



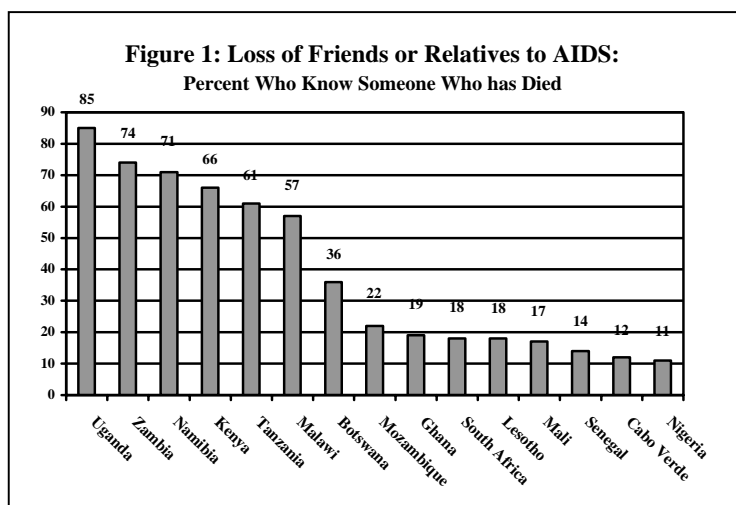
**Public Opinion and HIV/AIDS:
Facing Up to the Future?**

Across fifteen countries surveyed in Round 2 of the Afrobarometer, our data indicate that large proportions of people (especially in East and Southern Africa) have either lost family or friends to AIDS, or suffer under the burdens of AIDS by caring for sick family members or orphans. Yet despite exposure to the pandemic, we find that ordinary Africans have not yet grasped its full collective social, economic or political significance. Poor people demote AIDS to a low priority problem behind more immediately pressing concerns like jobs or hunger. Citizens are undecided about whether their governments should divert scarce resources from these and other important priorities to fight the AIDS epidemic in their country.

Personal Loss to AIDS

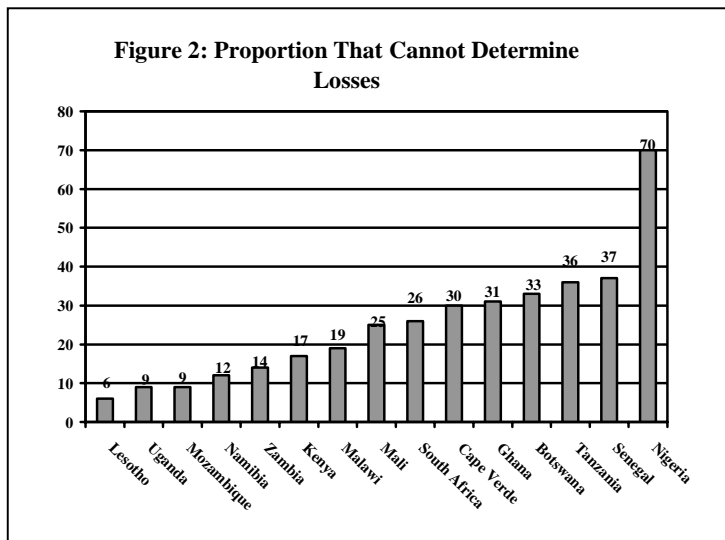
Africans are keenly aware of the impact of AIDS in their societies and large majorities are quite able to give a firm estimate of precisely how many people they know who've died of the disease. As a closing question before the interview ended, Afrobarometer interviewers asked respondents: "How many close friends or relatives do you know who have died of AIDS?"

In East Africa, 85 percent of Ugandans and 66 percent of Kenyans told us that they had lost at least one close friend or relative to the pandemic. In Southern Africa, three quarters of Zambians (74 percent), seven in ten Namibians (71 percent) and six in ten Malawians (57 percent) say they have lost someone. Some 68 percent had also experienced loss in our last survey in Zimbabwe in 1999. Lower proportions report experiencing loss in places where national epidemics started later, such as Botswana (36 percent), Mozambique (22 percent), Lesotho, and South



Africa (18 percent each). The figures for West Africa are generally considerably lower, ranging from one in five Ghanaians (19 percent) to one in ten Nigerians (11 percent) (see Figure 1).

