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TOP DOWN AND BOTTOM-UP PERSPECTIVES ON HIV/AIDS: COORDINATING THE PREVENTIVE LINKAGE: LESSONS FROM THE AJEGUNLE COMMUNITY OF LAGOS STATE NIGERIA

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Abstract:
HIV/AIDS prevention study of 2005 in Ajegunle discovered 'talking past each other' both on the part of the NGOs and the people living with HIV/AIDS in the community. After a decade, the narratives changed to 'talking to each other', which suggests a new preventive approach which has helped to curtail the infection and disunity within the families and the community at large. This research compares the official discourses on HIV/AIDS and those, which came from people and families in Ajegunle, Lagos, a deprived area of 1.8 million people made up of low-income families and rural migrants. The perspectives of INGOs, politicians, and government aid agencies along with local NGO's are contrasted with those of a range of stakeholders from Ajegunle- (sex workers, women in antenatal clinic, husbands of pregnant women in the hospital, doctors and nurses, clients of sex workers [young men of the street and truck drivers, etc]). Generally, the study indicated that effective preventive action is no longer severely inhibited unlike in the past where people talk past each other because of the disease. From a community development perspective it is argued that the distinctive features of the pandemic in Nigeria and its association with poverty and deprivation require that the felt needs and views of those on the "bottom of the heap" need to become the focus of an empowering "bottom-up" approach to HIV/AIDS prevention if it is to make a greater impact. This suggests that new thinking about multi-sectoral responses with full community participation is required to undertake more effective preventive action. This will require suitable policy response, focused around community capacity building.

KEY: **Ajegunle, HIV/AIDS, Talking To Each Other**

Introduction:

HIV/AIDS has become one of the leading cause of death in Nigeria, and other parts of Africa (UNAIDS, 2012; WHO, 2012), and has become the fourth main cause of death worldwide, according to *World Health Report* (UNAID, 2012). This paper argues that the failure of conventional approaches to both prevention and cure, which have been embedded in medical solutions of antiretroviral drugs and condoms without confronting the wide-ranging and complex socio-cultural and economic contexts that facilitate the spread of the disease dwell on status denials.

This comparative study (discourses) of HIV prevention in Nigeria among both high level organisations, and the grassroots people of the Ajegunle community of Lagos State arguably unleash preventive imaginations that made the infected persons to disclose their status. The study argues that effective prevention of the disease cannot equally be achieved only with a top-down approach from the International Non-governmental organisations (INGOs), and overseas governments or government organisations (GOs) without also linking their perspectives with the perspectives of those at the "bottom of the heap" through a bottom-up approach. The paper concludes by suggesting multilevel community empowerment and capacity building, with a more detailed/stranger focus on the role of culture as essential elements for effective HIV/AIDS prevention.

HIV/AIDS Prevention: State of the Play

This study adopts a holistic approach to prevention, usefully examined as operating at three levels namely: tertiary prevention (care of established disease), secondary prevention (prevention of infection), and primary

prevention (addressing structural issues that lead to vulnerability to the disease). Seen in terms of the above typology, the literature has been mainly about how to assist individuals avoid contracting HIV infection (secondary prevention) and how to treat and cure the disease or reduce or prevent adverse consequences among persons who are living with HIV (tertiary prevention). There seems to have been much less discourse on primary prevention. The literature on each level of prevention can be discussed in more detail.

Tertiary prevention

Tertiary prevention is aimed at reducing the challenging effects of HIV or AIDS in the community in order to maximise the quality of life of the sufferer. Its major interest is to prevent the effects of AIDS in the community (Wallace, 1998; Bognar, 2002; Sahasrabudhe & Vermund, 2009; KacaNg, 2012). The intent is to maximise the living potential of the person with AIDS or HIV infection. The prevention approach also helps prevent and manage some of the hopelessness and other transitional affective responses that surround the person who is ill, or others, and for the professional working with him or her (Shernoff & Palacios-Jimenez, 1988). Emphasis on tertiary prevention in this case is often narrowed to people living with AIDS, or HIV infection; care-partners of the infected person; and the health care providers working with the sick. It also seeks to reduce chronic disease progression and illness-related dysfunction (Hoff, 1995; Saag et al, 1998; Dahlui, 2015). Thus, there has been an emphasis on tertiary preventions with extensive discussion on vaccines and much pressure on the provision of antiretroviral drugs (UNAIDS, 2004a). There are huge technical hurdles to providing antiretroviral treatment and high prices of the drugs have been a major obstacle to scaling up of HIV in resource –limited settings (WHO, 2003). The concern is that medicines to treat HIV/AIDS are not within the reach of many families after many years of promises (Obi, 2005).

