports above 60% to South Africa. The nature of the goods exported is likely to fall as growth rises in South Africa.

Plots of the growth rates, in figure 4, of each member country against that of the whole region confirm the correlations reported earlier. The data also shows the effects of the global crisis that started in 2007 as well as the fiscal crisis in Swaziland from 2011 due to fall in SACU receipts.



Source:World Development Indicators, 2011 and African Development indicators 2012/2013

Figure 4. GDP growth rates of individual countries and the CMA.

Composition of Exports

The composition of exports is used as another proxy of whether countries will face asymmetric shocks or not. From table 8, it is evident that all the countries have hardly diversified their export mix as they are all largely dependent on few primary goods. Such lack of diversity diminishes the ability to diversify negative terms of trade shocks away and is likely to lead to asymmetric terms of trade shocks. Debrun, *et al.*(2003) confirm that countries that specialize in a limited variety of goods and are therefore less diversified, as is the case in the CMA, are more likely to face large asymmetric shocks. Table 9 below presents the export products of the CMA member countries.

The differences in the composition of exports together with variations in world prices of these export commodities are likely to result in asymmetry in terms of trade shocks in the CMA. Evidently, prices of gold, platinum, and other minerals, for example, have surged since the

Table 8. Composition of exports in the CMA

Countries	Export Products
Lesotho	Beverages, spirits, vinegar, footwear gaiters and wool.
Namibia	Pearls, precious stones and metals, coins, and fish.
South Africa	Mineral fuels, mineral oils, vehicles, and iron and steel.
Swaziland	Essential oils, perfumery, cosmetics , sugar, sugar concentrates.

Source: SACU Merchandise Trade Statistics, 2011.

1990s, which means improving terms of trade for South Africa and Namibia. At the same time, prices of textiles have continued to plummet. This has resulted in weakened terms of trade for Lesotho because textiles account for a large amount of the country's exports. For Swaziland, sugar prices have fallen and preferential treatment in various markets has either been reduced or lifted, leading to deterioration in terms of trade.

The differences in the composition of exports are related to the differences in industrial structures in the CMA shown by the contribution of each sector to output. Differences are an indication that countries will be impacted differently by industry specific shocks. For example, a shock in the agricultural sector is likely to affect Lesotho and Swaziland more than it would the other countries. Table 9 shows that Lesotho and Swaziland are highly dependent on agriculture, a sector that is highly vulnerable to shocks, compared to South Africa and Namibia. South Africa and Namibia are highly dependent on services and industry which also contribute a lot to output for Lesotho and Swaziland.

Table 9. Structure of output by sectors (%) for CMA Countries, 2005.

Countries	Agriculture	Industry	Manufacturing	Services
Lesotho	8.6	31.9	12.8	59.5
Namibia	8.1	28.9	12.9	63.1
South Africa	2.5	29.2	12.8	68.3
Swaziland	7.2	45.9	42.4	46.9

Source: African Statistical Yearbook, 2013.

The low correlation of growth rates and the differences in composition of exports in the CMA indicate that business cycles in the area are likely to be asymmetric. This, according to OCA literature, implies that these countries would incur huge adjustment costs should they form a monetary union.

CONCLUSION AND RECOMMENDATIONS

Adopting a common currency by countries is perceived as a more staid and long-lasting commitment. This is because it prohibits member countries from engaging in competitive devaluations. It also encourages foreign direct investment as well as long-term relationships among members. Moreover, it also encourages political integration. As a result, trade, economic, and financial integration intensify, which results in synchronisation of business cycles. This tends to boost economic performance as evident in the Euro area.

This paper has confirmed that countries in the CMA have strong ties. Firstly, there is strong evidence of nominal convergence depicted by the behaviour of interest rates and inflation rates. This suggests that the financial sectors in the area are highly integrated and there is

harmonisation in setting interest rates. Secondly, there is a fall in dispersions in per capita income overtime. This suggests that the smaller countries in the area are catching up with the larger country, South Africa. By forming a fully-fledged monetary union, CMA countries are likely to derive more benefits associated with such groupings. These include a more stable macroeconomic environment; hence, high economic activity, low unemployment rates, and higher investment emanating from coordination and harmonisation of macroeconomic policy in the region.

Empirical evidence also shows that CMA countries are likely to face asymmetric shocks. This is supported by the low correlation between individual countries' growth rates and that of the entire area, with the exception of South Africa. Furthermore, these countries export different products, which suggest that they are likely to face dissimilar terms of trade shocks. Based on the OCA criteria, when countries are prone to asymmetric shocks they are not suitable candidates for a currency union because they would face high adjustment costs. However, the existence of asymmetric adjustments among member countries does not provide sufficient reason against a move towards a monetary union. Instead, adjustment mechanisms must be put in place to reduce costs for individual countries should they be subjected to asymmetric shocks. Furthermore, in the OCA literature it is argued that the OCA criteria are endogenous and dynamic. This means that the net benefits of a monetary union are expected to increase after joining the union because trade integration and business cycle correlations are enhanced.

A monetary union in the CMA is likely to further enhance economic integration and induce changes in economic, financial, legal, and institutional structures in the CMA. Such a move in the area could facilitate much needed economic structural reform in the smaller members, especially Lesotho and Swaziland whose economies continue to falter. Given the foregoing, then the CMA is better off moving ahead to form a fully-fledged monetary union. There is a need to implement the whole process gradually given the differences in economic structure as well as the need to create other adjustment mechanisms to help any economy that could be in distress. Such a move can also be seen as a stepping stone for the creation of a SADC wide monetary union; hence, an Africa-wide monetary union as envisaged by the African Union.

REFERENCES

Adams, P. D. (2005). *Optimal Currency Areas: Theory and Evidence for an African Single Currency.* University of Manchester. Manchester.

African Development Bank (2006). Annual report for 2005/2006. African Development Bank. Abidjan, Cote d'lvoire.

African Development Bank African Statistical Yearbook (2013). African Development Bank. Abidjan, Cote d'lvoire.

Anthony, M.L. and Hallett, A. H. (2000). Is the Case of Economic and Monetary Union in the Caribbean Realistic? Blackwell Publishers Ltd., Oxford.

Aron, J. and Muellbauer, J. (2006). Review of Monetary Policy in South Africa since 1994. Centre for Study of African Economies. Working Paper Series/2006-07.

Bean, C. R. (1992). Economic and Monetary Union in Europe. *Journal of Economic Perspectives*, 6:31-52.

Beetsma, R. M. W. J. and Bovenberg, A. L. (2001). The Optimality of a Monetary Union without a Fiscal Union. *Journal of Money, Credit and Banking*, 33:179-204.

Bordo, M. and Jonung, L. (1999). The Future of EMU: What does the History of Monetary Unions Tell Us? National Bureau of Economic Research, Working Paper No. 7365.

Calderon C., A. Chong and Stein, E (2003). Trade Intensity and Business Cycle Synchronization: Are Developing Countries any Different? Central Bank of Chile, Inter-American Development Bank.

Central Bank (2004, 2005, and 2006). Annual reports for 2003/2004, 2004/2005 and 2005/2006. Central Bank of Swaziland, Mbabane, Swaziland.

Central Bank (2004, 2005 and 2006). Quarterly Reports for 2003/2004, 2004/2005 and 2005/2006. Central Bank of Swaziland, Mbabane, Swaziland.

Cheung Y. and Yuen, J. (2004). The Suitability of a Greater China Currency Union. Hong Kong Institute for Monetary Research, Working Paper No. 12/2004.

Corsetti, G., P. Pesenti and Blinder A. S. (1999). Stability, Asymmetry, and Discontinuity: The Launch of European Monetary Union. Brookings Papers on Economic Activity. 1999:259-372.

Debrun, X., Masson, P. and Pattilo, C. (2003). West African Currency unions: Rationale and Sustainability. Institute for Economic Research, 49:381-413.

Dellas, H. and Tavlas, G. (2005). Wage Rigidity and Monetary Union. *The Economic Journal,* 115:907-927.

Demyanyk, Y. and Volosovych, V. (2005). Macroeconomic Asymmetry in the European Union: The Difference Between New and Old Members, Centre for Economic Policy Research, Discussion Paper No. 4847.

Eichengreen, B. and Bayoumi, T. (1996). Ever Closer to Heaven? An Optimum-Currency-Area Index for European Countries. Centre for International and Development Economics Research Paper C96’078.

Eichengreen, B. (1992). Is Europe an Optimum Currency Area? National Bureau of Economic Research Working Paper No. 3579.

Frankel, J. and Rose, A. (1996a). The endogeneity of the optimum currency area criteria. *Economic Journal*, 108:1009-25.

Frankel, J. and Rose, A. (1996b). Economic Structure and the Decision to Adopt a Common Currency, Swedish Government Commission on EMU.

Feldstein, M. (2005). The Euro and the Stability Pact, National Bureau of Economic Research Working Paper No.11249.

Grandes, M. (2003). Macroeconomic Convergence in Southern Africa: The Rand Zone Experience, OECD Development Centre, Working Paper No.231.

Hughes-Hallet, and Weymark, D. N. (2001). The Cost of Heterogeneity in a Monetary Union, Vanderbilt University Working Paper No. 01-W28.

International Monetary Fund (1979-2007) International Financial Statistics 1979-2007. International Monetary Fund, Washington D. C.

Jefferis, K. R. (2007). The Process of Monetary Integration in the SADC Region. *Journal of Southern African Studies,* 33:No.1.

Kalemli-Ozcan, S., B.E. Sorensen and O. Yosha (2004). "Economic Integration, Industrial Specialization, and the Asymmetry of Macroeconomic Fluctuations", Journal of International Economics.

Kenen, P. (1969). The Theory of Optimum Currency Areas: An Eclectic View. *In*: Mundell, R and Swoboda, A. (Eds.). Monetary Problems in the International Economy, University of Chicago Press, Chicago.

Kocenda, E., A. M. Kutan, and Yigit T. M. (2006). Pilgrims to the Eurozone: How far, how Fast. *Economic Systems*, 30: 311-327.

Krugman, P. (1993). What Do We Need to Know about the International Monetary System? Essays in International Finance, No.190.

Maruping, M. (2005). Challenges for Regional Integration in Sub-Saharan Africa: Macroeconomic Convergence and Monetary Coordination. Africa in the World Economy-The National Regional and International Challenges, Fondad, The Hague.

Masson, P. and Pattillo, C. (2004). The Monetary Geography of Africa. Brookings Institution Press, Washington D. C., USA.

Mckinnon, R. I. (1963). Optimum Currency Areas. *American Economic Review*, 53:717-725.

Mihov, I. (2001) Monetary Policy Implementation and Transmission in the European Monetary Union, INSEAD and CEPR.

Mundell, R., (1961). A Theory of Optimum Currency Areas. *American Economic Review.* 51:657-665.

Nielsen, H., E. Uanguta and Ikhide S. (2005). Financial Integration in the Common Monetary Area. *South African Journal of Economics*, 73:710-721.

SACU (2011). SACU Merchandise Trade Statistics. SACU, Namibia.

Tavlas, G. S. (2007). The Benefits and Costs of Monetary Union in Southern Africa: A Critical Survey of the Literature. South African Reserve Bank Research Department Working Paper No. WP/07/04.

Ternreyo, S. and Barro, R. (2003). Economic Effects of Currency Unions. National Bureau of Economic Research Working Paper 9432.

United Nations Economic Commission for Africa (2004). Assessing Regional Integration in Africa. United Nations Economic Commission for Africa, Ethiopia. Addis Ababa.

Wang, J., Masha, I, Shirono, K. and Harris, L. (2007). The Common Monetary Area in Southern Africa: Shocks, Adjustment, and Policy Challenges. IMF Working Paper, 07/158.

World Bank (2007). World Development Indicators, 2007. Washington DC.

World Bank (2007). World Economic Outlook, 2007. Washington DC.

World Bank (2012/2013). African Development Indicators, 2012/2013. Washington DC.

THE ROLE OF FAMILY MEMBERS IN HIV-POSITIVE STATUS DISCLOSURE AND ANTIRETROVIRAL THERAPY UPTAKE IN SWAZILAND

Agostino M. Zamberia[1] and Lungile P. Mabundza[2]

ABSTRACT

This paper examines the role of family members in HIV-positive status disclosure and antiretroviral therapy (ART) uptake by people living with HIV (PLHIV) in Swaziland. The analysis is premised upon the view that the family typically plays a critical role with regard to social, economic, psychological and emotional support for family members following disclosure of their HIV-positive status and entry into therapy. The paper examines this assumption by noting that AIDS presents a challenge to the notions of care and support associated with other ailments and socio-economic needs, making disclosure of HIV status daunting for PLHIV. Additionally, the lack of adequate knowledge pertaining to HIV infection may negatively affect the family members' willingness and capacity to care for their relatives undergoing antiretroviral therapy. Using evidence from in-depth interviews and focus group discussions (FGDs) with people living with HIV (PLHIV), the paper explores the challenges faced by PLHIV within the family context with regard to disclosing their HIV status and receiving the necessary support for successful antiretroviral therapy uptake and adherence to treatment. The paper concludes that, in order to address the challenges of providing support for PLHIV undergoing ART in their families, there is need for agencies involved in HIV prevention and care activities to develop comprehensive sensitisation strategies on the nature of HIV and AIDS to promote disclosure and complement the care and support efforts of these agencies.