One quarter of all respondents could not say precisely how many losses they have experienced. The proportion of "don't knows" ranges widely, from between 5 and 10 percent in Lesotho, Uganda and Mozambique, to seven in ten Nigerians (see Figure 2). We are fairly certain that these responses do not mask stigma or refusal to speak about a sensitive topic because in Round 1, a differently worded question

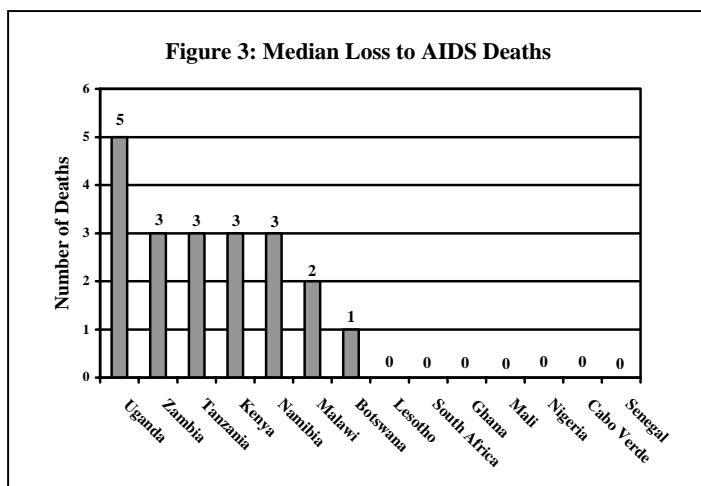


that simply asked people “Do you know of a close friend or relative who has died of AIDS?” found that less than one in twenty did not know, and about the same number refused to answer.¹

Among those who can offer an answer (including those who say “0”) we find the following. The average (median) Ugandan has lost 5 close friends or relatives to the epidemic, whereas the average Kenyan, Zambian, Tanzanian or Namibian has lost 3 people. In Malawi, the median level of loss is 2, and in Botswana it is 1. In all

other countries, including Lesotho and South Africa, the average (median) person still does not know, or is not aware that a friend or relative has died of the disease (see Figure 3).

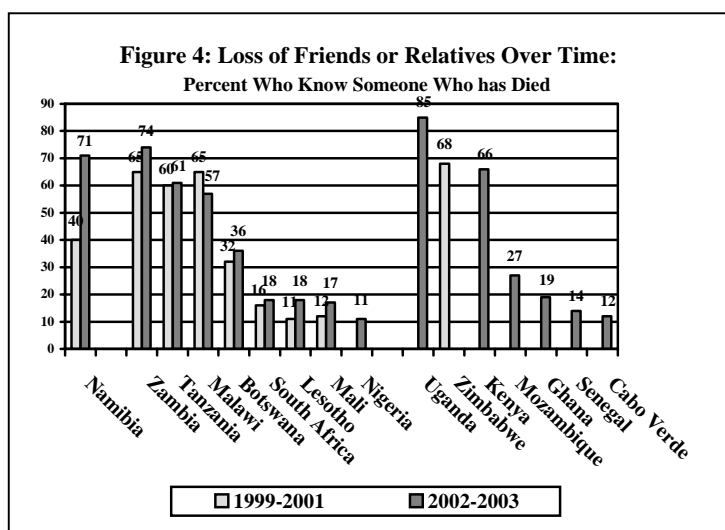
A direct comparison to results from Round 1 (conducted between July 1999 and October 2001) is hobbled by the fact that the questionnaire asked people only whether they knew of a close friend or relative who had died of AIDS, but not how many. Thus we can only compare the percentages that said they had experienced a loss, and must defer any question of changes in the extent of loss to the future. In doing so, we recognize that it is preferable to have at least three observations so that any changes are due to real, secular trends rather than random fluctuation or measurement error. In order to



minimize the chances of arriving at faulty conclusions we, therefore, only draw attention to differences in results of 10 percentage points or more (for any given Afrobarometer survey the confidence interval is plus or minus 3 percent; this interval doubles to 6 percent when two surveys are compared). We prefer to use an even larger margin – at least 10 percentage points – before speculating that any observed differences between Round 1 and Round 2 survey results reflect emerging changes in people’s experiences or opinions.