Secondary prevention

A number of studies (Champion and Hodgson, 1988; Kippax et al, 1990; O'Leary, 2002; Kennedy, 2010) have demonstrated that since the emergence of the HIV/AIDS and other STDs, blood screening, behaviour change and consistent use of condoms have been the standard prevention message given to individuals who are at the risk of becoming infected with HIV virus or transmitting it to others. Most efforts are directed at individuals, and studies have demonstrated that a variety of strategies can help individuals initiate prevention and sustain healthy behaviour to reduce risk of HIV and AIDS (Waldby et al, 1990). However, sometimes it may also be possible to apply secondary preventive interventions at the community level (moving towards primary prevention when disease prevalence is high). One example is government prohibition of prostitution in a community where prostitution is seen as the main source of HIV transmission.

Assessment of programmes have been documented with regard to secondary prevention and sexual behaviour change among adolescents and adults, men and women, people in developing and developed nations, and among groups that are vulnerable to infection (Cohen, 2003; UNAIDS, 2004a; United States department of Veterans administration {USDVA, 2018). Essential health information that encourages the use of condoms as behaviour change and abstinence can help individuals to reduce the risk of HIV/AIDS in the community. Another approach is the life-skills-based education that promotes the adoption of healthy behaviour (WHO, 2003; UNAIDS, 2004b).

However, careful review of the HIV prevention literature suggests that, while behavioural intervention focusing on consistent condom use can produce significant behaviour change, the two-thirds of the participants in some studies did not change their behaviour absolutely, and many did not change at all (O'Leary, 2002). This information shows the nature of the disease and how it spread in poor countries, thus, highlighting the need for primary prevention.

Primary prevention

Primary prevention seeks to exploit ways to prevent socio-cultural and environmental associated factors that increase the risk of contracting HIV/AIDS disease in our society (Hoff, 1995). This means taking action that will minimize new infection and the likely spread of the disease from the infected to un-infected in the

community. HIV has been experienced in all nations, either in high prevalence or low prevalence levels (Gibney et al, 2002), and these have necessitated the curiosity to examine from the level of primary prevention as clearly tertiary prevention and secondary prevention alone cannot prevent or markedly reduce the disease.

Some socio-economic studies on AIDS and HIV have found socio-environmental elements such as poverty, domestic violence, war, and migration as the causative of the disease in many communities (Collins and Rau 2000[1]; United Nations, 2001). Other development discourse (Cohen, 2002; Baylies, 2002) also suggests rooting out AIDS through development by tackling these elements, especially poverty. In Africa, poverty and war seems to be the leading factors that push people to migrate from one place to another in search of good life (push and pull theory of migration). These structural elements often create room for some women, especially sex workers, to indulge in sex work (prostitution), which makes them vulnerable to HIV/AIDS.

Objectives of the Study

The main objective of the study is to examine HIV/AIDS prevention discourse in Nigeria, especially with respect to its effectiveness in meeting the felt-needs of the most vulnerable, and to suggest some changes to make it more effective;

- To examine the discourse, and approach to prevention of the major HIV/AIDS organisations
- To involve vulnerable stakeholders, especially the sex worker, street youth, immigrants, and the ordinary married men and married women from Ajegunle community, in understanding the HIV/AIDS prevention from their perspectives.
- To compare these discourses and suggest some more effective preventive responses.

Research Methods/Methodology:

This study, albeit coming from a community development orientation, draws its method from across the social sciences and humanities in its focus on discourse. Discourse analysis is now a widely accepted form of analysis, which seeks to get beneath the surface of phenomena and see them in terms of how people construct their worlds (Wetherell et al, 2001; Aranda, 2004). It shows the recent influence of the work of Foucault.

According to Foucault (Foucault, 1980; Csaszar, 2005):

> "discourses" are subtle mechanisms that frame our thinking process. They determine the limits of what can be thought, talked, and written in a normal and rational way. In every society the production of discourses is controlled, selected and organized and diffused by certain procedures. This process creates systems of exclusion in which one group of discourses is elevated to a hegemonic status while others are condemned to exile (Bleiker, 2003).