Keywords: Antiretroviral therapy, focus group discussions, social support, status disclosure, stigmatisation

INTRODUCTION

The roll-out of antiretroviral therapy (ART) in resource limited settings has prompted governments, non-state agencies, communities, and families to get involved in the care and support functions for people living with HIV and AIDS (PLHIV) to ensure the success of ART programmes and the improvement of the quality of life of people living with HIV. Although coverage has steadily improved with more and more patients accessing antiretroviral medication, a number of challenges have made it increasingly difficult for people living with HIV to disclose their status, access medication and adhere to their medication regimens. Many of these challenges emanate from lack of resources to get the medication, and the stigma of being HIV positive. These challenges bring to the fore the question of the role the family should play in the care and support for PLHIV. In many sub-Saharan countries, the family plays a

[1] *Agostino M. Zamberia is Associate Professor and Dean of the Faculty of Social Science, University of Swaziland, Private Bag 4, Kwaluseni M201, Swaziland. Email: zamberia@uniswa.sz.*

[2] *Lungile P. Mabundza is a Lecturer in the Department of Sociology, University of Swaziland, Private Bag 4, Kwaluseni M201, Swaziland. Email: mabundza@uniswa.sz.*

critical part in supporting family members in adversity. HIV and AIDS, however, present a unique set of challenges which shake the core functions of the family.

The AIDS epidemic presents a challenge to the notions of care and support associated with other ailments and socio-economic needs, making disclosure of HIV status daunting for PLHIV.More specifically, the issue of stigmatisation and lack of resources limit the options available for family members to properly and adequately care for patients. These challenges contribute a great deal to weakening the bonds that hold together families and hence lead to the apparent neglect of people who need care. Of note is the fact that these challenges come at a time when the African family structure has been severely altered by modernisation, urbanisation, and a host of socio-economic problems that make it difficult to fulfil its core functions. Extended families have lost their viability, giving way to nuclear families that are also unable to adequately withstand the threats to the family brought about by the declining economic fortunes of communities and nations. These changes, and consequent challenges, constitute the context within which ART programmes have been rolled out.

This paper examines the issue of HIV-positive status disclosure within the family context and the nature of the roles of family members with respect to care and support of PLHIV needed during ART. Several studies have examined how stigmatisation adversely affects interpersonal relationships, and constitutes a barrier to HIV testing and HIV-positive status disclosure (see, for instance, Arnold *et al*., 2008; Körner, 2007; Zamberia, 2006; Zamberia, 2007). This paper provides further exploration of this issue, focusing on how family members confront the challenges posed by stigmatisation in providing care and support to people living with HIV and AIDS. The changes in the structure and functions of the family constitute the backdrop upon which this analysis explores the implications of social changes affecting the family for the care and support for PLHIV and, ultimately, for the quality of life of those living with the virus.

The analysis examines the nature of care and support provided to PLHIV by immediate family members, and the effects of this on those individuals. The key questions explored include: How does HIV-positive status disclosure affect relationships among family members? How does the family members' sense of belonging to both their families and communities influence their response to disclosure and to the needs of the HIV-positive members? On the whole, how do the initial reactions of family members and the nature of the subsequent care and support provided impact the lives of those living with HIV? The overall goal of the analysis is to provide in-depth understanding of how the changed family context influences the manner in which HIV-positive status disclosure is received by family members and how this reception ultimately shapes the way PLHIV access therapy within their families. The paper further intends to provide suggestions on how agencies involved in the care and support for PLHIV can bolster the families' capacity to care for the members living with the virus.

This paper precludes discussion of systemic challenges to scaling up ARV access in developing countries which have been the subject of a number of recent studies (see, for instance, Schneider *et al.,* 2006). Previous studies have examined diverse aspects of ART programmes in lower income countries including their administrative structures, physical infrastructure, and models of ART delivery (Wools-Kaloustian, 2006). Some other studies have examined the challenges inhibiting the progression of antiretroviral therapy rollout (Ojikutu, *et al.,* 2008), while others have explored the broader impact of rapid scale-up of HIV programmes on fragile health systems (Rabkin, *et al.,* 2009). This analysis focuses on the social and economic context of HIV status disclosure and subsequent treatment, elucidating how the context either impedes or facilitates disclosure and access to ART services. The paper thus

examines how a confluence of a number of social and economic factors constitutes barriers to HIV-positive status disclosure within the family. This focus is premised upon the view that, beyond access challenges relating to infrastructure and human resource constraints, the deficiencies in health care delivery systems are confounded by the social and economic circumstances of the communities within which ART rollout programmes are implemented that limit the accessibility of these services by the poor. An exploration of contextual elements will also include interpersonal dynamics within the family that contribute to PLHIV's inability to access health care services.

The goal of the analysis is to explain how the interplay between several factors within the family context frustrates the possibilities of disclosure and ensuring access to ART. The analysis explores the issues of disclosure, care and support within the family using accounts of PLHIV to comprehend the social context of ART. Scholars have argued that disclosure is necessary for support services such as medical information and care, social services, and emotional support from family and friends to be garnered (see, for instance, Kimberly *et al.,* 1995). The sections that follow begin with a brief review of previous research on HIV-positive status and antiretroviral therapy programmes and treatment issues in resource-limited settings. The study's methodology is then discussed, and the specific data gathering techniques are described. The findings are presented, followed by their discussion, and finally a concluding discussion.

THE FAMILY AND ANTIRETROVIRAL THERAPY IN RESOURCE-LIMITED SETTINGS: A BRIEF LITERATURE REVIEW

Nischal *et al.* (2005) argues that antiretroviral therapy (ART) has transformed HIV infection into a treatable chronic condition for a significant proportion of people living with HIV and AIDS. They further state that antiretroviral drugs delay progression of HIV disease and improve the quality of life of the infected, noting that with the availability of generic ART agents at a much lower cost, there has been an increased use of ART in developing countries. However, despite the availability of ART, many people in poor countries may not be able to easily access treatment. Garnett *et al.* (2002) argue that, in developing countries perhaps the most important task is to create an effective and durable infrastructure for both treatment delivery and counselling. This is imperative because patients who fail to adhere to the complex and sometimes difficult antiretroviral medication regimens cannot benefit fully from the treatment (Davies *et al.*, 2006), and poor adherence could lead to increased mortality and development of drug-resistant HIV strains (Miller *et al.,* 2003; Turner, 2002).

Stigma has been identified as a serious challenge to successful implementation of ART programmes as some HIV-positive people may fear to disclose their HIV status. Although a number of studies have documented a tendency among HIV-positive individuals to keep their status secret, the beneficial effect of social support on psychological distress has also been consistently demonstrated among HIV-positive women (Clark *et al.,* 1995) and gay men (Leserman, *et al.,* 1997). Klitzman *et al.* (2004) note how refusing to disclose HIV status can jeopardize patient compliance with prescribed regimens if patients strive to conceal their medication. In a study of the effects of HIV-related stigma on an early sample of patients receiving antiretroviral therapy in Botswana, Wolfe *et al.* (2006) found that 94 % of patients reported keeping their HIV status secret from their community, while 69% withheld this information even from their family. Importantly, after initiating treatment, 15% of patients

directly identified stigma as a factor that made it difficult for them to take ART regularly. Mshana *et al.* (2006) argue that stigma could interfere with sustained participation at all stages of the treatment continuum – from discouraging VCT and sharing results, to causing patients to hide their treatment – which could prove difficult over time and threaten adherence. They therefore assert that stigma was the most formidable barrier to accessing ART.

In a review article on improving adherence to antiretroviral therapy, Nischal *et al.* (2005) point out some of the factors which must be considered before starting ART. These are motivation to begin therapy, ability to adhere to therapy, lifestyle pattern, financial support, pros and cons of starting the therapy, and family support. They point out that family support is essential because expensive regimens and social stigma make psychological and financial support by the family crucial.

The greatest challenge to proper implementation of ART programmes is the poverty in many developing countries that makes it difficult for HIV-positive people to correctly and consistently adhere to the medication. Chinai (2003) notes that many patients who have tested HIV-positive in Mumbai are consuming antiretrovirals (ARVs) in fits and starts because of their unstable financial circumstances. He points out that due to lack of reliable counselling patients are unaware that once started, ARV treatment has to be lifelong and without a break. According to IRIN (2007), nearly half of Kenyans in need of life-prolonging antiretroviral drugs are now accessing them. However, a growing concern for healthcare workers is ensuring that these people stick to the medication. Two to three of every 10 of the patients attended to at Nairobi's Special Treatment Centre for resistant sexually transmitted infections (according to a nurse and counsellor at the Centre) defaulted on their medication (IRIN, 2007). The counsellor further pointed out that the new lease on life that ARVs give patients tempts some of them back into risky sexual behaviour and substance abuse, putting their drug regimens at risk and increasing their chances of re-infection.

Ferguson *et al.* (2002) argue that achieving adequate adherence to ARV regimens is a remarkably difficult task. They note that the regimens are often complicated, including several different medications with varying dosing schedules, dietary restrictions and adverse effects. Ferguson *et al.* considered a number of perceived barriers relating to, inter alia, knowledge and attitudes about the medicines (e.g. not understanding how to take medicines), social support (e.g. not wanting to be seen taking medications, feeling uncomfortable for people to know that the medicines are for HIV/AIDS, lack of support from family and friends), qualities of medicine (e.g. side effects, ceasing medication when feeling better), schedule, and memory. They confirmed that the level of adherence was associated with perceived barriers. Predictors of inadequate adherence include lack of trust between clinician and patient and lack of reliable access to primary medical care or medication while predictors of optimal adherence include availability of emotional and practical life supports, and feeling comfortable taking medications in front of others (Kress, 2004).

Apart from the actual medication and specialised treatment and care, many of the other critical needs of PLHIV depend largely on family resources. It is in this respect that such needs as food and transport to receive medication are negatively impacted by poverty and inadequate family resources. According to WFP (2004), for people living with HIV, food and nutritional interventions can have positive benefits both during the years before they progress to symptomatic AIDS, and when they enter advanced stages of AIDS and require antiretroviral treatment. Moreover, good nutrition not only helps to extend survival time and improve the quality of life, it also strengthens the body's ability to fight opportunistic infections, thus

allowing HIV-positive individuals to stay productive longer, and helping to keep families together and stabilise communities (WFP, 2004). Nischal *et al.* (2005) have pointed out that one of the interventions at the medication/treatment level is to modify the dietary pattern to suit the antiretroviral agents. We should however note that this is problematic in resource-poor nations without adequate food resources to feed their people. A report issued by the International Treatment Preparedness Coalition notes lack of nutrition as a major obstacle in the war against HIV and AIDS in Kenya (Mulama, 2007). In some cases, patients sell their ARVs to buy food (Mulama, 2007) ; other patients who live long distances from ARV sites and who are too weak to walk there – also too poor to afford transport – simply skip treatment, using what money they have to buy food (Mulama, 2007).

In a study of adherence to antiretroviral therapy in a home-based AIDS care programme in rural Uganda, Weidle *et al.* (2006) point out that poverty and limited health services in rural Africa present barriers to adherence to antiretroviral therapy. They point out that patients have extreme difficulty in accessing transportation to health centres in rural Africa. They argue that such barriers call for innovative options other than facility-based methods for delivery and monitoring of such therapy. Central to their argument is the view that barriers vary in different settings, and lessons from more developed countries need to be adapted to resource-limited settings. Weidle *et al.* found that the comprehensive home-based model of AIDS care used in rural Uganda removed those external constraints to retention in care and adherence by providing free antiretroviral therapy with home delivery. They point out that the comprehensive approach to supporting adherence in the home-based AIDS care programme, which included medicine companions, more extensive counselling, development of personal adherence plans, and weekly visits by field officers, successfully addressed barriers to adherence and achieved an excellent virological response.

SOCIAL CHANGE, HIV/AIDS, AND THE SWAZI FAMILY

According to the UNDP, urbanisation and modern development processes have precipitated social change which has given rise to non-traditional families in Swaziland (UNDP, 2008). This is evidenced in the evolution of the family structure towards more nuclear family forms characterised by single parent families, grandparent families, and child-headed families. The latter form has been mainly attributed to the effects of HIV and AIDS (UNDP, 2008). These changes, seen especially in the growing prominence of urban and modern lifestyles, have triggered further changes within the family structures, particularly with respect to the character of social support networks available to family members in need. Thus, families have less contact with each other, reducing the safety nets that existed in traditional society-consequently making it difficult for family members to get assistance in times of need (UNDP, 2008). In her examination of the impact of urbanisation on the family in Swaziland, Khumalo (2006) argues that urbanisation has influenced family formation, led to the shrinking or contracting of family size, and has largely impacted on security and welfare support for dependents, particularly children and the elderly. She states that the HIV and AIDs epidemic has led to the disintegration of family life and worsened the changing demographic situation within the family in both rural and urban areas, depleting the young and energetic adult population who are the breadwinners. Female-headed, single parent families are increasing and becoming predominant, and they are the worst affected by poverty (Khumalo, 2006; Zamberia and Mabundza, 2006). Nevertheless, despite the unravelling of the traditional safety

nets such as the extended familyhome-based care, which provides family resources such as materials needed by caregivers to assist sick people, continues to compensate for the inadequacies of the public health system (UNDP, 2008).

The foregoing issues highlight the context within which PLHIV receive HIV and AIDS related services such as HIV testing and antiretroviral therapy. The family is very central in this regard and the family members can play an essential role in ART uptake and HIV-positive status disclosure. This is particularly vital given the current emphasis on home-based care which, by its nature, implies an increasingly important role for family members in the care of those living with HIV and AIDS. However, with growing poverty and individualism, some PLHIV encounter enormous challenges in relation to HIV status disclosure and uptake of antiretroviral therapy. It is these challenges and promises that this paper seeks to explore using qualitative data from Swaziland.