Given this stricture, the data suggest that only Namibia has seen a real and dramatic increase in the proportions that have experienced AIDS deaths, rising sharply from 40 percent in 1999 to 57 percent in 2002 to 71 percent in 2003 (see Figure 4). No other apparent increases or decreases in any country between Round 1 and Round 2 exceed our conservative criterion. None of this is meant to suggest that the extent of AIDS deaths has ceased to grow, but rather that the felt effects of these events appear to have diffused only in Namibia.

¹ Alan Whiteside, Robert Mattes, Samantha Willan & Ryann Manning, *Examining the HIV/AIDS Epidemic in Southern Africa Through The Eyes of Ordinary Southern Africans* Afrobarometer Working Paper No. 21 (2003) (www.afrobarometer.org).



Besides an individual's country of residence, few demographic indicators – including personal levels of lived poverty – help us isolate the impact of national epidemics, suggesting that the impact of disease diffuses indiscriminately across class and gender. Rural people are more likely to have lost a close friend or family member, as are younger respondents, but these differences are only slight.²

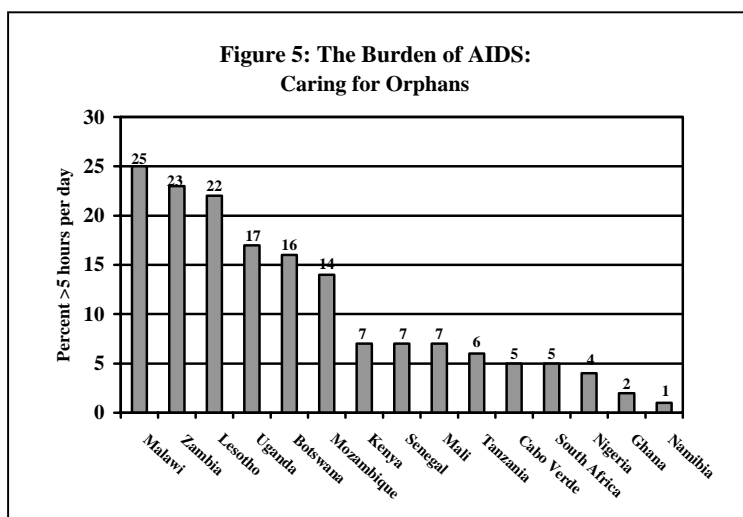
By contrast, cognitive factors such as formal education and media usage are much more helpful in

distinguishing between those who can ascertain the extent of AIDS losses and those who say they do not know. Even amongst those who offer a substantive answer, more educated and more informed respondents are much more likely to say they lost someone to the disease.³

The Burden of HIV/AIDS

As another way to monitor the impact of the pandemic, we asked how much time people devote to a variety of basic daily activities, including how much time they spend looking after either sick household members or orphaned children. Of course, we cannot be sure whether these children have been orphaned as a result of AIDS, but in most cases, the cross-national differences appear to reflect the social burdens imposed by the varying stages of national epidemics. In other cases, however, they seem to reflect unique national differences in social networks and other social conditions.

