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The Panacea and Perfidy Associated with ARVS and HIV/AIDS Disease in Selected Countries of the Developing World

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ABSTRACT The aim of this article is, through a review of literature, to discus and debate the panacea and perfidy associated with taking ARVs (Arghandab River Valley Antiretroviral Drug) and living HIV/AIDS with examples from South Africa and Botswana. Findings indicate that ARVs elongate lives; facilitates the fulfilment of both the Millennium Development goal number 6 of combating HIV/AIDS by 2015 and some country specific policies on HIV/AIDS. ARV's access is also associated with; draining national coffers; deterring commitment to behavioural change; serving as an entry point to grants; inadequate education to People Living With HIV/AIDS (PLWHA) in South Africa; dependence syndrome; discrimination; side effects; increased sexual libido; campaign funders extending imperialism; poverty ;promoting feminization of poverty and lowered accountability; and cultural disruptions.

INTRODUCTION

Since the first case of HIV/AIDS was discovered in 1985, different countries received the information with different reactions (Treatment Action Campaign (TAC) 2007). Many countries out of ignorance chose to distance themselves with the reality contained in the apparently new and strange information and therefore never put in place any infrastructure, either to disseminate the information for possible processing of it and react to the phenomenon, or to educate people on prevention (Barrett-Grant et al. 2001; Ramphele 2007). There was an absolute state of denial by many countries especially in Africa, with South African government leading the pack. Many people died and even the doctors were not telling people what was happening. The disease was stigmatized and once one was suspected to be succumbing to it, he/she was ostracized, abandoned, or mistreated (Byamugisha et al. 2002). The wave of stigmatization and cruelty reached unfathomable levels in South Africa when Gugu Dlamini in 1998 was killed in cold blood for disclosing she was living with the virus (Barrett-Gran et al. 2001; Kang'ethe 2013).

The disease was given many names such as "slim" etc (Barret-Grant et al. 2001). It was until the western based governments took it upon themselves to ring the bell and tell the world the state of HIV/AIDS and the need to put in place information dissemination and educational infrastructure in order to stage prevention. This global campaign started bearing fruits when in 2001, all countries and many international bodies through United Nations General Assembly Special Session (UNGASS) meeting agreed to work round the clock to buy ARVs for people who were infected. To this end, World Health Organization (WHO) came up with what it dubbed 3X5 targets indicating the target of accessing 3 million people in the hard- hit countries especially in Sub Saharan Africa with ARVs (Kang'ethe 2007a). It was at the same time that United Nations came up with 8 goals that were to guide development, the so called Millennium Development Goals (UNDP 2004). Among them was the sixth goal whose objective envisaged combatting HIV/AIDS, malaria and other diseases by the year 2015.

The 3x5 targets and its implementation saw countries such as Botswana and Namibia meet its targets in time. For example although Botswana's share was to have accessed 50,000 of its population living with HIV/AIDS, it was able by 2005 to access ARVs to 55,000 people (Kang'ethe 2007a). Perhaps this is the reason why United Nations has praised the leadership of Botswana especially under Festus Mogae for his vision and dedication in the fight against HIV/AIDS (Kang'ethe 2013a). Contrastingly, while Botswana was putting its HIV/AIDS infrastructure in order, their South African leadership under Mbeki was not doing much, fascinating the world by denying that HIV causes AIDS. Mbeki's opinion was that people needed to be concerned more with poverty and not HIV/AIDS. The then

Minister of Health Msimang Tshabalala, echoing and agreeing with Mbeki's unfounded and untested beliefs and theories was advising that people living with HIV/AIDS could heal if they were to take vegetables such as beetroots, garlic etc. The world, however, invalidated Mbeki's claims as pseudoscience (TAC 2007; Ramphele 2008).

It is this researcher's contention that other than largely the social discomfort associated with people being sick and of course those who have to physically bear the burden and responsibility for their comfort, upkeep or having to step in and fill the social emotional gaps left by the PLWHA, the actual and magnitude of the presence of HIV/AIDS is not adequately understood and mentally processed. Sometimes the impact of HIV/AIDS blurredly surface when people learn through print and electronic media of how funders especially from the Western world give their countries million and millions of foreign aid to tackle and mitigate the impacts of HIV/AIDS. However, people at a micro or mezzo level also partly understand the cost implication when people living with HIV/AIDS have to make many visits for viral load check up, refill, being attacked by fever now and then therefore requiring pain killers and possible treatment.