METHODOLOGY

This analysis is part of a broader qualitative research project on HIV-related stigma and social support for PLHIV in Swaziland. Using a purposive sample of informants and participants, in-depth interviews and focus group discussions (FGDs) were conducted to explore the experiences of PLHIV in Swaziland with regard to HIV-related stigma and access to health care. The nature of social support available was also explored. Thirty-seven (37) in-depth interviews with PLHIV and five (5) FGDs were conducted between September 2006 and February 2007. Although the interviews and FGDs were collected during this period, the data still constitutes a rich source of material for the analysis of the issues relating to stigma and ART in the country. Besides, HIV-related stigma has continued to be a major obstacle to effective provision of care and support for PLHIV. According to UNAIDS (2013), stigma and discrimination persist within many health care facilities, with people living with HIV experiencing judgemental attitudes from providers and refusal of services.

In-depth interviews were conducted with twenty-five (25) women and twelve (12) men who were HIV-positive and on antiretroviral therapy. The sample included two programme officers (a man and a woman) from the Swaziland Network of People Living with HIV and AIDS (SWANNEPHA) and the Swaziland AIDS Support Organisation (SASO), as well as three female caregivers who were trained rural health motivators (RHMs). The interviews were carried out within the offices of SWANNEPHA in Mbabane, the capital city, or in the homes of the interviewees or the home of the rural health motivator.

All FGD participants were affiliated with PLHIV support groups, and were recruited through World Vision Swaziland and SWANNEPHA as the two organizations are directly involved in working with PLHIV support groups in the country. The interviews and FGDs were conducted in English and siSwati and, with the permission of the participants, were audio-taped and transcribed verbatim throughout the period of data collection. After transcription, the siSwati interviews were translated into English. The main issues covered in the interviews and FGDs included HIV-related stigma and discrimination (and associated HIV status disclosure), available care and support structures for PLHIV, and experiences and coping strategies employed by PLHIV. The length of the interview sessions varied from 40 minutes to one hour.

Consent was obtained from the interviewees and FGD participants prior to the start of the interviews and discussions. To ensure confidentiality and privacy of the participants, no

information pertaining to the participants' identities was requested by the researchers. The Research Board of the University of Swaziland gave ethical approval for the study.

The data were analysed qualitatively through reading the interview and FGD transcripts repeatedly, followed by identification of themes, categories and patterns emerging from the data for analysis and interpretation. The analysis presented in this paper focuses on HIV-positive status disclosure and family support relating to ART.

FINDINGS

This section focuses on the social context of serostatus disclosure and antiretroviral therapy (ART) with reference to the family as the locus of communication about HIV-infection and care for PLHIV. The section highlights the complexity of HIV serostatus disclosure to family members, using PLHIV's experiences with regard to the challenges and fears associated with disclosing one's HIV status, and then examines how communication among family members relates to access to ARVs and adherence to treatment regimens.

The family and HIV-positive status disclosure

The fear of stigmatisation has been noted to be one of the greatest barriers to HIV-positive status disclosure (see Arnold *et al*., 2008; Körner, 2007). With regard to the family setting, people living with HIV fear the unknown reaction of family members, which they fear could lead to changed interpersonal relationships, denial of care, and discrimination by other family members.

Many PLHIV assess the possibility of disclosure by considering how they would be viewed by members of their families because these are the ones who ultimately have to care for them. A negative evaluation of the outcome of the disclosure leads to failure to disclose. As a male interviewee put it:

> The fear of being rejected and ostracised; the fear of being viewed differently from other members of my family prevented me from telling anyone. There wasn't much information on the disease and so I knew my family would not be in a good position to care for me appropriately. Above all I was afraid of being discriminated against and that would kill me faster than anything else could. The fear of bringing shame and disappointment to my family was another aspect that I couldn't handle and so I delayed disclosure.

This delay in disclosure implies that PLHIV cannot take advantage of available care and the sympathy and support of close family members.

Although in a number of cases PLHIV elicited a positive reaction from family members after disclosing their HIV status, there were cases where such disclosure was negatively received, adversely affecting the relationships among family members. In such cases, long-standing relationships and visitations between family members are severed. A female FGD participant from Mhlumeni stated:

> My big brother took things to the extreme. He couldn't stand to be where I am. He was no longer coming to where I am staying. Normally he would come and greet us whenever he was passing by my home, but that changed when he heard about my status. He would pass my gate like a stranger and pretend he didn't know us.

The FGD participant further gave an account that indicated that family members will portray non-discriminatory attitudes and behaviour when they interact with other community

members, but then display discriminatory behaviour toward PLHIV in their own families:

> My mother passed on and so I'm left with my siblings. The sad thing is that my sisters are the ones who are discriminating against me more than the brothers. My sister does not come to where I am. But they try to pretend as if things are okay when we are in funerals or other community gatherings. As soon as we are alone they do not want anything to do with me. They are the culprits who do not check on me when I am sick. I tell you they are ashamed to be associated with me.

The concern about the family getting to know about one's status is also echoed in the following statement by another male interviewee:

> There were two people who wanted to do a documentary while we were in Cape Town but I refused because I thought they might sell it to news people and my family would find out about my status. I realise now that I missed a great opportunity of my life.

Of note in this informant's account is his realisation of the opportunities that PLHIV miss when they do not disclose. These opportunities relate to getting accepted and the psychological relief that goes with knowing that one is not being viewed negatively despite being HIV- positive. Disclosure can, therefore, lead to acceptance and care from family members. The positive role of family members in this regard is evident in the reaction of some of PLHIV's siblings following disclosure. A male interviewee stated:

> So after disclosing to my sister it was like a load had been offloaded from my shoulders. Whenever we met she would assure me of her love and support as her big brother.

Further evidence of this support and understanding is shown in the following account from another male interviewee:

> My sister told me that I could tell mum because she was now born again and could handle this matter much better. Whenever I was about to tell her something would stop me. One day my sister called me and told me that mum already knows about my HIV status. Instead of being angry I got so excited I couldn't wait to get home. When I entered the door I wanted to see her reaction but she hugged me; something she had never done before. I cried because her action was telling me that she not only understands but that she loved me and was willing to support me all the way.

This demonstrates how disclosure to one member of the family can also facilitate disclosure to other members, and further engagement among family members regarding how to deal with the infection.

Sometimes the fear of the negative consequences of disclosure is not related to the feeling that others may react negatively towards the HIV-positive individual. There are cases when PLHIV themselves feel that their disclosure could negatively affect those close to them. Fear of disclosing is therefore also related to the fear of hurting other family members. A male interviewee said:

> One of my aunties asked me if I had given thought of what my disclosure will do to my grandmother and I told her that I hadn't. She told me that if I disclosed my status to the whole world it would kill her. This dampened my spirit and I had to go back to the drawing board. I had to delay my coming out and this was killing me.

The accounts cited above all indicate the challenges that HIV-positive individuals face in disclosing their HIV status. The accounts also show how family members have to deal with the complexity of dealing with an HIV-positive member and at the same time overcome their fear of infection and the potential for stigmatisation of the whole family.

The role of family members in antiretroviral therapy

The role of family members in helping meet the needs of PLHIV is also adversely affected by the weakening of family ties among relatives and siblings. Evidence from the findings suggests that with urbanisation and the consequent breakdown of closer ties between family members, PLHIV who return to their rural homes from the urban areas after falling ill with HIV are not accorded the support they need from their family members because they are viewed as having abandoned the family. A female interviewee observed:

> Many of us have left the rural areas to come and work in the urban areas. Unfortunately, once you get the virus you are forced to go back home where you hope your family will care and support you. When you get home the situation is the opposite of what you were expecting and suddenly you feel they are discriminating against you.

Some family members interpret one's residency in urban areas as abandoning one's duty of providing support to the rest of them when all is well. They, therefore, do not feel that they have an obligation to care for an HIV-positive family member who was once resident in an urban area.

Even the notion of sharing that used to be the norm in the family has been affected by the AIDS epidemic- as a female FGD participant put it:

> Most of the family members do not want anything to do with me. For now it's only my kids who do not mind my food, mostly because they are still too young to understand the disease and its magnitude.

This account demonstrates that, in the minds of PLHIV, there is a feeling that even their own children would discriminate them if they understood the nature of the virus and the prevailing beliefs about it.

Overt discriminatory actions are evident in some families whereby family members start interacting differently with PLHIV once they learn of their HIV-positive status. A male interviewee stated:

> Discrimination is due to fear. My food is cooked separately, they do not want to touch me, and I am given my own room and no one will sleep next to me. In some families you find that siblings wear each other's clothes, but the minute it is discovered that I am HIV positive no one will agree to share anything with the victim.

Access to antiretroviral therapy is made much easier in situations where PLHIV are accepted and supported by their family members. In this regard, the support from members of the family facilitates medication and care. A female interviewee observed:

> I told my mother- in-law that I am HIV positive and also informed her when I began the ARV treatment. I told her that my husband already knows about my status. She didn't understand it at first and was worried that it might be an airborne disease, but I told her that was not the case. So I had to explain how the treatment works. I also told my kids who make sure I take the medication in time.

When family members are accepting, they can facilitate the building of networks of support among people living with HIV. A female FGD participant noted:

> It is a different scenario when your family members are informed about the disease. When I told my sister she quickly connected me with a friend who is also HIV positive. She congratulated me on my bravery. My sister wanted to know the steps that I followed until I was told about my status; I was glad to explain it to her. In the end she told me that I had done well but she wasn't strong enough to hear such results about herself. She was the one who assisted me in disclosing to the whole family. I am currently receiving all the care and support I need. My family encourages me to medicate myself appropriately and to eat well.

The support of family members therefore moves beyond what they themselves do for PLHIV to embrace facilitation of relationships that would further support PLHIV beyond the confines of the family.

Family members can also play a central role in educating others in the family who do not understand the disease. A female FGD participant stated:

> My husband didn't want his family to know we were HIV positive, so we kept it our secret until he passed on. I then had to disclose to my mother because I returned to my parental home after my husband's demise. My mother accepted me but the problem was that my father didn't have a clue about HIV and how it is transmitted. My mother then decided not to inform my dad about my status but instead educated him about the virus. Having seen that he had come to grips with the disease and issues around it she then told him I was also living with the virus. He was able to accept me and also support me. In this regard I think educating the people about HIV issues is the key to acceptance.

The reaction of family members especially when there has been a case of death from AIDS-related illness also puts a strain on family relationships and hampers attempts at ensuring access to therapy associated support for PLHIV. Sometimes family members constitute a barrier to care by hiding the sick and preventing visitors from seeing them, including health care workers and rural health motivators (RHMs). A female interviewee explained:

> In some cases you find that some people are locked in houses such that this becomes a family secret and no community member should know there is a sick person living there.

Support and encouragement from a spouse, parents, and siblings bring hope to PLHIV. Such support can point to the future possibilities rather than dwelling on the present, i.e. the infection, which denies PLHIV the hope to carry on with life normally. This was echoed by a female interviewee who said:

> At first she was shocked by the fact that I also had the disease but she was also the one who congratulated me for bravery; she told me that at least my kids won't be orphans since I can get treatment which can make me healthier and strong. She told me I was no different from a person suffering from sugar diabetes because, like me, they must take tablets every day.

A similar instance is exemplified by a female interviewee who underscored the support of her spouse, and how this support boosts her morale and imbues her with a desire to live even during moments when she feels like giving up, as she put it:

> I am where I am today because he is my source of strength and inspiration. Sometimes I get so sick and tell him that I think I will die but he always assures me that it will pass. …He

> still assures me of his love for me every day, and that on its own sustains me. I think if my husband could turn his back on me I would die within a very short space of time. He cares for me at my weakest moments even if it means washing me and tucking me into bed.

Living positively is made possible when those infected with the virus support one another in the family. A male interviewee stated:

> I told my wife because we are one flesh; I told her because I also wanted her to go and get checked so that we can change our lifestyle if need be… She was shocked at first but eventually adjusted. Our lifestyle is now different…She encourages me to take my tablets and when I cannot come to the hospital she comes and collects tablets on my behalf.

Access to medication, vital care and support for PLHIV is difficult in instances where an infected family member is negatively perceived by the others. This negative perception is a result of either blaming the victim for the infection, or the feeling that the infected individual will bring shame to the family. This is also aggravated by the family members' fear of stigmatisation by the rest of the community, as well as the fear of getting infected as a result of contact with the HIV-positive member. These concerns are made worse by the care givers' inability to provide care especially when the needs of the sick call for more effort and knowledge. A male FGD participant stated:

> At home my mother is old and has a knee problem so my son was the one who had to care for me. But when I got worse he ran away and said he was unable to nurse me and he thought I was going to die. He said he couldn't continue because I was vomiting and so he left me alone. I would crawl if I wanted something.

Lack of sufficient family resources sometimes leads to blame being directed to PLHIV. The PLHIV are thus viewed as a burden by some of the family members. A female interviewee expressed this as follows:

> My mother also makes life difficult for me because she says that ever since I got this disease I am always broke; to the point that I always ask for bus fare when I am supposed to go to the hospital. She tells me that she is now burdened with my children too who constantly come to her for bus fare and school fees. Today when I asked for money she told me that I should ask it from my boyfriend instead of bothering her.

The cases discussed in the foregoing underline the centrality of the family in issues pertaining to serostatus disclosure and uptake of antiretroviral therapy. The treatment of PLHIV by their families thus also influences how the rest of the community views and treats them. As a female FGD participant aptly put it:

> If your family cannot care for you, who will? Sometimes the community reacts to what your family is doing; if they have no problem with your sickness then the community is likely to be okay with you too. Love covers a multitude of sins; likewise family love can protect us from the harsh realities in this world. If a family decides not to speak ill of its own no matter how bad the situation is then we can be able to help one another when it matters the most.

