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**An Ethical Claim for Administration of Pre-Exposure Prophylaxis
(PREP) in HIV and AIDS Burdened Africa**

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Abstract

It is morally justifiable for every person of good will to venture into HIV and AIDs prevention among the populace. Pre-exposure Prophylaxis (PrEP) administration promises to help meet the promise of this moral claim, which is founded on two ethical principles of ensuring well-being and justice for all. In spite of the efforts, challenges abound, especially in Africa. Some African tenets of sexuality, unavailability of contextualized and harmonized African sexuality theory as well as Africa's poor economic standing are major threats to the administration of PrEP. This paper highlighted the major challenges and calls for their resolution if PrEP administration is to be of help to the poor and HIV burdened Africans.

Key Words: HIV prevention, Preexposure Prophylaxis (PrEP), well-being, justice

Introduction

Despite the several interventions to prevent the Human Immuno-deficiency Virus (HIV) infection and Acquired Immuno-deficiency Syndrome (AIDS), new HIV infections are still on the rise. There is a general agreement that the leading cause of new HIV infections is

heterosexual relationships within or outside marriage (Extra-marital and or concurrent relationships).

Heterosexual transmission has been reported to be responsible for the majority of the new HIV infections (Gouws et al., 2006; UNAIDS, 2012). The Modes of Transmission Study (2008), attributed majority of new infections to varying heterosexual partnerships which was reported to be at 44.1 per cent. The study showed that both men and women who engaged in casual sex constitute 20 per cent of new infections. Sex workers and their clients, 14 percent, while men who have sex with men (MSM) and the prison population contributed 15 per cent of new infections. The remaining 6.3 percent represented the people who injected drugs (Ibid). The Kenya Demographic Health Survey (KDHS, 2008) report showed that an estimated 6 per cent of HIV positive couples are discordant and therefore at high risk of HIV infection.

In spite of the deliberate and strategic efforts towards elimination of the Human Immunodeficiency Virus (HIV) infection and Acquired Immuno-deficiency Syndrome (AIDS), new HIV infections are still on the rise (UNAIDS, 2018). Further, all people living with HIV (PLWH) are those who are in need of antiretroviral therapy (ART). In as much as decline in HIV prevalence is notable in the general population, increase in the new HIV infections among the married and young adults suggest a need for more attention.

This is because the married and young people are a distinct category for several reasons. Firstly, the young people are going through physical and biological growth and development which is usually accompanied by sexual maturation, often leading to intimate relationships which put them at risk of contracting the HI virus. Secondly, in Kenya the first generation born HIV positive babies are now approaching 30 years (Africa Health Dialogue, 2012). It was clinically argued that majority of such babies would die before they turn five years (UNAIDS, 2009). However, there is evidence now that perinatally HIV infected adolescents (PHIVA) are surviving into adolescents and adults, thanks to the commendable access to the highly active antiretroviral therapy (HAART) (Hazra et al, 2010). These PHIVA are long term survivors of HIV and are sexually active amidst the other non-suspecting age group.

On the part of married adults in Africa, the patriarchal nature embedded in our cultures allows polygamous marriages. Men are allowed to marry many wives as a sign of respect and wealth (Chitando, 2009). According to Cadwell (2002), men keep multiple partners since they hold a belief that they are biologically programmed to need sexual intercourse with many women. This culture of extramarital relationships creates a web of sex networks, which increases the risk of HIV infection in marriage (Whiteside, 2006). These behavioural patterns of extramarital affairs are inherently dangerous because ‘as soon as one person in a network of concurrent relationship contracts HIV, everyone else in the network is placed at risk, both the married and the unmarried (Halperin et al, 2004: 1914). This creates a vicious cycle of HIV infections and transmissions, since the unmarried persons engage in sexual relations with married men and women for economic support (transactional sex) among other reasons.

These scenarios put people at risk of contracting the HI virus. However, with the advent of effective antiretroviral therapy (ART), HIV is no longer considered a terminal illness but a manageable long-term condition. Taking a leap further, it is now increasingly being used for prevention-both preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP). The use of PrEP and PEP promises to help meet the strong moral claim to prevent infection with HIV. PrEP is defined as the administration of antiretroviral drugs to an uninfected person before potential HIV exposure to reduce the risk of infection and continued during risk (Naswa &

Marfatia, 2011). PEP is an emergency intervention to abort HIV acquisition arising from occupational or non-occupational exposure to HIV-infected blood or potentially infectious bodily fluids (Jain & Mayer, 2014).