Although the psychosocial costs could be apparent, the actual cost of the ARVs when they are dispensed is never made clear. Infact from the many workshops that this author held in Botswana, the ARV beneficiaries did not have a clue of the financial costs associated with the drugs (District Multisectoral AIDS Committee 2005). It is this author's contention that people as well as communities need to understand the cost of these drugs beside the psychosocial costs that are fairly understood. This, the author believes could have a far reaching effect in people valuing and appreciating the governments' contribution and gesture and could possibly have an effect in strengthening the much desired behaviour change.

The ARV infrastructure, to say the least, has cost governments a lot of money. Besides the grants from the western countries and bodies such as PEPFAR (Presidents Emergency Plan for HIV/AIDS Relief), United Nations and Global Funds that have been instrumental in funding the HIV/AIDS campaigns, especially in buying PLWHAs the much needed ARVs and meeting other psychosocial needs, it is the individual governments that have shouldered the responsibility (Government of Botswana (GOB) 2009). However, western funders have always led in funding HIV/AIDS activities in hard hit countries such as Botswana. They have usually done so through partnerships programmes such as African Comprehensive HIV/AIDS Partnerships (ACHAP) and the BOTUSA project.

It is therefore important to discuss issues surrounding this burden through debates and discourses whose effect could raise public awareness and ownership of this burden. This, it is believed could prompt and motivate individuals strengthening their behavioural change. This could promise breakthrough in the HIV/AIDS campaign in countries such as South Africa and Botswana with unacceptably higher levels of the epidemic.

Operational Definition

While the word panacea means or implies an answer or solution to all presenting difficulties, it is operationally taken to mean a situation which is satisfactory and desirable. The word perfidy that refers to a state of deception, disloyalty or treachery, operationally means a bad or undesirable state of affairs.

Problem Statement

This researcher considers debating issues surrounding the public burden associated with the costs of ARVS and the state of managing HIV/AIDS in selected African countries critical. This is because in his opinion, the burden that it imposes to the citizens is usually taken for granted by both the citizens and the beneficiaries. The paper also serves as a forum for showing the importance of behavioural change and the need to observe the medical regimen by those taking the ARVs; and also the need by all the citizens to avert behaviours that may lead to HIV/AIDS infections. Revelations of the costs associated with treatment of HIV/AIDS clients such as the costs of ARVS need to be owned by especially the beneficiaries. There is also the need to understand, not only the real costs, but also the fact that it is the citizens through taxes that meet the costs. The revelations could also act as a bell ringing process to make ARV beneficiaries embrace ownership and accountability through observing drug regimen and upholding

desirable behavioural change. The knowledge package, this researcher hopes, would be a motivation of behavioural change to all individuals in the society.

Article Rationale

Government especially of the HIV/AIDS hard hit countries of the developing world are increasingly incurring massive spending to ensure that all those in need of medication such as the ARVs and other psychosocial oriented needs are helped. However, the issue of owning responsibility and accountability to these public resources, in this researcher's view, remains a lagged out process, or non-existent altogether. This responsibility and accountability, need to sink and get processed in the minds of all the citizens, but crucially more to the ARV beneficiaries. They need to reciprocate the gesture by embracing an effective behaviour change such as observing the drug regimen. The debates and discourses embedded in this article should also serve as a platform of motivating behaviour change by all and sundry.

OBSERVATIONS AND DISCUSSION

Panacea Associated With Dispensing ARVs

Elongation of Life

Countries' quality of life indices on life expectancy is one of the measures of how strong a country is in resource mobilization and welfare advancement to its people, making life less stressful and ensuring higher life expectancy. It is an incontrovertible fact that the advent of HIV/AIDS in many countries especially of the developing world has had a downward effect towards people's life expectancy (UNDP 2004). In Botswana, for instance, the effects of HIV/AIDS had lowered life expectancy to below age 50. But after a successful roll out of ARV since 2001, the life expectancy has had an upward curve and is now slightly above 50. Deaths have also significantly declined (GOB 2009). This is something worth celebrating for it has brought hope to the population that was at the brink of losing hope after a decade of the country experiencing the highest HIV/AIDS prevalence rates in the globe. With ARVs, many people have reclaimed back their lives and got absorbed into productive activities. Perhaps at this juncture it is central to invoke the encouraging spirit of the South African court of appeal judge, Edwin Cameron who is idolised by the world for his magnanimous positive living. The power and of course understanding the terrain of living with the virus is also critical (Ramphele 2008; Cameron and Geffen 2005).