Through discourse, social rules emerge and select propositions for retention as valued propositions. Discourses render social practices intelligible and rational and hide the ways in which they have been constituted and framed. Consequently, patterns of domination are hidden and not questioned, but accepted as normal practice. These are what Foucault calls 'the certainties of the present' (Tembo, 2003). In this study,

[1] The epidemiological relationship between migration, prostitution, and HIV is well established in many ways in different countries of Africa (Collins & Rau 2000; Huang, 2014). A study in Senegal found that 27 percent of the men who had previously travelled to other African countries and 11.3 percent of spouses of men who had migrated were infected with HIV after having affairs with commercial sex workers. But, in a nearby community where men had not migrated, less than one percent of the people were HIV positive (ibid). Similarly, in Tanzania, women in urban and rural areas told the African service of the British Broadcasting Corporation (BBC) that they lived in fear of their husbands coming home after they have stayed away from home because they may contract HIV/AIDS from other women, especially from the sex workers and women in massage parlour (Philips 2002; Huang, 2014).

the associated concept of 'subject position' was used to go beneath the surface of discourse to analyse how people interact in the community in relation to their thoughts, and views, as well as how their views are affected by their social interaction in their social positions (Wetherell et al, 2001). The study involves analysis of discourses and policy of International Non-governmental organisations (INGOs), such as Global Fund, USAID, Family Health International (FHI), Government Organisations (GOs), and Local Non-governmental Organisations (LNGOs) that prevent HIV/AIDS in Ajegunle. The responses were collected in intensive interviews from the Ajegunle's low-income area and grassroots community members, which includes: female sex workers and male street youth, married men and married women, and doctors and nurses.

The data collection for the organizations was grounded in content analysis- primarily using web pages of official statements of policy and practice with respect to HIV/AIDS prevention. The Ajegunle data were based on purposive sampling of pre-determined characteristics where the researchers selected the informants across the spectrum of (theorised) vulnerability according to social position (Patton, 1990; WHO, 2002; Igulot, 2015). It covered a number of sex workers, clients of sex workers [street youth], married men and married women, and doctors and nurses. The Ajegunle responses vary both in content and form in relation to the socio-linguistic, and social position of the people (Yardley, 1997; Rahman, 2014). Thus, the summary of the discourses for each subject was analysed by:

i) Identifying their social position
ii) Identifying their views/discourse on HIV/AIDS prevention, such as knowledge of HIV/AIDS, preventive knowledge, their comments on risk behaviour etc; and
iii) Identifying in terms of their social interaction i.e. how their subject positions were established as they relate to each other in their social environment.

FINDINGS:

Official HIV/AIDS Prevention Discourse

Analysis was undertaken in relation to the discourse of a range of official organisations ranging from major International bodies (usually non-governmental) [INGOs] to localised Nigerian government responses [GO's] and to Nigerian non-governmental organisations [LNGO's]. The summary results of the analysis are presented below according to the above identification of social position[2].

The International Non-governmental Organisations (INGOs)

The Social Position of the INGOS

The INGOs, which are mainly from the Western countries, and coming into both Africa and Nigeria, as external influences- seemed to represent western prevention perspectives of the disease. Thus, they see Africa as a high-risk continent for HIV/AIDS, and that something needs to be done in order to reduce the incidence of the disease. The most important element was risk assessment, the assessment of incidence, and a general raising of awareness among 'ignorant' Africans of the seriousness of the issue. The general views of the INGOs were based on the medical model and its solution, both for 'cure' and prevention. Cure, as unsuccessful, looks to ARV drugs for maintenance, and prevention to the 'safe' sex models of the West, where condoms are used. Thus, who sought to put significant pressure on African governments to recognise the crisis, seek support for cheaper ARV drugs, and promote condom use.

Historically, the exception was the Catholic Church and its main aid arm, Caritas International (CAFOD), which use 'abstinence' as their prevention approach. And, more recently, some organisations from United States[3], such as Family Health (FHI) International has not been advocating the use of condoms, and instead advocating abstinence (Human Rights Watch, 2002; Oladepo, 2011). However, the overall medical approach

[2] Full report in Iyiani's forthcoming study.