DISCUSSION

The findings demonstrate that HIV serostatus disclosure is influenced greatly by the fear of how others would react to this disclosure, including family members. PLHIV therefore opt not

to disclose to their family members for fear that they will discriminated against. Given this way of thinking, family members play an important role in facilitating the process of HIV-positive status disclosure. The findings show that family life and family relationshipscan boost the psychological well-being of PLHIV. Following a positive reaction from family members after disclosure, HIV-positive individuals experienced a sense of control over their situation, thus reducing the psychological stress brought about by the HIV-positive diagnosis. These findings are consistent with previous research that suggests that individuals are better able to cope with ordinary and extraordinary life stressors in the presence of social support (House *et al*., 1988), although the perception of support may be more important than the actual support received (Uchino, 2009; Crocker and Canevello, 2008). In a similar manner, this study found that PLHIV found it easier to disclose their status if they thought that such disclosure would not elicit negative reactions from family members, and that it would facilitate support from them. Moreover, these interviewees realized the benefits of disclosure, a finding which validates an assertion made in earlier studies that some PLHIV feel that disclosure may be their first step towards securing the family support needed to manage their illness and improve their quality of life (Shehan *et al*., 2005).

The finding that, in some instances, PLHIV do not receive the necessary support following their HIV status disclosure, is consistent with findings from other studies that have found that HIV-infected women, in particular, report lower levels of support from friends and family compared to their non-infected counterparts (Dorsey *et al*., 1999). The accounts of some of the interviewees in this study revealed instances whereby an HIV-positive status led to loss of emotional closeness within the family instead of evoking open and supportive communication. The findings further echoed previous research on the pervasiveness of secrecy especially with regard to families coping with HIV and AIDS. In some cases of non-disclosure, the HIV-positive individuals chose not to disclose their status to family members because they anticipated rejection and blame, or because they were concerned about causing worry and grief in their families.

CONCLUSION

The analysis has proceeded along a line of argument that underscores the primacy of family members in the care and support for PLHIV. The underlying rationale for the argument and analysis was the need to recognize how the institutional strengths of the family can be tapped to bolster the existing external structures and agencies engaged in HIV prevention and care. It is evident that while providing ART is the essential component in the care and treatment for PLHIV, family members play a critical role in determining how the therapy is to be accessed and received by PLHIV. The study found that PLHIV are confronted with a broad range of challenges pertaining to, first, whether or not to disclose their HIV status to family members; second, fear of stigma and discrimination following HIV-positive status disclosure.

Evidence from the data showed that even when external agencies provide services meant for PLHIV, the effective use and/or non-use of these services will be mediated by the social context of the family unit, and the actions of individual members of the family. The analysis has shown that where family members provide sufficient support, the quality of life and general welfare of PLHIV are enhanced. This demonstrates that, despite the changes that have taken place in the structure and functions of the family, the family unit still remains a valuable vehicle for health promotion activities, in general, and care and support for PLHIV, in particular. The

findings, therefore, suggest the need for a family-oriented approach to social support for PLHIV and communication about HIV and AIDS. This approach could entail programmes aimed at providing accurate HIV and AIDS-related knowledge to family members, and promoting open communication about the epidemic within the family to encourage acceptance of HIV-positive individuals and facilitate care and treatment for people living with HIV. Such interventions should necessarily include knowledge about HIV transmission and issues of quality of life after infection. In order to address the challenges of providing support for PLHIV undergoing ART in their families, there is need for agencies involved in HIV prevention and care activities to develop comprehensive sensitisation strategies on the nature of HIV and AIDS, to promote disclosure and complement the care and support efforts of these agencies.

ACKNOWLEDGEMENT

The authors wish to thank the UNISWA Research Board for financial support for this study. We would also like to thank the Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA) and World Vision Swaziland for their invaluable support.

REFERENCES

Arnold, E. M., Rice, E., Flannery, D. and Rotheram-Borus. (2008). HIV disclosure among adults living with HIV. *AIDS Care* 20 (1) : 80-92.

Chinai, R. (2003). Antiretroviral misuse in Mumbai, India. *Bulletin of the World Health Organization* 81 (2) : 153.

Clark, L., Schoenbaum, E., Solomon, L. Schuman, P., Fiore, T. and Moore, J. (1995). Concealment of HIV infection and psychological distress [Abstract]. *In*:*Program and Abstracts of the HIV Infection in Women Conference: Setting a New Agenda* (S26). Richmond, VA: Philadelphia Sciences Group.

Crocker, J. and Canevello, A. (2008). Creating and undermining social support in communal relationships: The role of compassionate and self-image goals. *Journal of Personality and Social Psychology* 95 (3) : 555-575.

Davies, G., Koenig, L. J., Stratford, D., Palmore, M., Bush, T., Golde, M., Malatino, E., Todd-Turner, M. and Ellerbrock, T. V. (2006). "Overview and implementation of an intervention to prevent adherence failure among HIV-infected adults initiating antiretroviral therapy: Lessons learned from Project HEART." *AIDS Care* 18 (8) : 895-903.

Dorsey, S., Klein, K. and Forehand, R. (1999). Parenting self-efficacy of HIV-infected mothers: The role of social support. *Journal of Marriage and the Family* 61: 295-305.

Ferguson, T. F., Stewart, K. E., Funkhouser, E., Tolson, J., Westfall, A. O. and Saag, M. S. (2002). "Patient-perceived barriers to antiretroviral adherence: associations with race." *AIDS Care* 14 (5) : 607-617.

Garnett, G. P., Bartley, L., Grassly, N. C. and Anderson, R. M. (2002). "Antiretroviral therapy to treat and prevent HIV/AIDS in resource-poor settings." *Nature Medicine* 8 (7) : 651-654.

House, J., Umberson, D. and Landis, K. (1988). Structures and processes of social support. *Annual Review of Sociology* 14: 293-318.

IRIN. (2007). "Kenya: Growing concerns about adherence as rollout expands." *UN Integrated Regional Information Network – June 6, 2007.* Available at: http://www.aegis.org/news/irin/2007/IR070608.html. 14/6/2007.

Kimberly, J. A., Serovich, J. M. and Greene, K. (1995). Disclosure of HIV-positive status: five women's stories. *Family Relations* 44 (3) : 316-322.

Klitzman, R. L., Kirshenbaum, S. B. and Dodge, B. (2004). "Intricacies and inter-relationships between HIV disclosure and HAART: A qualitative study." *AIDS Care* 16: 628-640.

Körner, H. (2007). Negotiating cultures: Disclosure of HIV-positive status among people from minority ethnic communities in Sydney. *Culture, Health & Sexuality* 9 (2) : 137-152.

Kress, K. D. (2004). "HIV update: Emerging clinical evidence and a review of recommendations for the use of highly active antiretroviral therapy." *American Journal of Health-System Pharmacists* 61 (Supplement 3) : 3-14.

Khumalo, T.F. (2006). Urbanization and the changing Swazi family structure. pp. 64-80.*In:* Muzvidziwa, Victor N. and Zamberia, Agostino M. (Eds.). *Urbanization and Development in Swaziland.* JAN Publishing Centre, Manzini.

Leserman, J., Perkins, D. and Evans, D. (1992). Coping with the threat of AIDS: The role of social support. *American Journal of Psychiatry* 149: 1514-1520.

Miller, L. G., Liu, H., Hays, R. D., Golin, C. E., Ye, Z., Beck, C. K., Kaplan, A. H. and Wenger, N. S. (2003). Knowledge of antiretroviral regimen dosing and adherence: A longitudinal study. *Clinical Infectious Diseases* 36 (4) : 514-518.

Mshana, G. H., Wamoyi, J., Busza, J., Zaba, B., Changalucha, J., Kaluvya, S. and Urassa, M. (2006). "Barriers to accessing antiretroviral therapy in Kisesa, Tanzania: A qualitative study of early referrals to the National Program.' *AIDS Patient Care and STDs* 20 (9) : 649-647.

Mulama, J. (2007). "Health – Kenya: Using ARVs to fill empty stomachs." *Inter Press Service News Agency (IPS).* Available at: http://www.ipsnews.net. 10/2/2007.

Nischal, K. C., Khopkar, U., and Saple, D. G. (2005). "Improving adherence to antiretroviral therapy." *Indian Journal of Dermatology Venereology and Leprology* 17 (5) : 316-320.

Ojikutu, B., Makdzange, A. T. and Gaolathe, T. (2008). Scaling up ART treatment capacity: Lessons learned from South Africa, Zimbabwe, and Botswana. *Current HIV/AIDS Reports* 5: 94-98.

Rabkin, M., El-Sadr, W. M. and De Cock, K. M. (2009). The impact of HIV scale-up on health systems: A priority research agenda. *Journal of Acquired Immune Deficiency Syndromes* 52 (Suppleme mt 1) : S6-S11.

Schneider, H., Blaauw, D., Gilson, L., Chabikuli, N. and Goudge, J. (2006). Health systems and access to antiretroviral drugs for HIV in Southern Africa: Service delivery and human resources challenges. *Reproductive Health Matters* 14 (27) : 12-23.

Shehan, C. L., Uphold, C. R., Bradshaw, P., Bender, J., Arce, N. and Bender, B. (2005). To tell or not to tell: Men's disclosure of their HIV-positive status to their mothers. *Family Relations* 54 (2) : 184-196.

Turner, B. J. (2002). Adherence to antiretroviral therapy by human immunodeficiency virus-infected patients. *The Journal of Infectious Diseases* 185 (Supplement 2) : S143-S151.

Uchino, B. N. (2009). Understanding the links between social support and physical health: A life-span perspective with emphasis on the separability of perceived and received support. *Perspectives on Psychological Science* 4 (3) : 236-255.

UNAIDS. (2013). *Global Report: UNIAIDS report on the global AIDS epidemic 2013.* Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS).

UNDP. (2008). *Swaziland Human Development Report 2008: HIV&AIDS and Culture.* Mbabane: United Nations Development Programme.

Weidle, P. J., Wamai, N., Solberg, P., Liechty, C., Sendagala, S., Were, W., Mermin, J., Buchacz, K., Behumbiize, P., Ransom, R. L. and Bunnell, R. (2006). "Adherence to antiretroviral therapy in a home-based AIDS care programme in rural Uganda." *Lancet* 368 (4) : 1587-1594.

WFP. (2004). HIV/AIDS and Nutrition: Food in the Fight against AIDS. *World Food Programme (WFP).* Available at: http://www.wfp.org. 10/2/2007.

Wolfe, W. R., Weiser, S. D., Bangsberg, D. R., Thior, I., Makhema, J. M., Dickinson, D. B., Mompati, K. F. and Marlink, R. G. (2006). "Effects of HIV-related stigma among an early sample of patients receiving antiretroviral therapy in Botswana." *AIDS Care* 18 (8) : 931-933.

Wools-Kaloustian, K. and Kimaiyo, S. (2006). Extending HIV care in resource-limited settings. *Current HIV/AIDS Reports* 3: 172-176.

Zamberia, A. M. (2006). HIV-related stigma, interpersonal relationships and health-seeking behavior: A focus group analysis. *Global Development Studies* 4(1-2) : 5-28.

Zamberia, A.M. (2007). Stigma and HIV testing decisions: A qualitative analysis. *Lwati: A Journal of Contemporary Research* 4: 258-272.

Zamberia, A.M. and Mabundza, L.P. (2006). Urban poverty in Swaziland: A research agenda. pp. 81-100.*In:* Muzvidziwa, V.N. and Zamberia, A.M. (Eds.). *Urbanization and Development in Swaziland.* JAN Publishing Centre, Manzini.

A SOCIO-CULTURAL NARRATIVE OF MALE CIRCUMCISION IN SWAZILAND

Thandi F. Khumalo[1]

ABSTRACT

Swaziland has adopted and prioritised a national Male Circumcision (MC) programme. The MC programme is implemented in a non-circumcising and highly traditional cultural context that might influence its uptake and use. Furthermore, anecdotal evidence points to a growing concern among Swazis about the misconceptions or motives for male circumcision against its intended medical benefits. The result is that there is still no change towards risky sexual behaviour, with the most HIV affected 15-49 age group still reporting not using protection in their last sexual encounter. This paper presents a narrative of socio-cultural perceptions of MC in Swaziland and how this is impacting on the new health initiative to reduce HIV transmission. The study employed a qualitative approach, entailing the use of focus group discussions and a narrative thematic content analysis.

Keywords: Male circumcision; neonatal circumcision; sociocultural; perceptions; narrative; qualitative

INTRODUCTION

In 2007, the World Health Organisation and Joint United Nations Programme on HIV and AIDS (WHO/UNAIDS) recommended Adult Male Circumcision (AMC) as an important additional intervention that ought to be part of a comprehensive HIV prevention package in communities with generalised HIV epidemics and low AMC prevalence (WHO/UNAIDS, 2010). In line with this recommendation, efforts are being made to roll-out safe and effective AMC services in several Eastern and Southern African countries. Data from a range of observational epidemiological studies conducted since the mid-1980s indicated that there is lower prevalence of HIV infection among circumcised men than among uncircumcised men. Three randomised controlled trials conducted in Orange Farm, South Africa; Kisumu, Kenya and Rakai District, Uganda, showed that circumcision reduced the incidence of HIV infection in men by more than half (WHO/UNAIDS, 2010).

Based on this evidence, it is here argued that male circumcision (MC) should be considered an important new intervention for HIV prevention and should be promoted as part of a comprehensive HIV prevention package. The WHO/UNAIDS conclusions and recommendations on male circumcision for HIV prevention specify that countries with a high prevalence of HIV, low prevalence of male circumcision and heterosexual epidemics should consider the scaling up of male circumcision as part of the comprehensive HIV prevention package. In the Eastern and Southern Africa (ESA) Region, 13 focus countries have been identified by the UN Interagency Task Team (IATT) for technical support to increase male circumcision programmes (WHO/UNAIDS, 2010).