Prevention of HIV to the general population is a moral venture. In using PrEP, two broad ethical domains are of special relevance: well-being and justice. Ethical issues related to well-being include: safety, parameters of use, risk behaviours, resistance, stigma, and diversion. Those related to justice include: access and competing priorities (Sugarman & Mayer, 2013).’ The use of PrEP for HIV prevention has been lauded to change the pace of prevention struggles. Its cost, affordability in its administration and uptake according to Eakle et al (2018), requires serious practical and social scrutiny in order to meet the ethical claims. In Africa, achievement and realization of these two ethical domains may be challenged by prevailing cultural practices and economic standing.

It is from this backdrop that this paper questions the appropriateness of prescribing PrEP to healthy persons who are at risk of becoming infected with HIV and those at risk for being infected, especially in an African setting. Even though the use of PrEP promises to help meet the strong moral claim to prevent infection with HIV, holistic well-being of individuals and communities ought to be considered. This paper argues that the administration of PrEP must be balanced against an array of other challenges to the well-being of African individuals and communities.

Brief Tenets of African Sexuality and HIV

Africa has been shown to be a hotbed of sexual diversity and sexual controversies. African sexuality has however, endured despite dynamism in culture, increasing liberalization, plurality of ethnic beliefs and relativism on matters of sexual ethic on the African continent. Many African old sexual traditions and practices have tended to endure, with a considerable impact on HIV transmission in particular and in sexuality in general. For instance, some African communities still embrace polygamy to date, in spite of heterosexual concurrent relationship being a major contributor to HIV transmission. Levine and Walter in the *Journal of Comparative Family studies* (1980) pointed out that women in Asia, South Africa and Northern Nigeria are allowed by customary law to marry several husbands. Polygamy and polyandry complicate the use of PrEP because it requires support by multiple partners otherwise its results will be jeopardized. Amidst these cultural diversities in practice, several outstanding aspects on African sexuality stand out.

According to Mbiti (1986), sexuality in Africa is key in marriage and bearing of children. Reproduction is viewed as a neutralizing component of death. Children are valued as a sign of wealth and continuation of clan lineage. Sex in Africa is a taboo subject, Kinoti (1983) noted in her thesis on *Aspects of the Agikuyu Traditional Morality* the essence of sex being a taboo among the Agikuyu community. The same is echoed by Echezano (2008) in his article on *Sexual taboos and HIV and AIDS in Africa*. This implies that taboos and secrecies on sex fuels HIV and AIDs to continue thriving uncontrollably in Africa and Discussions on PrEP are also not likely to arise. As such, many people in Africa shy away from discussing it. Further, virginity, especially for the girl child is highly esteemed. This is a fact that is known to be fuelled by patriarchy that allows men to proudly marry several wives while the opposite is detested. Wife inheritance, ritual cleansing and early marriages are among the many detrimental practices that hasten the spread of HIV.

As such, Africa morally requires attention in the administration and use of PrEP. The HIV and AIDS burden in the continent is however, straining its economic standing. Many African countries already struggle to provide ARVs to people who are infected and say they cannot afford PrEP for the large uninfected populations who need it most. People at substantial risk of becoming infected by HIV may not know about PrEP. Further, the secrecy with which sex is regarded in Africa may not allow a chance for its administration.

Socio-Economic Dilemma in the Administration of PREP

According to Phelan and Link (2013), socio-economic status of a nation is directly associated with multiple health risk issues and mortality. The socio-economic status influences multiple illness results. This is because distribution of resources plays a critical role in the relationship between socio-economic status and health –mortality in particular.

Owing to the Africans socio-cultural behaviours regarding sex, majority of them are at an elevated risk of contracting HIV. The continued rise of transmission as new HIV infections is due to traditional risk factors that impact of one's economic status. Polygamy and early marriages are some of the traditional risky practices that have so far been 'modernized' into concurrent relationships and the concept monetization of sex. According to Hubbard (2017) commodification and consumption of sex in exchange of a legal tender either by sex workers or their consumers into business spaces calls for ethical continuance. These high-risk behaviours are fuelled by among other factors poverty and a search for 'self-actualization'. Cultural practices, further complicate the scenario by making it difficult to negotiate and adapt to safe sex practices (Bond & Gunn, 2016).

One potential option to curb the spread of new HIV infections in this economic challenged environment is an embrace of PrEP, for the individuals who are HIV negative (Centre for Disease Control and Prevention, 2016). Given the African context where sex is a taboo subject and as such, HIV and AIDS patients still face stigma and discrimination, PrEP may slow the HIV transmission. This is because the preventive method is discreet and individually controlled (ibid) and is not dependent upon partners who have grown and socialized under patriarchal regimes. According to Valdiserri (2002), HIV and AIDS patients were considered to be immoral and undeserving of care owing to the tight moral standing that is purely male-dominated. These cultural dictates are difficult to evade since people have been socialized to perceive them as normative, both men and women, even when they are repressive.