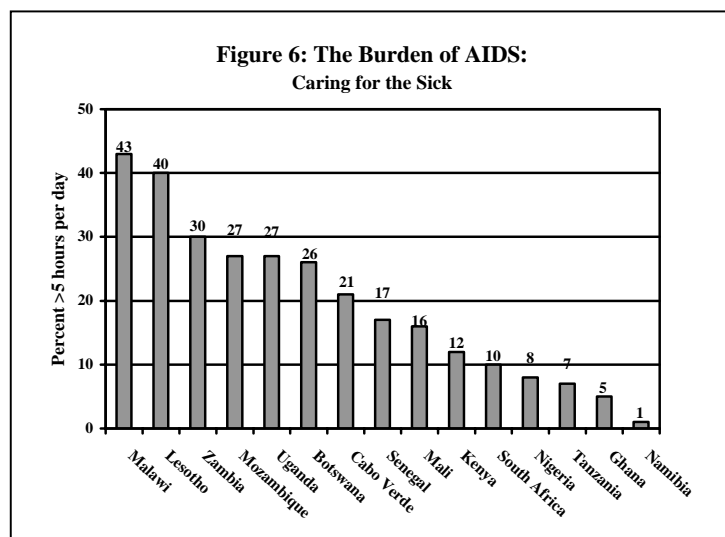
Between one quarter and one fifth of Malawians (25 percent) and Zambians (23 percent) say they spend more than five hours a day caring for orphans, but so do Basotho (22 percent) (see Figure 5). In Lesotho's case, the results might reflect people who care for children of migrant labourers away in South Africa. Ugandans rank somewhat lower than might be expected, at 17 percent: however, this might indicate that the children orphaned at the height of the epidemic in that country are now young adults. Some 16 percent of Botswana and 14 percent of Mozambicans (14 percent) also devote more than 5 hours a day to this task. Yet other societies afflicted by the



² For urban-rural residence, the correlation is .058 ($p < .001$, $N = 18,001$); for age, it is $-.070$ ($p < .001$, $N = 17,640$).

³ The correlation between formal education and loss is .176 ($p < .001$, $N = 17,941$) (where those who do not know how many people have died are treated as not knowing anyone). The correlation between formal education and loss (excluding those people who say they do not know) is .213 ($p < .001$, $N = 13,341$). For newspaper readership, the correlations are .133 ($p < .001$, $N = 18,001$) and .151 ($p < .001$, $N = 13,476$) respectively.

epidemic register relatively low levels, such as Kenya (7 percent), Tanzania (6 percent) and Namibia (1 percent). It is hard to imagine that these burdens are being alleviated by the state in these countries. Instead low levels of orphan care may reflect severe deficiencies in social networks that otherwise might help cushion the impact of the epidemic. Or they may suggest that other actors, such as private or church run orphanages, are relieving families of this burden.

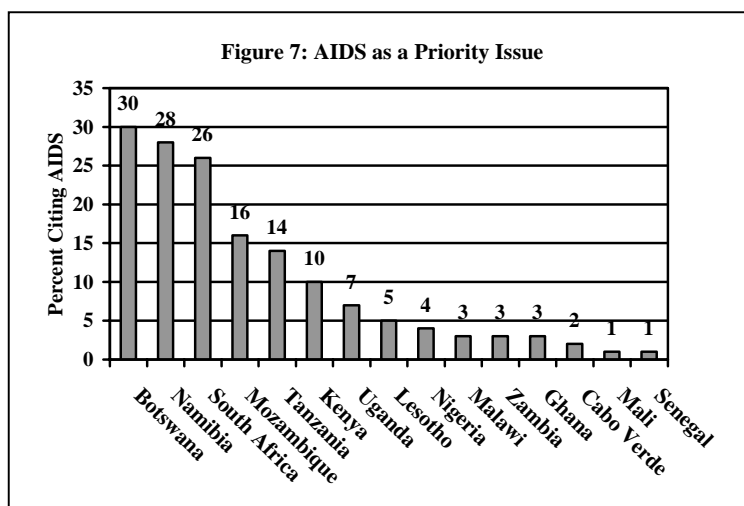


The same general patterns can be observed with respect to the burden of illness. Four in ten Malawians (43 percent) say they spend more than 5 hours a day looking after sick household members, as do anywhere from a third to a fifth of Zambians, Mozambicans, Ugandans, and Botswana (see Figure 6). Yet 40 percent of Basotho also give this answer, reflecting the unexpectedly high levels of illness we uncovered in Lesotho in Round 1.⁴ And few Tanzanians and Namibians say they devote this amount of time to caring for sick family members, again suggesting inadequate caring networks in these societies.