In December 2009, the Government of the Kingdom of Swaziland adopted a policy, strategy

[1] *Ms. Thandi F. Khumalo is a lecturer in the Department of Sociology, University of Swaziland. Email: tkhumalo@uniswa.sz*

and an implementation plan on Safe Male Circumcision for HIV Prevention. Swaziland is one of the few countries supporting an accelerated nation-wide MC plan. The Accelerated Saturation Initiative (ASI) is known as *Soka Uncobe* meaning, "to circumcise is to conquer", a slogan that has been received with mixed feelings by the nation. There are those who argue that some men have misinterpreted the slogan to mean once circumcised they have conquered HIV and AIDS.

The MC campaign began in 2010 and was meant to be a short but intensive exercise to last until September 2011 and, with resources permitting, to be extended to September 2012, which did happen. Support for the campaign was received from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The male circumcision programme began by targeting 15 – 24-year olds [and in 2012 the catchment started from 10 year olds] and the strategy has been designed to increase the demand for services through communicating the benefits of male circumcision while addressing risk compensation. Demand generation is through trained agents who identify clients at various locations such as schools and colleges, fairs and public events, and within their residential catchment area. Role models have also been used to promote male circumcision (WHO/UNAIDS, 2010) and King Mswati III has publicly supported the MC campaign.

LITERATURE REVIEW

A historical narrative

While there is evidence of the practice of MC in some ancient societies, including societies in Africa, there is indication that not all African societies practised male circumcision. Wagner (1949) notes that amongst the Kikuyu of Kenya, and the Maasai of Kenya and Tanzania, male circumcision has historically been the graduation point of an educational programme which taught tribal beliefs, practices, culture, religion and history to youth who were on the verge of becoming full-fledged members of society. The circumcision ceremony was very public, and required a display of courage under the knife in order to maintain the honour and prestige of the young man and his family. The only form of anaesthesia was a bath in the cold morning waters of a river, which tended to numb the senses to a minor degree. After circumcision, young men became members of the warrior class, and were free to date and marry. The graduants became a fraternity which served together, and continued to have mutual obligation to each other for life.

A review of literature suggests that ritual circumcision is not exclusively practised by one cultural group in South Africa. Historically the Zulus circumcised but the practice has become rare or got abandoned. The Tswana and Sotho and Shangaan-Tsonga also circumcise. Not all Xhosa-speaking groups circumcise. For instance it is not practised amongst the Bhaca, Mpondo, Xesibe or Ntlangwini (Stinson n.d). In some South African ethnic groups, circumcision has roots in several belief systems, and is performed most of the time on teenage boys:

> ...The young men in the Eastern Cape belong to the Xhosa ethnic group for whom circumcision is considered part of the passage into manhood... [due to deaths after traditional circumcision]. A law was recently introduced requiring initiation schools to be licensed and only allowing circumcisions to be performed on youths aged 18 and older. Boys as young as 11years die and many young men do not survive the ordeal... (BBC, 2003)

Currently, about 25% of men world-wide are circumcised. These are mostly men from North America and Africa and the Muslim and Jewish communities of the Middle East and Asia (Moses*et al.*, 1998).

Initiation schools

Traditional practices were commonly of a particular and rather narrow profile linked to the toughening, training and initiation of male adolescents into warrior status. For those groups the normal social context of circumcision was in the adolescent rites of passage typically called 'initiation schools' in ethnographic literature. These in turn were highly associated with 'age-grades', age ranked male cohorts whose membership was defined by participation in the same initiation schools in the same year (Marck, 1997).

After circumcision, candidates proceed to seclusion huts in a special compound or 'lodge' in the bush and the initiation school begins, running over a few months. 'They (initiates) are separated from their relatives and live under the care and control of a number of tutors or guardians'. The initial phase centres around the lodge where the guardians 'instruct them both in general knowledge and in the particular ritual observances which are demanded from the initiates... The only other persons with whom the initiates regularly come into contact are young girls whose main tasks are to bring food to the initiates and to provide them with water and firewood..." Deaths of initiates are 'passed over in silence. His relatives are not properly informed but... told by the tutor that they do not need to bring food for him regularly...,' (Wagner, 1949:353).

At the initiation camp they are taught practical skills such as making household items and hunting, along with learning the avoidance behaviours that must be followed at the time (Wagner, 1949:361). Life at the initiation camp ends with 'a series of elaborate ceremonies and a period of 'feasting' and finally, a feast of coming out,' (Wagner, 1949:363). There is lovemaking but 'they are warned not to go beyond the customary limits of premarital sexual enjoyment'.

A profound aspect of the initiation school is the acquisition of cultural knowledge. It is where young men receive instruction in courtship and marriage practices. Cultural expectations regarding social responsibilities and their conduct as men in the community are transmitted and, following initiation, the men are afforded numerous privileges associated with their status. *"Men who've been through initiation are distinguishable by their social behaviour and a particular vocabulary they learn during their time in the bush"* (Stinson, n.d.). These very crucial educational aspects have not been fully absorbed into the MC programme in Swaziland, yet the initiation schools play a major role in the recipients behaviour change.

While MC is a new intervention in Swaziland, studies from elsewhere indicate that male circumcision can reduce the chance of HIV infection in heterosexual men (Bollinger *et al.*, 2011). Encouraging the adoption of adult male circumcision has, however, not gone without criticism especially in areas or populations heavily affected by HIV. It has been observed within some excellent studies that MC as a preventative measure merely reduces the chances of infection by 60 percent and is not absolutely preventative (Bollinger *et al.*, 2011). On a cautionary perspective, it has been pointed out that MC may encourage the recipient to wilfully undermine the demonstrably safe methods of serial monogamy and condom usage in sexual encounters with new partners.

While circumcision was found to reduce risk by about 50 to 60 percent for heterosexual males in three highly controlled short-term clinical trials, condom promotion and safe-sex

education have already been shown to reduce infection rates more effectively for both males and females, at a lower cost (Johnson *et al.*, 2008). Furthermore, anti-retroviral drugs have shown a promising 92% reduction in HIV transmission. A 2008 study from South Africa revealed that condoms are 98% effective at hindering HIV transmission, and 95 times more cost-effective than circumcision. Consistent condom use reduces lifetime risk by 20% as compared to circumcision's 8%. The report shows condom use significantly increased from 2002 to 2008 in South Africa, and the HIV rates finally began to level off.

Adult males are vulnerable to the belief that circumcision offers them immunity from HIV, raising ethical concerns about promoting adult male circumcision, and questions regarding the effectiveness of the intervention. Further, circumcision does not protect men who have sex with men (Bollinger *et al.*, 2011).

The writers conclude that education, safe-sex practices, and consistent condom use are proven effective measures of curbing HIV transmission. Uganda demonstrated a 47% reduction in HIV prevalence from increased safe-sex education and condom promotion; this social-prevention programme is available now and is highly effective.

Swaziland needs to conduct contextual studies on adult MC to determine the medical, psychological, sexual and social effects of MC including the human rights, ethical and legal consideration of promoting the MC intervention programme.

ANALYTICAL FRAMEWORK

Understanding what motivates people's behaviour, knowing how to address these motivations appropriately, and taking into consideration people's cultures when developing programmes addressing HIV and AIDS are essential to changing behaviour and attitudes towards HIV/ AIDS (UNESCO, 1995-2012). Thus, UNESCO advocates for responses to HIV and AIDS that are culturally appropriate, gender and age responsive, grounded in human rights and involve people living with HIV at all stages. Swaziland needs interventions that are culturally appropriate for successes to be recorded.

OBJECTIVES

The general objective for the reported study was to understand the motivations of enrolling for MC as another intervention for managing HIV and AIDS in Swaziland. The study's specific objectives were to understand the perceptions of participants on male circumcision in Swaziland; and to analyse the effectiveness of MC against other interventions preventing the spread of HIV and AIDS in Swaziland.

METHODOLOGY

Methods and sample

A qualitative approach adopted from Ratcliff (2002) was used, including a narrative approach for data analysis and writing. Qualitative research attempts to understand reality by discovering the meanings people attach to it in a specific setting. Focus Group Discussions (FGDs) were conducted by the author in 2012 assisted by two research assistants. Five FGDs were conducted, each consisting of 10 participants. There were 3 male FGDs and 2 Female FGDs. Community inner council meetings were used as an entry point and a convenient place to recruit participants. Except for age of participants there were no defined inclusion and exclusion criteria stated.

Participants and location

Focus Group Discussions (FGDs) were conducted in two areas selected based on convenience for the study participants: Three (3) FGDs at KaLanga in the Lubombo Region (2 male and 1 female FGDs) and two (2) FGDs at Ezulwini in the Hhohho Region (I male and 1 female). Although their view is important, due to time and resource constraints, participants under the age of 18 years were excluded to minimise the cumbersome process of obtaining informed consent from parents or guardians.

Data collection and analysis

An interview guide was used in the FGDs which lasted approximately 45 minutes, with the shortest being 35 minutes and the longest 1 hour. Thematic analysis of transcripts and notes from FGDs was conducted, developing themes and categorising data for analysis and writing. In addition, documents, reports, and news articles served as literature and evaluation material.

Ethical considerations

The objectives of the study were explained to participants and consent was sort through verbal engagement. Participants were informed that confidentiality would be assured, that no identifiers would be attached to the data collected, and that they could opt out at any stage of the interview.

Limitations of the study

It would have been ideal to supplement the FGDs with in-depth interviews but limited resources and time made it impossible to provide a variety of interviews.

Not all regions of the country were covered and the respondents formed a very small proportion of the people in the regions covered; thus, the results of this exploratory study are skewed and cannot be generalised to the entire country.

It is possible that male participants were reserved because a female interviewed them. The author who is a female was assisted by two other female volunteers to conduct FGDs simultaneously to minimise the waiting time between interviews.

FINDINGS

This study received overwhelming support and cooperation from participants who confirmed male circumcision as a new phenomenon and practice by the people of Swaziland. There was general excitement and willingness to participate in the FGDs by young and middle aged males (18-35 years) and a bit of restraint was exercised by older males (above 50 years). Females were eager to participate, both young and old.

An overwhelming majority in all FGDs supported male circumcision with no status, educational, and geographical boundaries observed when the responses were compared between the various groups. All participants were aware of male circumcision as it was introduced by the Ministry of Health (MoH). Awareness of the objectives of the male circumcision campaign was high as many confirmed that the major objective was to reduce the chances of contracting and transmitting HIV and other sexually transmitted diseases. Circumcision was neither hidden nor publicised and most participants discovered other circumcised males by discussing, bathing together or going for circumcision in a group.

Perceptions of circumcision in Swaziland

Almost all participants reported no knowledge of circumcision in Swazi culture which has subsequently presented no pressure for males to circumcise. Only one elderly man reported having heard from elders that there was traditional circumcision in Swaziland but was eroded by problems associated with hygiene and medical complications.

Even though Swaziland is a non-circumcising country, knowledge about male circumcision was broad among the participants. Participants defined male circumcision as *"removing the foreskin from the penis"*. The knowledge of the procedure was enhanced by the male circumcision campaign that was rolled-out by the MoH in 2010 as a measure to reduce the transmission of the HIV. Participants exhibited adequate knowledge about the circumcision campaign, stating that *"Circumcision is meant for males from 18 years upwards and its aim is to reduce the chances of acquiring and transmitting HIV and sexually transmitted diseases"*.

Although Swazis are a non-circumcising nation, participants revealed that some males had circumcised early in the 1980s adopting the practice from some ethnic groups such as the Xhosa, Sotho and Ndebele, while working in the mines in South Africa. Others circumcised due to perceived religious reasons following their interpretation of the Old Testament.One participant quoted the book of Genesis 17: 10-12 as follows:

> "This is my covenant with you and your descendants after you, the covenant you are to keep: Every male among you shall be circumcised. You are to undergo circumcision, and it will be the sign of the covenant between me and you. For the generations to come every male among you who is eight days old must be circumcised…"

This is when Abraham was instructed by God to circumcise his people to distinguish them from other nations. A similar interpretation pertains to the book of Joshua 5:2-8.

The FGDs confirmed earlier observations from literature on religious male circumcision. The circumcising nations initiated young men into adulthood through circumcision. The young men were educated about adult responsibilities, including relationships with women, and controlling their sexuality, although this does not happen in non-circumcising nations like Swaziland.

The majority of participants supported neonatal circumcision due to the pain of healing when a person is older; particularly, when there is an erection of the penis. One participant noted that all his male children were circumcised at birth, while some participants observed the need to be better informed about neonatal circumcision and its advantages and disadvantages.

Perceptions on possible benefits of circumcision

Improved hygiene

Circumcised participants (who identified themselves) appreciated the qualities of circumcision associated with hygiene (cleanliness of a circumcised penis). The perception was that the foreskin accumulates dirt and disease causing germs.

> *"The foreskin is a good place for germs to accumulate and cause disease"*.

> "When you spend a night outside your marital home (nawufohlile) you don't take a bath until evening by which time the foreskin would have harboured a lot of dirt, yet with a circumcised penis you just wipe with spirit and you're good for the day".

Such perceptions are a demonstration of the necessity of education on circumcision in the country. Even though the means used to arrive at cleanliness in the above case are medically flawed, the perceptions on cleanliness are supported by a study conducted in Uganda whereby both men and women felt it was easier to maintain genital cleanliness in circumcised men. Although this is true, the relation between genital hygiene and the risk for HIV and other genital infections still requires clarification (Ntozi, 1995).

Improved intercourse

Younger male participants were more excited by the perceived enhanced sexual intercourse benefits, as they felt their sexual performance improved after circumcision. They argued that their women appreciated them more for the improved sexual performance.

> "I now have lengthy sex rounds, you can drive an hour's journey and I'll still be at it".
>
> "Problems of pre-mature ejaculation are now a thing of the past".
>
> "The penetration is now smooth without the skin blocking my way".
>
> "I can continue for a long time because I don't suffer from cuts on my foreskin". "The penis also grows bigger, particularly the head (glans/knob/helmet) it hardens giving more pleasure to the female partner".