[3]Apparently, this is because of the so-called "catalytic consensus" of the United States Government- "White House"[3].

has remained focused on the use of antiretroviral drugs in place of cure, and USAID, Family Health International, DFID, and CIDA are still supporting poor countries with funds for the procurement of antiretroviral drugs. Thus, we can summarise INGOs' approach as starting with awareness creation with an overall discourse based on medical solutions, and most recently being shaped by specific cultural values from fundamental Christians, especially those from United States.

Regional/Nigerian Political Leadership and Governments

Many African political leaders and individuals initially denied the presence of AIDS in their countries, allegedly in order not to turn away foreign investors and tourists (Obi, 2005; Gwaambuka, 2015). However, the Nigerian democratic President, Chief Obasanjo, in an attempt to respond to Aids/HIV prevention in Nigeria, established the National Action Committee on AIDS (NACA) in 2000 and supported the establishment of the first universal blood bank in Nigeria in 2005. He has also at different times called on Nigerian medical researchers to discover an AIDS vaccine. Indeed, every state and local government area in Nigeria has now established AIDS committees that work to mitigate the impact of the disease as well as seeking prevention of the disease in their particular area. The political leadership of Nigeria has also acted to reduce the cost of antiretroviral drugs for individuals and family living with HIV/Aids by paying part of the cost while some countries such as Botswana and Nigeria are making plans to increase the number of people receiving free antiretroviral drugs in their countries.

Nationally, the social interaction between the presidency/NACA and the state governors/state Action Committee on AIDS have led to similar responses at those levels while, at an even lower level, has happened between the state governors/State Action Committee on AIDS and the Local government Chairmen/Local Government Action Committee on AIDS. Generally, the discourse has developed within the parameters of medical discourse with much attention to the use of antiretroviral drugs and condoms.

The Local Non-Governmental Organisations (LNGOs) in Nigeria

All the relevant LNGOs in Nigeria are involved in providing the medical solution/cure of antiretroviral drugs, with few advocating the use of condoms. As the disease continued to spread, the views and focus of the LNGOs has shifted to technical medical solutions (antiretroviral drugs in place of cure, and condoms even though they are still scarce, and expensive) along the direction of the INGOS and GOs.

Notably, some of the faith-based organisations such as the Catholic Church and Islamic faith organisations do not advocate condoms. In addition, a significant number of the LNGOs have gradually stopped advocating the use of condoms in order to attract support funds from the United States, since most of the American INGOs such as USAID, FHI are downplaying condom use as part of their government's agenda. These LNGOs are the closest to grassroots oriented organisations, and have also sought to undertake community education about the risks, and ways to avoid the disease in order to attract support from the locals and get them to change those behaviours that elicit HIV/AIDS- depending on the type of grant or support funds they receive. Some of the views and focus of the LNGOs in Nigeria include:

- LNGOs in Nigeria create HIV awareness in their community of work and often engage themselves in preventive community education/information programmes that address other community issues while emphasising HIV;
- To provide care services, advocating abstinence- through pastoral outreach; and
- To engage and equip community members with HIV management skills, so that they can in turn work effectively with other members of the community[4].

[4] The Ajegunle Community Partners for Health (AJCPH) and Beebat Dyad have recently been informing pregnant women during antenatal visit the dangers of HIV, while caring and working with families infected and affected with HIV/AIDS.

Overall, however, at this level of HIV prevention, the whole AIDS prevention discourse is mainly dominated by the Western ideas through the international organisations that support the work of the LNGOs. Some of these LNGOs have links or special attachments to the Western NGOs[5].

Interaction Between Organisations

What has been notable in all the three groups of organisations has been significant change over time as various forces have interacted. There has not been broad consensus on key trends as the discourses continue to shift over time. International AIDS Conferences demonstrate this well. They are interactive fora where information and experience about HIV prevention were shared among individuals and bodies. Such interaction 'provides unique opportunity for activists, government representatives, public health experts, HIV/AIDS service providers, and scientists from around the world to meet and discuss the latest advances in HIV/AIDS research, prevention, public policy, and treatment and care—and seek to build partnerships to fight the global pandemic (amfar, 2002:1).' They serve therefore as something of a forum through which to follow shifting and changing discourses over time. In brief some of the major changes have been as follows:

- The early conferences of 1985 Atlanta and 1986 Paris had a focus on HIV Knowledge and awareness;
- By 1993 Germany conflict between the AIDS activists, resource poor countries, and the developed world led to an increasing emphasis on poverty and development in relation to HIV/AIDS;
- However, medical dominance was re-established during the 1994-2003 conferences focusing mainly on medical vaccines and treatment. The Durban, South African conference of 2000 underscored how fear, stigma, and denial about HIV/AIDS had hindered prevention and care efforts, especially in developing countries- it made ARV a big issue due to South African President Mbeki's stand on HIV/AIDS as a disease;
- The 2004 Bangkok conference with the theme "*Access to all*" witnessed another shift from purely medical solutions to including cultural values. During the conference, the major discourse was around cultural values, with Christian fundamentalists stressing fidelity and family values.
- This focus seems to have been retained for the 2005 Abuja conference with its theme of *HIV/AIDS and the family*.

Thus we can see how interaction, as demonstrated through international conferences, results in shifting discourses which moved from an absolute focus on medical solution to now paying more attention to socio-cultural issues that affect the families, though not always from an African cultural position.

The discourse thus highlights interaction between the three major organisational groups covered above and their changing positions. Within Nigeria, the interaction between the INGOs, the regional and national political leaders and governments, and the LNGOs seems to indicate a top-down relationship since the ideology of the INGOs largely seem to influence national government and LNGO discourses on prevention. It can most plausibly be interpreted as a demonstration of power and powerlessness in the interaction, since the INGOs are of the western countries and possess all the economic and political power, whilst the national governments and LNGOs being resource constrained and, thus in most cases, relatively economically and politically powerless. They cannot take major action in HIV/AIDS prevention without adequate support in terms of funding, technical, and policy advice from the INGOs. So, the major approaches and decisions are driven from the West (Obi, 2005). The source of their support fund has dictated discourse and ideology over time.

The general views of the state/federal governments of Nigeria and other African governments have successively moved through awareness creation, medical solution, and behaviour change, on the reality or

[5] For instance, the AIDS Prevention Initiatives in Nigeria (APIN) has its link to Harvard University, while the Ajegunle Community Partners for Health (AJCPH) gets support from FHI and BASIC/USAID group

at least the assumption of attracting support funds from the Western countries. Interaction has encouraged political leaders and governments of Nigeria and other African countries to acknowledge that a good number of their population are vulnerable or at high-risk of the disease and to start responding to the disease. There seems little doubt that the shift in the ideological position of the political leaders and governments of Nigeria and other African countries from their initial reluctance and denial to belated recognition of the disease was as a result of inducements, especially from AIDS support funds.

Their repositioning and acknowledgement of the presence of the disease coincide with the discourses around support funds being provided by international non-governmental organisations and overseas governments. However, it should also be noted that it would be a mistake to suggest that international pressure was the only influence. Local political issues and responses could also be seen as raising broader, albeit less influential, factors:

- Governments have seen HIV as a development crisis and not merely health issue;
- Local opposition parties blamed the ruling government for not curtailing the disease;
- There was a strong sub-theme from the INGOs, African governments and the LNGOs emphasising that HIV should be tackled as an integral part of poverty reduction and sustainable development agenda of every government (see the 2001 Abuja Declaration).
- The influence of alternative voices at AIDS Conferences, especially the 13th International AIDS Conference in Durban South Africa- where some wives of the Head of African governments, government organisations and LNGOs emphasised HIV in relation to reproductive health rights of women.

In summary, the International AIDS Conferences, as they have been the fora where all the actors engage with each other over time, provide an excellent backdrop against, through which to note the changes. The support funds dominated interaction between the three groups of organisations (INGOs, African/ Nigerian political leaders and governments, and LNGOs) and have dictated the largely medical changing discourse for HIV/AIDS treatment prevention in Nigeria. However, there have also been signs of a subordinated alternative discourse around human rights, poverty, and development.

ORGANISATION	**VIEWS** (1985-1986)	**ACTION/ BEHAVIOUR** (1994-2015)
INGOs	Awareness creation	Medical Solutions to (Socio-cultural issues)
International Conference on HIV/AIDS		
GOs, Regional/National s	Awareness creation	Medical Solutions (to Socio-cultural issues)
LNGOs	Awareness Creation	Medical/ condom (less accepted)
International Conference on HIV/AIDS		
Source: Ajegunle interview responses, 2015		

Ajegunle Responses

In accordance with the subject position focus, the emphasis in Ajegunle community is on the perception of the different social groups (sex workers, street youth, women at antenatal clinic and their husbands, and health professionals) about HIV. Their discourses represent a range of attitudes with the Ajegunle community. The subject- discourses are identified in terms of social position and analysed in terms of their social interaction with other groups. The views of those at the "bottom of heap", those most vulnerable to HIV/AIDS (sex workers and street youth), the ordinary people (married men and women), and the medical professionals (doctors and nurses) were linked to their social positions and their dynamic social interactions.