Given the struggling economic history of most of the African nations, efficient administration and reception of PrEP may be a challenge. Africa bears the greatest burden of people living with HIV and AIDS (PLWH) and in need of ARVs, which is already constraining their budget. In order to ensure wellbeing, Africa is so dependent on foreign aid to ethically support life and its dignity. Thus, the handout culture becomes a breeding ground for deterring factors such as transgenerational and transactional sex as fuelled by poverty. This complicates the prevention of new HIV infections. Older men will sexually engage with young girls and vice versa for the exchange of money.

Apart from economic challenges, African cultural practices challenge the administration of PrEP. In as much as health care providers and public health professionals are championing new and emerging preventive and treatment efforts, barriers to their implementation in Africa has to be recognized, negotiated and addressed (Krakower & Mayer, 2012). For instance, Africans proud themselves of tight moral values with regard to sexuality. This fact however, may not

linger well with global north scholars, who use their contextualized theories on sexuality to analyze this sensitive topic on African sexualities (Arnfred, 2004). Acceptance and use of PrEP may be seen as an avenue of watering down their morality. In a society where virginity is treasured and a resounding perception that fear of contracting HIV and AIDS has ensured a tight hold on to chastity, introduction of PrEP among the healthy persons may not be welcome. In agreement with Liu et al (2008), there is a need to educate the populace on the efficacy and ethical importance of PrEP.

Foreign AID and HIV Prevention

Owing to the economic constraint, most African nations have turned the funding and management of HIV and AIDS programme over to foreign donors, instead of putting their own monies to their health care system (Younde, 2010). Donor funding for HIV and AIDS programmes even though laudable has contributed to unethical precedents. The donors may mean well as far as respect for life and human dignity is concerned. The hidden agenda however, may not settle well with what we may call uncompromising integrity/ethics.

According to National Security council (2006), developed nations defined HIV and AIDS among other infectious diseases as a global security issue. They argued that poor health can pose a threat to national security through increased instability, weak government institutions and stagnation in economic growth (ibid). Feldbaum et al (2006) however opinionated that, turning a disease into a security issue threatens to focus attention on one disease rather than promoting general health for all. In as much as HIV and AIDS is a concern in Africa, cancer and Ebola are threats that need instant attention. Further, if security becomes the driving force in funding HIV and AIDS programmes, then the nations that do not cooperate with the donor nations may receive disproportionate share of funds, hence compromising the lives of human persons.

Such fear was and still is witnessed following the 1980's attachment of conditionalities to grants and loans by international financial institutions. Developing nations had to adopt to Structural Adjustment Programmes (SAPs) in order to receive funding (Younde, 2010). According to Bond (2007), the conditions put in place by SAPs targeted the nations that had fewer alternatives, thus putting social services out of reach to too many people. This in turn aggravated health problems even further. Instead of the donor fund benefitting the countries receiving it, SAPs helped the donor nations by creating market for their finished products and also access to their natural resources.

The function of foreign aid has received lots of criticism and scrutiny. Jeffery (2008) and Moyo (2009) asserted positively that the international community can address majority of the health problems facing the developing world be it HIV and AIDS, maternal mortality and or the spread of infectious and life style diseases. This can be achieved by increasing foreign aid in terms of grants and not loans. According to Moyo (2009), foreign aid dispatched as a loan does more harm than good to the African states. She argues that foreign aid contributes to corruption amongst government officials, encourages dependency between developing nation and the developed donor nations. This scenario discourages the African governments from coming up with structures and strategies of funding their own social service.

It is important to note that HIV and AIDS is a humanitarian concern more that it is a security need, even though the later may be implied. It is thus ethical that the donor states focus more on the humanitarian factor. Increased donor funding on well-being and a commendable

decrease of new HIV infections is justice served on a clean platter. As such, the two ethical principles of well-being and justice will be met if the relationship between HIV prevalence, government spending on health, foreign aid for HIV and countered cultural risky sexual behaviours mutually complement each other, while upholding one's self identity.

Conclusion

Effective training, provision and administration of PrEP can curb the spread of HIV and AIDS that has constrained the economy of most of the African nations. African sexuality creates an environment that necessitates further spread of the HI virus. Traditional and cultural practices such as polygamy and early marriages that are being practiced currently as concurrent relationships, transgenerational and transactional sex are founding reasons for the embrace of PrEP in HIV prevention efforts. Following the poor economic standing of African nations, we recommend an increase in donor funding in terms of grants and not loans that further constrain African economy. The affluent nations are known for their solid social health care systems can also employ different strategies that can help the African countries develop integrated methodologies of providing social health care to all her populace without hurting their culture and lifestyles. In the end, the virtues of justice and well-being have to be upheld in the health care sector.

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