ARVs Access and Impacts Facilitates a Score in MDGs and Other National Policy Fulfilment

The capability of developing countries to access its people living with HIV/AIDS with ARVS has been globally politicised and acknowledged. It is globally taken to be a meaningful score in the countries' national policy development and implementation as well as a score in the global Millennium Development Goals that will take its success stock by the year 2015 (UNDP 2004). To this end, many countries have drawn their operational millennium development goal to oversee their countries' progress towards fulfilling the goals. For example, Botswana has its own country specific Millennium Development Goals (UNDP 2004). The country, judged by the WHO organization's 3x5 targets that took stock of countries capacity to access ARVs to its PLWHA in 2005, is doing well to fulfil the MDG number 6. Just before 2005, Botswana, Mauritius and Namibia were found to have done well in accessing its citizens in need of ARVs (Kang'ethe 2007a).

Perfidy Associated with ARVs

ARVs Drains National Coffers

Currently in the developing world, the budgetary allocation to respective ministry of health has arisen especially due to the need to buy its citizens ARVs. This was very evident after the WHO 3x5 targets for many countries in Africa (Kang'ethe 2007a). According to the target, hard hit countries especially from Africa were allotted their share of the population that needed to take ARVs. For example in 2008, approximately $340 million was spent on Botswana's HIV/AIDS response. Although most countries have benefitted from foreign funding for the campaign, 66% of the campaign money came from the Botswana Government coffers (GOB 2009). However, this funding was mainstreamed through bodies

such as the African Comprehensive HIV/AIDS Partnerships (ACHAP) and the BOTUSA project.

ARVs Deter Commitment to Behavioural Change

In this researcher's observation and experience in South Africa and Botswana, the access of ARVs to PLWHA has apparently been abused (GOB 2009; South African National AIDS Council 2007). This is because of the ARV miraculous effects of making people regain their lost muscular power and making them go back to enjoy their health, feel no pain in their bodies, and therefore afford to enjoy positive living. Unfortunately, instead of these benefits motivating them to remain positive and positively effect desirable behavioural change and avert any situation that can promote further spread of the virus, this is not the case. Cases of increased excessive alcohol intake and pregnancies among the PLWHA show less care and possibly more unprotected sexual interaction (Kang'ethe 2007a,b). This researcher is informed by a research in 2008 in Tsabong in which PLWHA indicated they were involved in prostitution as a way of surmounting their life's economic challenges. There was subjective thinking that people were generally not worried of getting infected with the virus as the ARVs were free (Kang'ethe 2010, 2012). This left doubt then, and still indicates that the issue of public understanding and procession of the costs associated with ARVs and living with HIV/AIDS is still not adequately achieved. This researcher believes that efforts to educate the masses on this subject have not been adequately made. It should be clear that the costs are borne by both citizens and non citizens with taxable capacities. In the same vein, the many cases of drug defaulting in Botswana and South Africa is a clear testimony of the fact that access to ARVs make people relax on commitment to behavioural change (Kang'ethe 2007b; TAC 2007).

Access to ARVs Serves As an Entry Point to Accessing Grants

While governments of countries hard hit with the epidemic such as South Africa and Botswana have struggled to raise budgets to ensure that all the people needing ARVs are accessed with them (TAC 2007; SANAC (South African National AIDS Council) 2007; Kang'ethe 2010), the direction and the will to reciprocate the gesture through staging formidable behavioural change has taken another route among some of the ARV beneficiaries. Subjective information in South Africa suggests that some people wish they were sero-positive in order to start accessing ARVs and hence the grant. This is worrying considering the costs of ARVs and the impact they have on countries national budgets (SANAC 2007). Perhaps the issue of jobless ness and poverty could be driving this unfortunate dynamic. The scenario indicates that the PLWHA subscribing to this ideology may not see the public burden associated with ARV access, but see it as an opportunity to be accessed a grant which is currently around R1050. This may also point to an inextricable relationship between poverty and HIV/AIDS prevalence (Ramphele 2008; TAC 2007; Kang'ethe 2010).