Rural people are more likely to bear the burden of illness and care for sick household members.⁵ While lived poverty is not linked to awareness of AIDS, it is strongly linked to the social burdens associated with the epidemic. Poor people are doubly affected in the sense that they are more likely to devote significant amounts of time to both looking after orphans and to taking care of sick household members.⁶

HIV/AIDS and the Public Agenda

Even though AIDS has touched the lives of large proportions of Africans, it has yet to register very high on what we call the “people’s agenda.” We ask: “In your opinion, what are the most important problems facing this country that government should address?” They are encouraged to mention up to three issues. Across the fifteen countries surveyed, just one in ten respondents (11 percent) mentioned “AIDS” (see Figure 7). In Southern Africa, the current epicentre of the pandemic, the average is not substantially higher (15 percent)

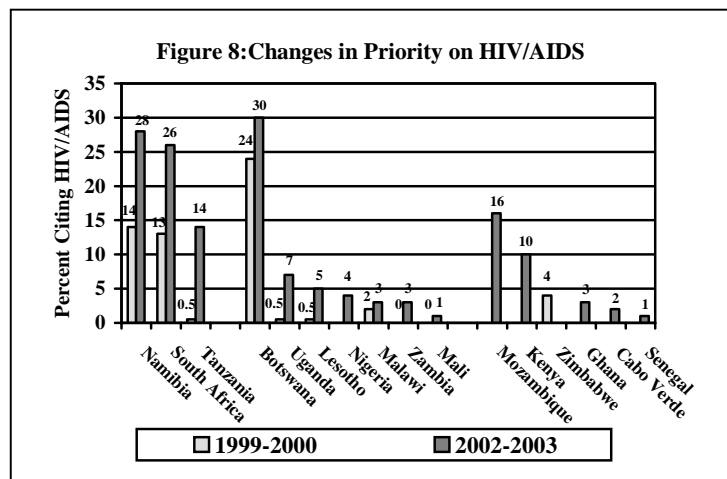


⁴ See Whiteside et al, *Examining the HIV/AIDS Epidemic through the Eyes of Ordinary Southern Africans*.

⁵ The correlation of urban-rural status and time spent caring for orphans is .117 ($p < .001$, $N=18,001$) and caring for sick household members is .135 ($p < .001$, $N=18,001$).

⁶ The correlation of lived poverty and time spend on caring for orphans is .194 ($p < .001$, $N=17,574$) and caring for sick family members .232 ($p < .001$, $N=17,574$).

though it does rise above this in Botswana (30 percent), Namibia (28 percent) and South Africa (26 percent). At the other end of the spectrum, hardly anyone explicitly mentions “HIV” or “AIDS” in Lesotho (5 percent), Malawi (3 percent) or Zambia (3 percent). No more than 4 percent mention “AIDS” in any West African country.



By this measure, we can see significant increases in public consciousness of the AIDS issue over time in Namibia (moving from 14 in 1999 to 28 percent in 2003), Tanzania (from less than 1 percent in 2000 to 14 percent in 2003) and South Africa (the 26 percent in 2002 is up from 13 percent in 2000 and 1 percent in 1994) (see Figure 8).

Yet these limited advances should not obscure the larger question of why a pandemic that has caused such widespread sense of *personal* loss in

many countries, and is imposing significant burdens on *households*, is not named as a priority *public* issue more frequently.