Most vulnerable groups (Sex worker/street youth), and Views on HIV/AIDS

The social position of this group is understood as one of the most vulnerable to AIDS. They have low socio-economic status and political influence in society because the community sees sex work as a trade that is not culturally acceptable while the street youth are seen as jobless miscreants or mischievous persons. Both the sex workers and the street youth had the HIV information in their head as factual knowledge (indeed there was general concern among these groups about HIV/AIDS), but they stated that they did not (always) act on it. Although, the street youth (and some sex workers) stated that they do not believe that they are susceptible to HIV, those who felt that they are susceptible see the use of condom as a preventive measure, and use condoms because they are afraid of the disease. Few sex workers indicated that they went for testing, and some, who stated that they use condoms, also suggested they may not be using them with all their sex partners, especially when they are drunk. The street youth reported not using condoms due to poverty, poor, and fake condoms in Ajegunle and argued that condoms reduce sexual pleasure. The street youth did not assess themselves as being at risk of HIV, although they know about the disease and its mode of transmission. Some even refused to believe that HIV is real, but saw it as a Western anti-Muslim plot- since Muslims marry up to four wives!

Some of the sex workers stated that they often have sex with partners who refuse to use condoms. This seems to result in talk of a scarcity of condoms in Ajegunle, lack of access to original/reliable condoms, and that they do engage in sex without condoms when their clients demand it. Both sex workers and street youth are reluctant to do HIV testing, reportedly because of shame and associated stigma. Generally, sex workers had what might be called fatalistic attitude to their situation knowing what they should do, but not always doing it for a variety of stated reasons. The attitude of the street youth was similar, but seemed to be related to broader feelings of hopelessness about their whole life situation. They were, however, vociferous in blaming the Nigerian government for not doing enough to better the life of the people in Ajegunle, with respect to poverty and AIDS.

The Interaction Between Sex worker and Street youth

Both groups often have different sex partners who may not always use condoms during sex, [ostensibly because of its gratification], and they seem to blame each other initially but now have started talking to each other about the implications of HIV/AIDS. The location of the sex workers makes them vulnerable, especially in a situation where their sex partners (street youth) become violent and put their life in danger coercing them into sex without condoms. This type of risky behaviour makes both the sex worker and the street youth susceptible to HIV/AIDS, which perhaps explains the overall description of the discourse between groups as those of- as fatalism/hopelessness with sex workers being fatalistic about the whole situation and the street youth- a broader hopelessness.

Married Couples' social position: Married women and their husbands

The social position of the majority of the married women in this study is that of "ordinary housewives", while the men had different skills and jobs. From observation of the culture of Ajegunle, women are seen as people who are subordinate to the men, while the men are seen as the head of the family. In this view, the men protect the women and often provide them with the necessities of life. The women in return support their husbands while producing children for the continuity of the family.

Their Views on HIV and AIDS- Married women and Married men

The level of HIV knowledge among both married women (interviewed at antenatal clinic) and their husbands was very high, although the majority of them felt powerless to influence their situation. They understood HIV as a disease that can be contracted through unprotected sex, blood transfusion, and exchange of needles. Their personal assessment of the disease revealed that they saw themselves as people who could contract the disease but were not using condoms. However, they suggested that both husband and wife should adhere to abstinence, and faithfulness as a way of saving the family from the disease. They also emphasised the need for practical prevention where government should take action on poverty- as a way of reducing the spread of the disease while arguing that the community has a role to play if the disease is to be stopped. The women

also acknowledged that traditional norms and cultural practices in Ajegunle work against women, especially with regard to their reproductive health rights. The issue of women's rights was highlighted during the women's focus group discussion where the women suggested that women's rights should be addressed so that women can be empowered if HIV is to be reduced in the community. Some of the men believe that those with HIV should be separated from others while emphasising the need to reduce poverty.