Inadequate Education to PLWHA in South Africa

Since the 2002 court battle between the TAC and Government of South Africa whose results ordered the government to access all the people in need of ARVs, the government has worked hard to fulfil and honour the court order. The government also changed its erstwhile attitudinal approaches in the fight against HIV/AIDS, forgetting the apparent mythical advice that people living with HIV/AIDS can surmount the challenge by eating vegetables such as garlic, beetroot etc (Ramphele 2007; TAC 2008). Today, the government shows immense goodwill demonstrated by massive public expenditure. However, the commitment to access PLWHA with ARVS has not been paralleled with commensurate community education to motivate the PLWHA to observe the rules of drug adherence and behavioural change. Subjectively comparing South Africa campaign with that of Botswana reveals that South Africa's grassroots community education is weak and needs to be strengthened (Kang'ethe 2013a).

PLWHA Succumbs to Dependence Syndrome

It is now a strong borne fact that many developing countries are increasingly achieving milestones in fulfilling the 2001 United Nations General Assembly Special Sessions (UNGASS)

declaration to deal with HIV/ADS head-on and increase their budgetary allocation to fight HIV/AIDS. To that effect, many people needing ARVs are now able to get them. In South Africa, for example, the government had to be coerced to address the quagmire through a court order that was staged by Treatment Action Campaign NGO (TAC 2007; Ramphele 2007). However, even though access to ARVs has been a panacea in that people who could long have died are alive and able to work just like the sero-negatives, there is an unfolding state of dependence syndrome that, if not addressed timeously will eat away the hard gained benefits associated with ARV access. To face facts, ARVs are expensive and drains immense public coffers. If people who are accessed them and getting grants do not want to work but want to rely on these benefits, then countries will have double tragedy, one of experiencing and meeting the costs of ARVs, and the other one of having a weaker human resource. It therefore means that the objective of accessing PLWHA with ARVS and have them elongate lives so that they can contribute to their individual, community and national development falls flat. This situation is serious in South Africa where some PLWHA want to live on the grant and do little. Since idleness is a vice that encourages or motivates other illicit behaviours such as drinking and taking of drugs, the campaign architects have a lot to worry as the pace of behavioural change among both PLWHA and the sero-negatives takes a snail's pace in both South Africa and Botswana (Kang'ethe 2007b).

Subjective information among some South Africans wishing they could be sero-positive in order to benefit from the grant associated with living with HIV/AIDS offers a very sad state of affairs to government, NGO's and researchers in the domain. Equally in Botswana, subjective information in Botswana among the PLWHA support group members that people were no longer motivated to take the route of behavioural change because ARVs are free is worrying (Kang'ethe 2010). This means that people are not processing the public burden associated with being accessed with the ARVs. Excessive alcohol intake and repeated pregnancies among the PLWHA are convincing indicators. It is therefore high time that community mobilization campaigns, advocacy and lobbying through print and electronic media strongly emphasize on the public burden associated with medication such as ARVs. In the opinion of this researcher who was a HIV/AIDS campaigner in Botswana, such campaigns are increasingly paying dividends, although at a lagged-out pace (Kang'ethe 2007b),

Discrimination Associated with ARVs and Living with HIV/AIDS

Despite the miraculous power of ARVs, societies in both South Africa and Botswana still associate the phenomenon with stigma. This could explain why many people living with HIV/AIDS have resisted the phenomenon of disclosing as part of encouraging positive living (Cameron and Geffen 2005). People also keep on taking their medication secretly. Perhaps its worth mentioning that stigmatization in South Africa has a historical dimension since the killing in 1998 of Gugu Dlamini, upon disclosing during the AIDS Day that she was sero-positive. In the same spate and fate, a man in the year 2000 upon being diagnosed sero-positive killed his wife and his father in law and then he killed himself (Barrett-Grant et al. 2001). Although the above two cases did not involve ARVs, the same spirit of stigmatization to PLWHAs has most likely been extended to those taking the ARVS. This is when community perceptions take ARVs and HIV/AIDS to bear the same weight

ARVs Side Effects

In addition to the stigma associated with ARVs, it is believed that those who take ARVs become bulgy especially around the stomach area. Subjective information suggests that women especially change their texture, become beautiful and attractive. These are not qualities that are pleasing to those on ARVs who would like to retain and contain their normal body structure and texture. Taking ARVs has also other social costs especially when one has to change from one line to the next meaning taking stronger ARVs. The change has a very devastating effect in that those who get to the third line are believed to be nearing their death bed. Therefore, although ARVs elongate lives, PLWHA in the third line feel engulfed by fear of imminent death (Kang'ethe 2010).