One reason appears to be that the collective, society-wide scope of the pandemic is difficult for less politically literate people to grasp. We find, for example, that the higher a person’s level of formal education and the more often they read newspapers, the more likely they are to cite “AIDS” as an important issue.⁷

Another reason seems to be that on a continent in which many people go without basic necessities on a regular basis, the relatively longer term threat of AIDS must stand in line behind more pressing, immediate concerns. At the individual level, we find that while those who have experienced loss are *more* likely to cite “AIDS” as a national problem requiring government attention, those who suffer higher levels of lived poverty are *less* likely to cite the issue.⁸ We also find that at the societal level, the poorer the country (in terms of national wealth), the less likely it is to see AIDS collectively as an important issue. Perhaps this is why people collectively seem to think that their country has the resources to combat HIV/AIDS only in sub-Saharan Africa’s wealthiest democracies.⁹

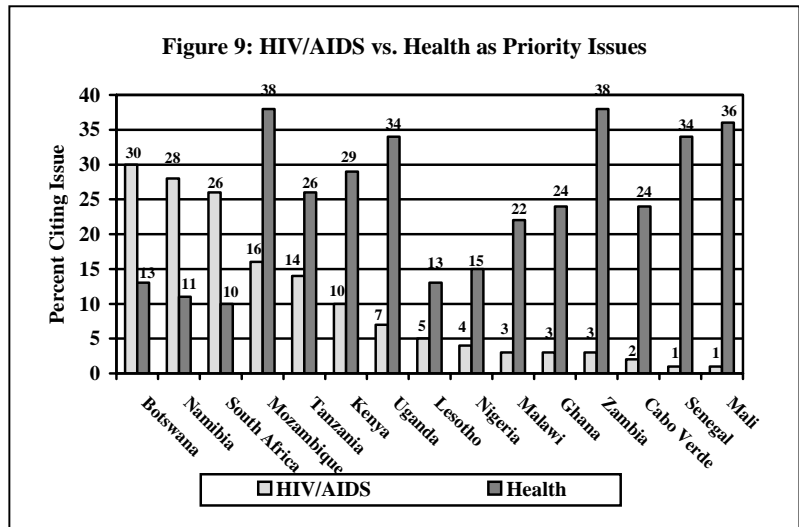
Finally, it appears that poverty also interacts with people’s conception of the problem, or the way that leaders and citizens “name and frame” political issues. We note that while only one in ten respondents cite “AIDS” as one of their three most important problems, almost one quarter (24 percent) of all respondents mention “health” or “health care” as an important issue. We also note that public attention to health issues is high in countries where the AIDS epidemic has hit hard, such as Zambia (38 percent), Mozambique (38 percent), Uganda (34 percent) and Kenya (29 percent) (see Figure 9).

⁷ The relationship of formal education and naming AIDS as a problem is .121 ($p < .001$, $N = 17,941$); the relationship of newspaper readership and naming AIDS is .135 ($p < .001$, $N = 17,941$).

⁸ The correlations of loss and naming AIDS as a problem is .097 ($p < .001$, $N = 13,746$); the correlation lived poverty and naming AIDS is $-.101$ ($p < .001$, $N = 17,574$).

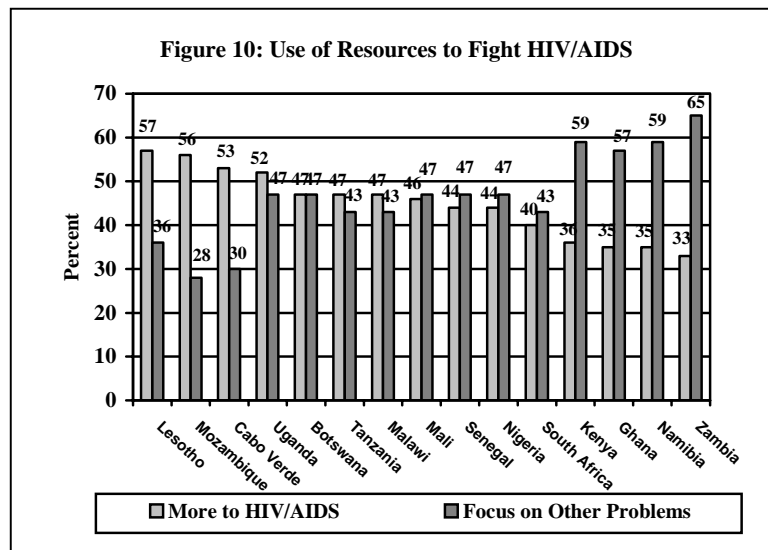
⁹ The relationship between national wealth (GNI Per Capita) and the percentage who cite AIDS as an important problem is .799 ($p < .001$ level, $N = 15$).