Some male participants were under the impression that penetration had been enhanced with the foreskin removed. The impression existed that the foreskin obstructed penetration in some way. The perception was that intercourse was more pleasurable for both partners because it was less painful.

While circumcising nations provide initiation schools with circumcision, the males in non-circumcising nations do not benefit from this very important school which is supposed to inculcate cultural values of manhood and responsible sexual behaviour. This creates a void that has to be filled by other means of education after circumcision.

Women's views on male circumcision

All the women commended circumcision for improving penis hygiene and the possible reduced chances of men transmitting HIV to women. The perception was that *"many people have lost their lives due to AIDS and this campaign can assist if properly observed"*. Another participant suggested that men are forcing them to perform oral sex and without the foreskin, penis cleanliness is visible.

Some women were shocked by the energy for sex that men supposedly acquired with circumcision. *"The men demand too much sex from us and you are forced as a woman to satisfy them or else they go out for more and that is where they get HIV."*

Such perception if not corrected with factual information poses danger to the prescribed goals of circumcision in the country. Further, some women commented that there is a danger that men will become more complacent with circumcision and ignore condom use which will increase HIV than reduce it.

The women lamented that not enough education was provided to the men before the circumcision campaign; as a result most of them rush to experiment with sex to experience the difference after circumcision instead of exercising restraint. In fact, some men were of the view that if they still have to use the condom after circumcision, there is no need for enduring the pain of circumcision. This is the kind of perception that puts at risk the achievements made in

promoting safe sexual practices.

One participant was of the view that circumcision should have been rolled-out for boys and not older married men. Some men do not even wait for complete healing to have sex which causes medical complications and further puts the wife in danger.

Some participants felt the whole subject was sensitive and some of the men do not want to discuss it with them. One participant said her husband interrogated her about her knowledge of MC: "*Where did you learn all this about circumcision?", "do you mean I'm not clean-is that why you want me to be circumcised?" "Why should I remove my foreskin when nature gave it to me?"* For this reason the women recommended a widespread education campaign on male circumcision.

DISCUSSION

The MC campaign was introduced without sufficient consideration of cultural factors, attitudes and human psychology that might influence its effectiveness as an intervention against HIV and AIDS. Swaziland has for decades maintained a high HIV prevalence and a number of interventions have been introduced without much success in reducing the infection rate that has remained at a high of 26%. The biggest challenge is high risk sexual behaviour exhibited in heterosexual multiple-sexual partner relationships, non-use or inconsistent condom use, among others. There is evidence that condom use has a guaranteed protection of 98% against HIV infection, and studies have found that only about 20 percent of Swazi men consistently used condoms (IRIN, 2008), leaving a larger sexually active population vulnerable. The misguided perception of protection offered through MC exposes women and men to more danger of being infected by men not using condoms because they have circumcised.

Research on HIV and AIDS and Culture (UNDP, 2008) confirmed that women are most vulnerable to HIV infection due to the culture that condones multiple-sexual partners for men and lack of power by women to negotiate condom use by men.Education on MC should stress a clear and consistent message that MC is enhancing the existing HIV prevention measures and is not a replacement of the existing interventions; failing which, women will be infected with HIV and male circumcision may do more harm than good if it is misused to deny women full protection.

The literature reviewed clearly articulates evidence-based benefits and risks of male circumcision, a message that has not been transmitted effectively at all to the Swazi nation. Seemingly, the government (MoH) has been preoccupied with fulfilling the mandate from WHO and UNAIDS without fully preparing the nation on consequences of male circumcision. Among other things, Bollinger *et al.* (2011) notes that for fully informed consent to occur, men must be educated about the risks and sensory losses from circumcision, as well as be made aware that it does not offer full protection and that they will still need to wear condoms during sex. The number of reports emerging regarding African males agreeing to circumcision so they will no longer need to use condoms reveals that fully informed consent is not always occurring.

Enhancing knowledge on MC

Studies conducted elsewhere are synthesised below to increase knowledge on claims held about male circumcision. These studies present a challenge to the MoH, MC providers and educators to intensify the knowledge base of MC candidates and the Swazi nation to give full consent.

Circumcision decreases sexual pleasure

A questionnaire was used to study the sexuality of men circumcised as adults compared to uncircumcised men, and to compare their sex lives before and after circumcision. The study included 373 sexually active men, of whom 255 were circumcised and 118 were not. Of the 255 circumcised men, 138 had been sexually active before circumcision, and all were circumcised at >20 years of age. Masturbatory pleasure decreased after circumcision in 48% of the respondents, while 8% reported increased pleasure. Masturbatory difficulty increased after circumcision in 63% of the respondents but was easier in 37%. About 6% answered that their sex lives improved, while 20% reported a worse sex life after circumcision. There was a decrease in masturbatory pleasure and sexual enjoyment after circumcision, indicating that adult circumcision adversely affects sexual function in many men, possibly because of complications of the surgery and a loss of nerve endings (Frisch *et al*., 2011).

Another study on the sensitivity of the adult penis in circumcised and uncircumcised men found that the uncircumcised penis is significantly more sensitive. The most sensitive location on the circumcised penis is the circumcision scar on the ventral surface. Five locations on the uncircumcised penis that are routinely removed at circumcision are significantly more sensitive than the most sensitive location on the circumcised penis (Sorrells *et al*., 2007). Further studies can be conducted in the Swazi context for conclusive evidence.

A report published in the British Journal of Urology assessed the type and amount of tissue missing from the adult circumcised penis by examining adult foreskins obtained at autopsy. Investigators found that circumcision removes about one-half of the erogenous tissue on the penile shaft. The foreskin, according to the study, protects the head of the penis and is comprised of unique zones with several kinds of specialized nerves that are important to optimum sexual sensitivity (Taylor *et al*., 1996).

Circumcision associated with sexual difficulties in men and women

A new national survey in Denmark, where about 5% of men are circumcised, examined associations of circumcision with a range of sexual measures in both sexes. Circumcised men were more likely to report frequent orgasm difficulties, and women with circumcised spouses more often reported incomplete sexual needs fulfilment and frequent sexual function difficulties overall, notably orgasm difficulties, and painful sexual intercourse. Thorough examination of these matters in areas where male circumcision is more common is warranted (Frisch *et al*., 2011).

These studies are meant to provoke more research in the Swazi context to increase the knowledge about circumcision and to inform further policy decisions and direction in the health sector.

CONCLUSION

The paper has provoked issues that require more evidence-based research into the area of male circumcision in Swaziland, taking into account MC in relation to existing HIV and AIDS interventions. For instance, high risk sexual practices and behaviour change challenges have been noted by various authors as the major driver of HIV and AIDS in Swaziland. What then is the potential value of MC in reducing high risk sexual behaviour change to be considered as a worthy intervention for Swaziland?

The perception by participants that male circumcision effectively protects against sexually transmitted diseases is dangerous and should be addressed fully through education,

particularly by service providers and advocacy organisations. Included should be, exploring the concept of risk, the significance of lowering risk and the implications of MC for the recipient so that the recipient is not left with myriad impressions that could have been addressed with adequate knowledge on MC.

Further research is necessary to assess the feasibility, desirability and cost-effectiveness of circumcision to reduce the rate of HIV in Swaziland. Education on circumcision, its benefits and potential risks have to be rolled-out to the general population and intensified with the recipients of circumcision for full consent.

REFERENCES

BBC Online. (15 July 2003). *South Africa circumcision deaths.*http://news.bbc.co.uk/2/hi/africa/3069491.stm. 07/04/2009.

Bollinger, D., Craig, A., Travis, J.W. and Chapin, G. (2011). Male Circumcision-A Dangerous Mistake in the HIV Battle. Intact America. Wikipedia. Retrieved 30/09/2012.

Darby, R. (2003). Medical history and medical practice: persistent myths about the foreskin. *Medical Journal of Australia*, 178(4) : 178-9.

Engelbrecht A., Smith S., (not dated).Whydo male patients request circumcisions? Department of Family Medicine, Kalafong Hospital, University of Pretoria, South Africa.

Fox, M. and Thomson, M. (2010). HIV/AIDS and Circumcision: Lost in Translation. *Journal of Medical Ethics* 36:798-801.

Frisch, M., Lindholm, M. and Grenbek, M. (2011). Male Circumcision and Sexual Function in Men and Women: A Survey-based, Cross-sectional Study in Denmark. *International Journal of Epidemiology:* 1-15.

Goldman, R. (2004). Circumcision Policy: A Psychosocial Perspective, *Paediatrics & Child Health* 9:630-633.

Green, L., McAllister R., Peterson K. and Travis J. (2008). Male Circumcision is Not the HIV "Vaccine" We Have Been Waiting For! Future Medicine 2(3) :193-199.

Immerman R. and Mackey, W. (1997). A Biocultural Analysis of Circumcision. *Social Biology* 44(3) : 265–275

IRIN. 2008. Swaziland: Circumcision gives men an excuse not to use condoms. Humanitarian news and analysis. UN Office for the Coordination of Humanitarian Affairs. 31 July, 2008.

Johnson L. F., Hallet, T.B., Rehle, T. M. and Dorrington, R. E. (2012). The effects of changes in condom usage and human immunodeficiency virus incidence in South Africa: a model-based analysis. *Journal of the Royal Society* 9:1544-1554 (http://rsif.royalsocietypublishing.org/content/early/2012/01/09/rsif.2011.0826.full)

Maimonides, M. *(translated by Michael Friedländer)* (1885). The Guide of the Perplexed. pp. 267–9. Trübner and co. London.

Marck J. (1997). Aspects of male circumcision in subequatorial African culture history. *Health Transition Review, Supplement to Volume 7: 337-359*

McAllister, R.G., Travis, J.W., Bollingerc, D., Rutiserc, C. and Sundaand, V. (2008). The Cost to Circumcise Africa. *American Journal of Men's Health*7: 307-316.

Ministry of Health. (2010). Prevention of Mother to Child Transmission of HIV and AIDS Policy. Mbabane.

Ministry of Health. (2009). Swaziland National Multisectoral HIV and AIDS Strategic Framework 2009-2014. Mbabane.

Ntozi, J. P. M. (1995). Using circumcision to prevent HIV infection in sub-Saharan Africa: the view of an African. *Health Transition Review* 5(1) :97-100. Ratcliff, D., (2002). Qualitative Research. Part Five: Data analysis. http://www.don-rat-cliff.net/qual/expq5.html. 30/09/2012.

Sorrells, M. L., Snyder, J. L., Reiss, M. D., Eden, C., Milos, M. F., Wilcox, N. and Van Howe, R. S. (2007). Fine-Touch Pressure Thresholds in the Adult Penis. *BJU International* 99: 864-869.

Taylor, J. R., Lockwood A.P. and Taylor, A. J. (1996). The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision. *British Journal of Urology* 77: 291-295.

United Nations Development Programme (UNDP). (2008). Swaziland Human Development Report. HIV and AIDS and Culture. UNDP, Mbabane.

Van Howe, R. (2004). A Cost-Utility Analysis of Neonatal Circumcision. *Medical Decision Making* 24:584-601.

Wikipedia, The History of Male Circumcision, http//en.wikipedia.org/wiki/History_of_male_circumcision#Male_circumcision_in_Africa. 30/09/2012.

Wilson, C.G. (2008). Male genital mutilation: an adaptation to sexual conflict. *Evolution and Human Behavior* 29(3) : 149–164.

World Health Organization (WHO) / Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). Scaling-up male circumcision programmes in Eastern and Southern Africa Region: Country update meeting to share lessons, explore opportunities and overcome challenges to scale-up. Arusha, Tanzania. http://www.MCcampaigncountry_progress_meeting_report_jun10.pdf. 30/09/2012.

THE WTO TRIPS AGREEMENT, DOMESTIC REGULATION AND ACCESS TO HIV/AIDS MEDICINES IN SOUTHERN AFRICA: THE CASE OF BOTSWANA AND ZIMBABWE

Jimcall Pfumorodze[1], Emma Chitsove[2] and S.T. Morolong[3]

ABSTRACT

Access to medicine, in particular HIV and AIDS medicines, is critical for countries in Sub Saharan Africa which is the region bearing the brunt of the HIV/AIDS pandemic. The TRIPS Agreement contains provisions which can allow sufficient flexibility to developing countries to enable them to acquire life-saving drugs at affordable rates. This article provides an overview of the patent laws of Botswana and Zimbabwe and analyses the extent to which these two countries have incorporated and utilised the flexibilities in the TRIPS Agreement to facilitate access to medicines.

Keywords: access to medicines; developing countries; HIV and AIDS, patent, generic

INTRODUCTION

As compared to the other regions of the world, the HIV/AIDS pandemic is highly prevalent in Sub-Saharan Africa which bears around 35% of HIV infections worldwide. This region has many countries which are low income earners and which do not afford to provide the essential drugs for HIV/AIDS to their citizens. As a result, these countries are exploring ways of providing their citizens with cheap and affordable essential drugs. One of the ways to fulfil this objective is to fully utilize the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement flexibilities. This Agreement contains provisions that can allow sufficient flexibility to developing countries to enable them to acquire life-saving drugs at affordable rates.This article provides an overview of the patent laws of Botswana and Zimbabwe and analyses the extent to which the two countries have incorporated and utilised the flexibilities in the TRIPS Agreement to facilitate access to medicines. It also examines World Trade Organization (WTO) TRIPS flexibilities and how they promote access to medicine and how these have been domesticated and utilized in Botswana and Zimbabwe. The paper will wind up by a conclusion and suggestions for reform.