ARVs and Sexual Libido

Although this does not present an explicit cost, it presents an important implicit or latent cost. For people living with HIV and AIDS, some report that ARVs increases their sexual libido to an extent that their will to achieve a positive behavioural change diminishes. In a research done in Botswana by BONEPWA (Kang'ethe 2010), PLWHA asked whether there was any medication they could be given to lower their sexual libido. Some PLWHA explained that they had to continuously engage in sex due to increased sexual libido that compromised their desire to effectuate a positive behavioural change.

Global Funding

As some researchers may have pointed out, global funding has always strings attached to it (Mulinge and Mufune 2003). Some indicate it is a sure way of western world extending their imperialism, capitalism and control of the developed world (Kang'ethe 2009). The fact that many donors would like to change the goal posts of the agenda of the countries they assist provide such examples. For example, although circumcision has been empirically validated to mitigate the impacts of HIV/AIDS (Kang'ethe 2013d), the way the western world have pushed the agenda to developing countries without giving these countries ample time to brainstorm, consult and reflect is suspicious. It is usually because the developing world wants money and other possible benefits that they accept the agendas that the western world comes with. In some cases, the developed world has been accused of making demands and alterations of the circumstances in the beneficiary countries that they end up benefitting from them. This is through recommending their well-established consultancies to implement such changes. This, therefore, end up draining back the money that they give to particular projects. In the 1980's, for example, when the developed world mobilized and urged the developing countries to adopt structural adjustment programmes (SAPS) such as having the public sector reduce its work force and give the laid workers money to start income generating projects, the net result was leaving these countries poorer than they were. For one, the implementation of these SAPS projects was also placed under the consultancies of some western based firms that drained a lot of money donated for SAPS implementation. This is why some scholars such as Osei Hwedie, Mupedziswa and Kangethe are clamouring for indigenous driven strategies as a solution to African's economic woes (Mupedziswa 2001; Osei Hwedie 1996; Kang'ethe 2013b). Kang'ethe especially has challenged African countries to recognize the indigenous knowledge systems embedded in cultures and other ways of life that can move social and economic development (Kang'ethe 2011).

Poverty among Communities

HIV/AIDS, the worst epidemic in human history especially in the developing part of the world has many ramifications such as lowering life expectancies, increased absenteeism in the work places as people attend the funerals of their relatives, visit them in the health centres, and having to deal with the ever burgeoning cases of orphans. This has posed a serious public burden to the government, NGOs and communities in general (Department of Social Services 2005). All these occurrences have had the impact of poverty. A few empirical researchers have validated an inextricable relationship between HIV/AIDS and poverty (Kang'ethe 2004). HIV/AIDS has also been validated to have a skewed gender dimension resulting in what is called feminization of poverty. This is because of societal structures that skew resources in favour of men as opposed to women (Musekiwa 2013). This state of poverty has been a deterrent to social and economic development. This has lowered the human value and capacity as agents of social and economic development. This has to a larger extent led to economic stagnation of many countries in the developing world, with growths averaging around 5% or lower (Mulinge and Mufune 2003). However, the advent of ARVs, despite their costs appears to be giving the PLWHA a new phase of life in which they are increasingly able to work. Perhaps the ARVs impacts will be seen in some years to come in terms of improved human resource capacity to mobilize economies.

Feminization of HIV/AIDS

In many societies, more women than men are getting infected giving strength to the concept

feminization of HIV/AIDS. However, there appears an inextricable relationship between feminization of poverty and feminization of HIV/AIDS (Kang'ethe 2013c). This is because factors that lead to feminization of poverty are the very same ones that influence feminization of HIV/AIDS. The fact that women are discriminated in the phenomenon of job acquisitions, education and in allocation of resources generally has led them weak in negotiating for safer HIV/AIDS prevention methodologies. The increased spate of gender based violence in countries such as Botswana, South Africa and Zimbabwe has heightened chances of women vulnerability to HIV/AIDS (Kang'ethe 2009b; Gender Link 2012). But feminization of HIV/AIDS has also a biological dimension. The fact that men are empirically validated to be more promiscuous than women as well as being effective transmitters of the virus compared to their female counterparts, also adds strength to the possibility of feminization of HIV/AIDS in developing countries (Kang'ethe 2009b). To say the least, feminization of HIV/AIDS continues to impede breakthroughs in the HIV/AIDS campaigns. This researcher is of the opinion that it is only effectuating a paradigm shift by men regarding gender dynamics and a realisation of how they contribute to forces of disempowering women that could hopefully and meaningfully contribute to addressing the vice, feminisation of HIV/AIDS (Musekiwa 2013; Kang'ethe 2013c).