It would be easy to conclude that in these countries, people who mention “AIDS” and those who mention “health” issues are essentially describing the same problem. Yet this would miss some important subtleties. For instance, we find that to the extent that people see the epidemic as meriting government action, they tend either to see it as an AIDS issue, or as a health issue, but not both: those people who mention health are less likely to cite “AIDS”; and national publics that collectively prioritize “health” are much less likely to prioritize “AIDS.”¹⁰ We also note that, in contrast to formal education’s *positive* contribution to citing “AIDS,” more educated respondents are *less* likely to cite “health” as a key issue.¹¹ Finally, we note that the poorer the society, the more likely it is to frame the problem as one of “health” rather than “AIDS.”¹²



Diverting Scarce Resources to Fight HIV/AIDS

Whether or not people spontaneously mention AIDS as a key problem, we wanted to know whether they would support devoting extra resources to combating the epidemic, even if it meant



diverting resources from other key societal goals. Across Africa, people are evenly split on the issue. When asked to choose between two contrasting statements, 45 percent agree that “The government should devote many more resources to combating AIDS, even if this means that less money is spent on things like education,” while 47 percent agree with the alternative, that “There are many other problems facing this country besides AIDS; even if people are dying in large numbers, the government needs to keep its focus on solving other problems” (see Figure 10).

Even in East and Southern Africa, regions heavily affected by the pandemic, support for prioritizing AIDS in terms of resources and budgets is not overwhelming. Slim majorities in Lesotho (57 percent), Mozambique (53 percent), Uganda (52 percent), and pluralities in Tanzania and Malawi (47 percent each) are in support. Yet in other countries with high death rates and widespread popular awareness of the pandemic, support for prioritizing anti-AIDS spending is clearly a minority position: Zambia (33 percent), Kenya (36 percent), Namibia (35 percent), and South Africa (40 percent).

¹⁰ The micro level correlation is $-.120$ ($p < .001$, $N=18001$). The macro level correlation is $-.561$ ($p < .05$, $N=15$).

¹¹ The correlation of formal education and naming “Health” is $-.073$ ($p < .001$, $N=17,941$).

¹² Conversely, the relationship between national wealth and the percentage who cite “Health” as an important issue is $-.667$ ($p < .01$, $N=15$).

At this point, we can find no individual indicators (of demographics, political literacy or social values) that help us differentiate between those who favour diverting resources away from other key budget sectors to fight AIDS, and those who do not. Perhaps this indicates that these preferences are not yet well formed, and that this is an issue that many people simply had not thought about before they were asked by our interviewers.

However, at the macro level, we do find some suggestion that the proposal to divert resources away from other key delivery areas conflicts with the very substantial levels of hope for the future that we have reported in Afrobarometer Briefing Paper No. 11. That is, the larger the proportion of people in a country who forecast that their children will have a better quality of life than themselves, the *less* that society is willing to shift scarce resources to fight AIDS.¹³

This suggests that advocates who want to mobilize a popular coalition for greater government commitment to fight the pandemic need to convince ordinary people that effectively combating the disease today does not detract from a bright future for their children, but on the contrary, is a prerequisite.

The Afrobarometer is produced collaboratively by social scientists from 16 African countries. Coordination is provided by the Institute for Democracy in South Africa (Idasa), the Centre for Democratic Development (CDD-Ghana), and Michigan State University. Several donors support the Afrobarometer's research, capacity-building and outreach activities, including the Swedish International Development Cooperation Agency, the Netherlands Ministry of Foreign Affairs, and the U.S. Agency for International Development. For more information, see: www.afrobarometer.org

¹³ The relationship between the expected improvement of one's children's quality of life over their own, on one hand, and their support for diverting resources to fight AIDS on the other, is -.506 (N=15).