BACKROUND AND CONTEXT: BOTSWANA AND ZIMBABWE

The common denominators of these countries are that both are land locked developing countries, similarly situated in southern Africa with high HIV/AIDS prevalent ratios. Both countries are members of the WTO and have domestic legislations meant to promote health and access to medicine. Additionally, both countries respect and protect patents and rights thereof through the Patent Act and Industrial Properties Act for Zimbabwe and Botswana, respectively. However, these two countries have striking differences herein highlighted below.

[1] *Senior Lecturer in Law; University of Botswana, Email: jimpfumo@gmail.com*
[2] *Senior Consultant, Mcall Consultancy, Harare, Zimbabwe.*
[3] *Head of Legal, Stanbic Bank, Botswana.*

Botswana

Botswana is classified by the World Bank as an upper middle income country. It has an estimated population of 1.7 million people, and is one of the countries with the highest prevalence rates of HIV in the world. As at 2011, adult HIV prevalence percentile was 23, 4% and it was estimated that 300 thousand people inclusive of all ages were living with HIV. The groups most affected by HIV were considered to be women and children respectively estimated at 160 thousand and 15 thousand, (UNICEF 2011).[1]

Many adults in their productive years succumbed to the virus; their death having serious economic implications for Botswana as the many AIDS related deaths resulted in the loss of a skilled work force in various sectors of the economy such as agriculture and mining. Some families were pushed into poverty due to the cost of HIV/AIDS medical care, loss of income and funerals. It was projected that in the absence of provision of antiretroviral therapy the average real economic growth would be reduced by 1.5% to 2.0% a year over the period of 2001-2021 resulting in the economy being 25% to 35% smaller as a result of HIV/AIDS than it would have been otherwise (Econsult, 2007). The provision of ARVs, however, will contribute to raising economic growth by adding 0.4% to 0.8% to average annual growth over the 20 year period as a result of a larger and healthier workforce (UNITED NATIONS, 2004).

Given the dire situation, the Botswana Government launched a national comprehensive, free of charge HIV/ AIDS treatment programme known as MASA (meaning New Dawn) National ARV programme in 2002. The aim of the programme was to enable those with the HIV virus to live longer and healthier lives; to decrease the number of children orphaned by HIV/AIDS and to ensure that there was maintenance of a skilled workforce necessary for economic development. The MASA programme provides a life sustaining antiretroviral therapy for eligible citizens and non-citizen spouses. Eligible for this therapy are HIV infected adults with a CD4 cell count under 250 cells or with an AIDS defining illness, all HIV infected children under one year; children over one year with advanced or severe immunosuppression or an AIDS-defining illness (Ministry of Health, 2008). Under MASA, pregnant women who qualify for ARV therapy receive priority care. Paediatric patients are also given special care and support.

Drugs which are used under Botswana's national ARV programme are branded and include: Ritonavir, Efavirenz, Nevarapine, Aripla, Parunavir and Raltegravir (Ministry of Health, 2008). It costs the Botswana government roughly US$ 1 million to treat 1000 patients and approximately half of this amount is spent on drugs (BONELA, 2005). The government currently is able to run the ARV programme. However, questions have been asked about the long-term sustainability of the programme as more people enrol on it. When MASA was launched, its aim was to provide medication to 19000 of the 110, 000 infected people. By mid-2008 it was estimated that 100, 000 people out of an estimated 130, 000 people eligible for treatment were on ARV therapy under the MASA programme. As of 31 December 2009, 125 991 people were being treated by the public sector and 19 199 were being treated by the private sector under the MASA programme (NACA, 2010). It is estimated that 220 600 people will need to be enrolled on the MASA programme by 2016 and that this number will almost double by 2021(BONELA, *2005*). At a World AIDS Day commemoration in 2008, President Ian Khama stated that the cost of enrolling an estimated 220 600 people into the treatment programme by 2016 may be unaffordable (BONELA, *2005*).

[1] *http://www.unicef.org/infobycountry/botswana_statistics.html*

In light of the concern about sustainability, calls have been made for the review of Botswana's patent laws to ensure that they incorporate the flexibilities in the TRIPS Agreement and the Doha Declaration to facilitate access to cheaper medicines.

Zimbabwe

Unlike Botswana which has a better and stronger economy, Zimbabwe is a low-income economy with an estimated population of 13 million.[2] Its economy took a downturn from the early 2000s upon the government's embarking on a controversial land redistribution exercise which saw most of the white-owned commercial farms being expropriated without compensation. This marked a sharp nosedive in the economic development of the country in various ways.By the end of 2008, inflation was hovering around 300 million per cent and unemployment was hovering around 90%.[3] During this economic downturn, there was a high exodus of health professionals and the country's health delivery system was almost on the brink of collapsing.This economic downturn was harnessed in in February 2009 when the three main political parties in the country formed a government of national unity under the Southern African Development Community (SADC) guaranteed Global Political Agreement.

This political union ended in June 2013 with the harmonised elections which saw ZANU PF winning the elections by an overwhelming majority. Notable developments during this period were the dollarization of the economy; low inflation rate and increase in targeted donor funding to the health sector.[4]

The first reported case of AIDS was documented in 1987. Since then Zimbabwe has experienced severe HIV/AIDS and tuberculosis epidemics. By 1999, Zimbabwe was considered to be one of the countries with the highest prevalence of HIV infection worldwide[5] . As of 2012, the adult prevalence percentile was 14.9.[6] It is estimated that 1, 2 million people are living with HIV/AIDS and only about 7% of that population have access to HIV/AIDS drugs.[7] About 180 000 people die from HIV/AIDS annually and there are about 1 million children who are orphaned due to HIV/AIDS.[8] Interestingly, Zimbabwe has attempted to utilise some of the TRIPS flexibilities. The ensuing section seeks to investigate how patent flexibilities have been utilised by both countries so as to address medicine shortages in their respective countries.

THE WTO TRIPS FLEXIBILITIES AND ACCESS TO MEDICINES

The TRIPS Agreement which came into effect in 1995 incorporates provisions for the administration as well as judicial enforcement of intellectual property rights. It seeks to harmonise and standardise national intellectual property laws. Whilst on one hand this Agreement seeks to protect intellectual property rights, on the other hand it also gives some

[2] *See International Monetary Fund Report at http://www.imf.org/external/country/ZWE/index.htm accessed 4 June 2009.*

[3] *See International Monetary Fund Report at http://www.imf.org/external/country/ZWE/index.htm accessed on 4 June 2009.*

[4] *Ibid*

[5] *UNAIDS 2000. Report on the global AIDS epidemic (UNAIDS, 2000).*

[6] *UNICEF (2012). Report available at http://www.unicef.org/infobycountry/zimbabwe_statistics.html accessed 24 September , 2013*

[7] *UNICEF (2011) (supra)*

[8] *UNICEF (2011) (supra).*

flexibility which may be utilised by developing countries. This strikes a balance between patent holder protection and promotion of access to health by developing countries. This paper discusses these flexibilities which are meant to improve access to medicines. These include compulsory licencing, the paragraph 6 system, parallel importation and exception to patent rights.

COMPULSORY LICENSING

A compulsory license, also referred to as a non-voluntary license, is a license granted by an administrative or judicial body to a third party to exploit a patented invention, without the consent of the patent holder. Article 31 of TRIPS allows any member of the WTO to issue a compulsory license when faced with a national or an extreme emergency, or in cases of public non-commercial use.[9] However, there are some procedures to be followed. First, there should be negotiations between the member who intends to use this flexibility and the patent holder and, if negotiations fail, the member then grants a compulsory license.[10] However, negotiations are waived, in cases of emergency or where it is for public non- commercial use.[11] The license is only limited for a duration and in scope to the purpose for which it was granted.[12] The patent holder should be given adequate remuneration.[13] Article 31(f) requires that generic drugs manufactured under compulsory licensing should be used domestically and should not be exported to other countries even if those other countries lack manufacturing capacity. Most developing countries do not have the capacity to manufacture their own drugs and as a result, they cannot not utilise this flexibility.

Compulsory Licensing of Medicines in Botswana

Compulsory licensing in Botswana is governed by the Industrial Properties Act. This Act provides for three types of compulsory licences namely: (i) compulsory licences that authorize a government agency or other person to use the patented invention in the public interest or to remedy an anti-competitive conduct on the part of the patentee; (ii) compulsory importation licences and (iii) compulsory licences for failure to exploit the patent. These licences are discussed below.

Section 31 of the Act allows a government agency or other person authorised by the Minister to exploit a patented invention without the consent of the owner if (a) it is in the public interest to do so for purposes of national security, nutrition, health or the development of other vital sectors of the national economy or social service, [14] or (b) a court or administrative body has determined that the manner of exploitation of an invention by the owner of the patent is anti-competitive or constitutes an abuse of the patent.[15] The granting of such licence is made subject to a hearing with the patent holder and upon the payment of adequate remuneration to the owner of the patent.[16] The Act provides that in determining adequate remuneration, the Minister shall take into account the economic value of the patented invention and the need for

[9] *See Article 31 (b) of the TRIPS Agreement.*
[10] *See Article 31 (b) of the TRIPS Agreement.*
[11] *See Article 31 (b) of the TRIPS Agreement.*
[12] *See Article 31 (c) of the TRIPS Agreement.*
[13] *See Article 31 (f) of the TRIPS Agreement.*
[14] *Section 31 (1) (a) of the Industrial Property Act 2010*
[15] *Section 31 (1) (b) of the Industrial Property Act 2010*
[16] *Section 31(1) Industrial property Act 2010*

the elimination of anti-competitive practices.[17] A licence shall be granted under section 31 only after the Minister has given a hearing to the patentee and any interested party.[18] A compulsory licence granted under section 31 authorises the licence holder to exploit the patented invention for supply to the domestic market in Botswana only, except where paragraph 1 or 3 of Article 31 *bis* of the TRIPS Agreement applies.[19] The authorisation to exploit a patent under section 31 cannot be transferred unless with the enterprise or business within which the patented invention is being exploited.[20]

Further, section 32(1) of the Act provides that the Minister may issue a licence to a government agency or any authorized person for the importation of patented products such as generic pharmaceutical products from any legitimate alternative foreign source without the approval of the patentee if it is in the public interest to do so, or if the product is not being supplied in sufficient quantities or on reasonable terms in relation to market demand. Whatever is imported shall be solely for public non-commercial use within Botswana except where Article 31 *bis* of the TRIPS Agreement applies.[21] The importation licence must include the name of the pharmaceutical product and an estimate of the quantities of the pharmaceutical product required, although the estimate shall not limit the quantity required to address the public health problem that the importation seeks to address.[22] The Act further stipulates that if remuneration for the licence has been paid in the exporting country, the obligation to pay remuneration for the compulsory licence to import that product into Botswana shall not apply.[23] These provisions are more aligned to the waiver in the paragraph 6 system and therefore enable Botswana to import generic versions of the patented drug if there is a need.

Section 33 of the Act makes provision for the grant of compulsory licences to any interested person. Licences under section 33 of the Act can only be granted after the expiration of three years from the date of grant of the patent or four years from the application date, whichever happens latter.[24] These are to be granted on application to the High Court, where any interested person shows either that a market for the patented invention is not being supplied, or is being supplied on unreasonable terms in Botswana.[25] On granting an order for such a license the High Court is required to set out the scope and function of the licence as well as its conditions and time limit and the amount of remuneration to be paid to the patentee.[26] It must be highlighted that this provision requires an initial moratorium of three years from the date of grant of the patent or four years from the application date, whichever happens latter before a compulsory licence can be granted under its provisions. This provision unnecessarily goes beyond the TRIPS requirement by providing that such a moratorium must be removed.

Botswana is yet to utilise any of these flexibilities to ease access to medicine. It has rather resorted to fund the MISA programme through its budget and supplement it with funds raised from international NGOs, the U.S. government, pharmaceutical manufacturers, and other

[17] *Section 31(2) Industrial Property Act 2010*
[18] *Ibid.*
[19] *Section 31 (3) of the Industrial Property Act 2010*
[20] *Section 30 (7) of the Industrial Property Act 2010*
[21] *Section 32(2) Industrial property Act 2010.*
[22] *Section 32(3) Industrial property Act 2010.*
[23] *Section 32(4) Industrial property Act 2010.*
[24] *Section 33(1) of the Industrial Property Act 2010*
[25] *Ibid.*
[26] *Section33(3) of the Industrial Property Act 2010*

agencies.[27] These measures have not resulted in reducing the price of antiretroviral drugs; rather, it has been estimated that in 2003, the drugs alone cost the government between $1, 200 and $3, 000 a year per patient; and between $7, 000 and $10, 000 a year per patient when the cost of clinics and equipment was included.[28] This entails that the financial costs to the government is staggering and such a cost determines the amount of drugs that the government can procure on behalf of its citizens. It logically follows that access to medicine is limited.

These predicaments can to a great extent be solved by utilising the TRIPS flexibilities, including compulsory licensing. This, however, will not work alone; rather, it can be incorporated with other options such as parallel importation. In Botswana compulsory licensing can be effective because it has a stable economic environment as compared to other countries in the Southern Africa.

Compulsory Licensing in Zimbabwe

Compulsory licensing is provided for in Section 35 of the Zimbabwean Patent Act. This Act contains some provision which can be utilised by the state to override a patented invention during emergency. During any period of emergency the Minister has the authority to make, use, and exercise and vend the invention for any purpose which appears to the Minister necessary or expedient. In terms of this section the "period of emergency" means any period beginning on such date as may be declared by the Minister, by statutory instrument, to be the commencement and ending of such date as may be so declared to be the termination of a period of emergency. Thus it can be argued that the Minister has wide discretion to issue a compulsory license in times of emergency. It is interesting to note that this power has been exercised in Zimbabwe where the Minister of Justice, Legal and Parliamentary Affairs, issued a notice declaring a six-month period of emergency on HIV/AIDS in May 2002.[29] This Declaration was later extended from January 2003 to December 2008.[30] This was in accordance with the government policy to promote manufacturing and importing of generic HIV/AIDS drugs.