Lowered State of Accountability

Since resources are meagre, people should be motivated to take responsibility of their actions. This is why WHO in the 1995 AIDS Day called for people living with HIV/AIDS to also take responsibility alongside considering their rights (National AIDS Control Programme (NACP) 30 1996). It is therefore important that those who are the beneficiaries of government services also support the government in being good agents of desirable change. Among the PLWHA in several African countries such as Botswana, the call for them to adopt positive behavioural change for their own health and for the benefit of their community and national participation has sometimes fallen on deaf ears. This means that they have not reciprocated the government facilitation and spending of public coffers for their sake. Cases of ARVs pills being left in the bars and cases of increased repeat pregnancies without doctoral prescription among the PLWHA in Botswana indicate lowered phenomenon of accountability and failure to process the fact that ARVs cost a lot of money (Kang'ethe 2007b). Perhaps serious community mobilizations and education on responsibility and accountability is critical.

Cultural Disruption

The HIV/AIDS campaign has come with ways that disrupts cultural ways of life. For example, a mother who wants to wash his son/daughter with her hands as is culturally and socially appropriate has to come into grips with using the gloves for her safety. Experience of this researcher in Botswana holds that some elderly women especially at the earlier phases of the campaign were resistant to use gloves and chose to go the route of culturally appropriate methodologies that they knew, for example by washing/bathing their ailing children with their bare hands. They could not come into terms with the meaning of the new disease. However, serious campaigns for a paradigm shift and adopting safer prevention methodologies have been emphasized, cultural norms notwithstanding (Kang'ethe 2009b). In the same vein, emphasis and adoption of newer methodologies of mitigating the effects of HIV/AIDS such as circumcision has left many countries especially those that never practised the norm at crossroads as whether to accept the norm or not. In Botswana, the culture of circumcision has been culturally practised by the Bakgatla Ba Kgafela sub tribe. However, the norm had died for many years and was only resuscitated in 2009 (Kang'ethe and Rhakudu 2010). However, with the global clamour for countries to adopt surgical male circumcision as a methodology of mitigating the effects of HIV/AIDS, this has set confusion making governments spend a lot of money in making the communities buy in the idea (Kang'ethe 2013d). Many countries in Africa are still not adequately persuaded. For example in Zimbabwe, statistics indicates that those who are circumcised are more prone to HIV/AIDS. This is a myth that needs to be demystified (Jackson 2002). However, there could be possibilities that some people could be taking circumcision as a full proof methodology of mitigating HIV/AIDS and therefore fail to use preventative tools such

as condoms. That can then justify the higher prevalence of HIV/AIDS among the circumcised. The underlying message here is that circumcision has not been a cultural norm and therefore not adequately understood.

CONCLUSION

It is pertinent that discourses and debates surrounding the actual costs and burden associated with HIV/AIDS are mainstreamed to the society. This is because of the apparent low pace of behavioural change by individuals especially those benefiting from ARVS in both Botswana and South Africa. This mainstreaming will hopefully raise awareness of the costs and possibly and probably raise the sense of accountability among the people. The fact that governments have taken responsibility of accessing its people living with HIV/AIDS with ARVs should demand people to reciprocate through staging and upholding desirable behavioural change that will promote zero transmission of the virus. It is therefore important that the government, NGOs and private bodies doing HIV/AIDS campaign take the message of costs and burdens associated with ARV access and living with HIV/AIDS seriously. People should own and internalize the fact that these costs are borne by the taxpayers. All should embrace accountability of their actions and realize that the contrary poses a burden to fellow citizens and non- citizens of taxable capacity.

RECOMMENDATIONS

PLWHA Need to Take Responsibility of Their Behaviours

It is pertinent that PLWHA take responsibility of managing the virus by effectuating a positive behavioural change. This is because failure to effectuate a positive behaviour change may lead to possible earlier deaths. This would be a huge loss to the countries, both in terms of human capital and also the cost of the ARVs.

Strengthen HIV/AIDS Education

Although many people now understand HIV/AIDS, this researcher thinks that the dynamics surrounding HIV/AIDS may not be well understood. It is therefore pertinent that people from all cadres are continually and perpetually engaged in HIV/AIDS education.

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