The Zimbabwean pharmaceutical manufacturing companies utilised this opportunity to the benefit of Zimbabweans. First, Varichem, agreed to produce antiretroviral or HIV/AIDS drugs and to supply three-quarters of these drugs to State-owned health institutions at fixed prices (Oh, 2006:26). It also agreed to provide price differentials between the patentee's drugs and its own manufactured drug. Caps Holdings Ltd also followed suit in manufacturing immunotherapy ARV drugs. This is commendable because these local pharmaceutical companies manufactured generic ARV drugs which are cheaper than patented drugs. Since the licence was given to many local companies, there was competition in the market and this in turn pushed down the prices of drugs from US$1, 168 to US$412 per patient per year (CP Tech, 2002). Interestingly, some patent holders are giving voluntary licenses to Zimbabwean companies; a case in point being Roche, a Swiss drug manufacturer, which offered a voluntary

[27] *Guzik B (2008). "Botswana's Success in Balancing the Economics of HIV/AIDS with TRIPS Obligations and Human Rights"*Loyola University Chicago International Law Review *Volume 4, Issue 2 255. Funding has come from the Bill & Melinda Gates Foundation ($50 million over five years), pharmaceutical manufacturer Merck & Co., Inc. (matching the Gates Foundation), the United StatesPresident's Emergency Plan for AIDS Relief ($24.4 million in 2004 to support prevention, and close to $51 million in 2005 to combat AIDS), the Global Fund to Fight AIDS, Tuberculosis and Malaria ($18.6 million), and other agencies.*

[28] *Guzik B (2008) @ 268*

[29] *Declaration of Period of Emergency (HIV/AIDS) Notice 2002, General Notice 240 of 2002.*

[30] *Statutory Instrument 32 of 2003.*

license to Varichem, for the production of a generic drug, Saquinavir, in 2007.[31] This further leads to cheap and affordable drugs. Thus it can be concluded that compulsory licensing is a success story in Zimbabwe.

THE PARAGRAPH 6 SYSTEM

The Paragraph 6 seeks to cater for the shortcomings of the compulsory licencing regime. Under Article 31(f), production under a compulsory license was predominantly for the supply of the domestic market. The Paragraph 6 system waives this requirement for exporting members in cases of production or export of a pharmaceutical product to eligible importing members, subject to conditions of transparency and safeguards. These measures include the prevention of re-exportation of generic drugs, payment of remuneration, taking into account the economic value of the authorization of the importing member; and notification of the intention to use this system. This notification should include specification of names and expected quantities of the products needed; should establish that a Member has insufficient or no manufacturing capacities; and, the confirmation of a grant or intention to grant a compulsory license, if product is patented in the importing country. The importing member is required to give notice to the WTO as well as the website of the licensee and should post the quantities being supplied to each destination and the distinguishing features of the product. Imported products should be clearly identifiable through specific labelling or marking; and special packaging or colouring or shaping of products. It is noteworthy that Zimbabwe authorized Datlabs and Omahn and thus received government authorization to procure ARVs from India.

PARALLEL IMPORTS

Parallel import may be defined as "the import and resale in a country, without the consent of the patent holder, of a patented product that has been legitimately put on the market of the exporting country under a parallel patent" (Musungu and Oh, 2005:27). Once the product is on the market, the patent holder cannot prevent the subsequent resale of that product since his right over the product has been exhausted by selling it. Parallel importation is provided for under Article 6 of the TRIPS Agreement as well as under the Doha Declaration on TRIPS Agreement and Public Health. It can be used to source pharmaceutical products in different markets where they are cheap and affordable, especially where such a developing country has an international exhaustion regime.

Parallel Importation and Exhaustion in Botswana

The Act limits exhaustion only to goods placed on the domestic market by the patentee or with his/her consent. [32] This provision indicates that the Botswana legislators have opted to provide for domestic exhaustion rather than the wider notion of international exhaustion. It is my view that the Botswana legislators should have opted for the doctrine of international exhaustion to apply. This would have particularly benefited Botswana in the health sector and particularly in relation to the HIV /AIDS epidemic given the prevalence rates in the country. By allowing the operation of the international exhaustion doctrine it would have been possible to import patented medicines, particularly HIV/AIDS drugs, where they are sold cheaper and this would

---

[31] *See news reports at http://www.fdanews.com/newsletter/article?articleId=93992&issueId=10246 accessed 30 May 2009.*

[32] *Section 25 Industrial Property Act, 2010.*

probably ensure that a greater number of people would then benefit from antiretroviral drugs. As the law stands now, Botswana will always have to invoke the compulsory licencing mechanism, which is a long process.

Parallel Importation in Zimbabwe

Section 24A of the Zimbabwean Patent Act provides for parallel importation and international exhaustion of patent rights.This provision was inserted by section 7 of the Patent Amendment Act 9 of 2002 and this is evidence of incorporation of TRIPS flexibilities into domestic legislation. Zimbabwean pharmaceutical companies like Datlabs import Zidovudine from Ranbaxy, India, and this has significantly contributed to access to cheap and affordable medication in Zimbabwe.

EXCEPTIONS TO PATENT RIGHTS

Article 30 provides for limited exceptions to patent rights. The TRIPS Agreement provides that an exception should not unreasonably conflict with normal exploitation of the patent; should not unreasonably reduce the legitimate interests of the patent owner; and should take into account the legitimate interests of third parties. Examples of permissible exceptions include early working (bolar) exceptions and exception for research or experimental use of an invention.

This provision has not been utilised in Botswana. As for Zimbabwe, Section 24 (4) of the Act provides that granting of patent rights should not be "construed as prohibiting any person from making, constructing, using or selling the patented invention solely for uses reasonably related to the development and submission of information required under any law that regulates the manufacturing, construction, use or sale of any product". In addition, section 24B also provides for early working exceptions. According to this section, test batches of a patented product may be produced without the consent of the patentee six months before the expiry of the patent, provided that the test batches shall not be put on the market before the expiry date of the patent. This early working exception ensures that as soon as the patent expires, cheap and affordable generic drugs would come into the market; thus this measure promotes access to cheap medicines in Zimbabwe. Datlabs and Varichem successfully utilised this provision in manufacturing their generic versions of Combivir and Zidovudine.

CONCLUSION

A discussion of the domestication and utilization of the TRIPS flexibilities by the two countries referred to in this paper illustrates a paradox in developing African countries. First, Botswana was the first country between these two to come up with a TRIPS compliant legislation as early as 1996. However, this legislation did not include most of the flexibilities included in the TRIPS Agreement and were consequently not utilized in Botswana. On the other hand, Zimbabwe, which amended its legislation in 2002, did incorporate most of the flexibilities. It is only now that Botswana is in the process of amending its Industrial Property Act to include most of the TRIPS flexibilities. Secondly, although Botswana has not issued any compulsory licenses, its government-sponsored MASA programme which utilizes patented drugs only, has enabled access to medicines to a significant number of Batswana, despite its access to expensive medicines and not so cheap generic versions. On the other hand, Zimbabwe which was the first country to issue a compulsory licence in the post-Doha period, did not manage

to afford access to medicine for most of its people. This is mainly due to her political and economic instability. Thus it can be concluded that issuing a compulsory licence is only a starting point in the process of affording access to cheap medicines. It should be accompanied by a relatively stable political and economic environment which allows for efficient administration and administration of the programme.

Overall, it is without doubt that TRIPS flexibilities, if properly incorporated and utilized, enhance access to medicines in developing African countries. If, while utilizing patented drugs, Botswana can afford drugs to most of its people, what more if it was utilizing generic drugs. However, in order to ensure the long term success and sustainability of the MASA programme, it is recommended that Botswana should incorporate TRIPS flexibilities and utilize them. Use of cheaper generic drugs in the MASA programme would ensure cheaper and affordable drugs and long-term sustainability of the programme. Meanwhile, in the wake of the on-going global financial crises, use of cheaper generic drugs would ensure a big cut in government spending in the MASA programme. As Zimbabwe is slowly going through the economic recovery path, it is suggested that it should fully domesticate TRIPS flexibilities and utilize generic drugs. These measures, it is hoped, will enhance access to medicines in developing African countries, in general; and in Botswana and Zimbabwe, in particular.

REFERENCES

Abbott, F.M. (2005). The WTO Medicines Decision: world pharmaceutical trade and the protection of public health. *The American Journal of International Law* 99(2), 317–358.

Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement).

Amendment of the TRIPS Agreement, WT/L/641, 8 December 2005.

Doha Declaration on TRIPS and Public Health of 2001.

Gerhardsens, S. (2007). Brazil takes steps to import AIDS drug under Trade Law. Intellectual Property Watch. http://www.ip-waitch.org 30/06/2013.

Guzik, B. (2008). Botswana's Success in Balancing the Economics of HIV/AIDS with TRIPS Obligations and Human Rights. Loyola University Chicago International Law Review 4(2) : 255.

Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health, WT/L/540 and Corr.1, 1 September 2003 (Decision of the General Council of 30 August 2003).

Industrial Property Act 2010, Botswana.

Lidgard, H.H. and Atik, J. (2005). Facilitating compulsory licensing under TRIPS in response to the AIDS crisis in developing countries. Loyola Law School (Los Angeles) Legal Studies Paper No.18. http://ssrn.com/abstract=794228 25/05/2013.

Maonera, F. and Chifamba, T. (2003). Developing a regional framework on access to medicine for protecting public health needs in COMESA. COMESA, Lusaka.

Matthews, D. (2004). WTO decision on implementation of paragraph 6 of the Doha Declaration and Public Health: A solution to the access to the essential medicines problem? *Journal of International Economic Law* 7 (1), 73-107.

Matthews, D. (2006). From the August 30, 2003 WTO Decision to the December 6, 2005 Agreement on an amendment to TRIPS: Improving access to medicines in developing countries. Intellectual Property Quarterly 2, 91-130.

Musungu, F. and Oh, C. (2005). The use of flexibilities in TRIPS by developing countries: Can they promote access to medicines? Commission on Intellectual Property Rights, Innovation and Public Health (CIPIH), Study 4.

Oh, C. (2006). Compulsory Licenses: recent experiences in developing countries. International Journal of Intellectual Property Management 1, 22-356.

Outterson, K. (2005). Pharmaceutical arbitrage: balancing access and innovation in international prescription drug markets. *Yale Journal of Health Policy*, Law and Ethics 5, 193-291.

Satyanarayana, K. (2005). TRIPS, patents, and HIV/AIDS drugs. *Indian Journal of Medical Research* 121(4), 211-214.

Srinivas, R.K. (2003). Interpreting Paragraph 6 deal on patents and access to drugs. Economic and Political Weekly http://www.epw.org.in. 20/05/2013.

Understanding on Rules and Procedures Governing the Settlement of Disputes (DSU).

Valach, A. (2005). Protecting the rights of patent holders and addressing public health issues in developing countries. *Chicago-Kent Journal of Intellectual Property* 4, 156-185.

Zimbabwean Declaration of Period of Emergency (HIV/AIDS) Notice 2002.

Zimbabwean Patent Act [Chapter 26:03]

Zimbabwean Statutory Instrument 32 of 2003.

NOTES FOR CONTRIBUTORS (UREJ)

EDITORIAL POLICY:

The UNISWA Research Journal is published twice a year, in June and in December. It publishes papers in Commerce, Education, Humanities, Social Science and related disciplines. Articles should be written in English and, generally speaking, will fall into one of the following categories in the above disciplines:

- original research, both empirical and theoretical
- review of literature on any topic
- analysis of problems or phenomena needing to be researched
- accounts of professional practice
- policy papers

SUBMISSION OF PAPERS:

Manuscripts should be sent to The Secretary, Editorial Board, UNISWA Research Journal, University of Swaziland Research Centre, Private Bag, Luyengo, Swaziland or Email to research@uniswa.sz. The cover of the paper should indicate the author's name, title (Dr., Prof., Ms …), position, department and contact numbers.

Submission of an article is taken to imply that it has not been published elsewhere nor is being considered for publication elsewhere. Since the Journal employs computerized type-setting, submissions may be made on disk, using Word or compatible programme, and accompanied by a print-out. Articles should be typed, double-spaced, with an ample margin on A4 paper, they should have a minimum length of 5000 words excluding references and appendices. Book reviews should not usually exceed 1000 words.

An abstract of 100 words or less, summarizing the main points, should accompany the typescript. Endnotes (for supplementary comments) should be typed at the end of the text. Footnotes are not employed. Tables should be typed at the appropriate place in the text; figures should be submitted on separated sheets, done in black ink on white paper and ready for camera production. The style to be followed is that of Hart's Rules for Compositors and Readers.

REFERENCES

References should be indicated in the text by giving the authors name with year of publication (in brackets) and page number when direct quotation is made. At the end of the paper, the references should be listed (without numbering) alphabetically according to the first author's name, as shown in the examples below:

Crush, J. (1986). Colonial coercion and the Swazi tax revolt of 1903-07, In: Daniel, J. and Stevens, M. (Eds.), Historical perspectives on the political economy of Swaziland, SSRU, University of Swaziland.

Dumane, M. and Saunders, P. (1974). Lithoko, Sotho praise poems. Oxford University Press, Oxford.

Hopkins, A. (1973). An economic history of West Africa. Longman, London.

Nyeko, B. (1976). Pre-nationalist resistance to colonial rule: Swaziland on the eve of the imposition of British administration. Trans-African Journal of History. 5: 68-84.

**Manuscripts should have at least one citation from UNISWA Research Journal.
Manuscripts which do not comply with these requirements will be returned to the authors.