The preventive discourse of both men and women emphasised the need to address certain elements in the community such as the culture of the community, poverty, and lack of reproductive health and women's' rights. Both men and women also blame the immigrants for spreading the disease in the community. These immigrants according to the women include uniformed men such as soldiers, police, and sailors who often visit and live in the community without their wives.

The Social Interaction Between Married men and women

The comments of both the women at antenatal clinic and their husbands indicated that women often blame their errant husbands for giving them AIDS, while men in return blame their wives for being promiscuous and giving them HIV. Overall, this discourse seemed very much aimed at protecting themselves and to excluding a source of HIV from within the family, but with a basic issue of trust involved even within the marriage. This is termed 'protectionist' discourse

The Social Position of the Medical Professionals (Doctors and Nurses)

Doctors' and Nurses' level of expertise and professions, generally seem to lead them to assume that appropriate HIV knowledge would lead Ajegunle people to avoid high-risk behaviours as well as make them seek HIV tests. They also hoped that HIV information will close the gap between them and their patients who often do not believe in them and many sought treatment from the hands of traditional healers first before visiting the medical doctors.

The medical doctors highlighted the need for effective AIDS governance, which will largely consist of giving the correct preventive answers through information, education, and communication of HIV prevention. The nurses felt that in the face of this 'irrational' behaviour that they witnessed, stigma was believed to be among the elements that hinder some people from seeking HIV test, especially the sex workers and street youth. They also blamed young unmarried girls for engaging in early sexual activity and promiscuity. General discourse was one of technical medical solutions, which emphasised the use of condoms, HIV testing, antiretroviral drugs etc.

Nurses focused more than doctors on social relationships and specifically stated that there is need for abstinence, faithfulness to one's partner, empowerment of women, addressing poverty, women's rights, and the position of immigrants (who are believed to be spreading HIV in the community) in order to avert risk behaviour among the Ajegunle people, which will help to prevent the disease.

The Social Interaction Between Doctors and Nurses

Interactions between the medical doctors and nurses highlight the conventional dominance of doctors as people with high medical status. The professional interdependence and social interaction between doctors and nurses are based on the use of technical medical solutions. Personally, the nurses seemed closer to the married women because of their gender [biological] vulnerability, a lower socio-economic status, and an imbalance of power in sexual interactions with regards to the tradition and custom of the people as some of them reported that they do not generally accept condoms due to their religion and culture.

Table 2 showing the position of different Groups and their Responses

Social Location	Knowledge of HIV/AIDS	Assessment of Personal Risk	Risk Behaviour	Prevention Action
Sex workers	Yes	Yes, condoms	FATALISM	Free medicare, anti-rape/sexual violence, poverty reduction
Street Youth	Yes	No Condoms	HOPELESSNESS	Government action on poverty
Married Women	Yes	Yes, but do not use condoms	PROTECTIONIST DISCOURSE blame errant husbands	Abstinence, faithfulness to one's partner, empowerment of women, position of Immigrants, poverty reduction
Married Men	Yes	Yes, but do not use condoms	PROTECTIONIST DISCOURSE, blame Promiscuous wives	Abstinence, faithfulness, Separate people with AIDS from the community
Doctors	Yes	Yes, condoms	TECHNICAL MEDICAL DISCOURSE	Medical solution (antiretroviral drugs), tackle ignorant
Nurses	Yes	Yes, ts condoms	MEDICAL SOCIAL DISCOURSE (social Perspectives)	Medical solution, Abstinence, faithfulness, Poverty alleviation, HIV ignorance, immigrants, cultural issues, and Women's Rights

(Source: Ajegunle interviews Nov –Dec 2015)

Grassroots Views

Clearly the discourses relate to vulnerability and the fact that female sex workers, and male street youth interact in high-risk settings such as brothels, while the medical professionals male, and female doctors, and nurses interact in hospitals, and the married men and women interact in matrimonial homes.

Virtually all the groups know how HIV can be contracted or stopped, but did not necessarily act on it-showing that it is not information as such that is important. The social position of different groups in the study arguably was generated by their views. Thus the female sex workers are often fatalistic about HIV/AIDS, because they are powerless to control their clients, while the male street youth seem hopeless about their overall situations including AIDS. The discourse among ordinary married men and women signified that both men and women felt they need to protect themselves from the disease, but spread of disease was responsible for distrust between partners. The third major discourse from the medical professionals (doctors and nurses) was high on technical medical solutions. The social position of the doctors and nurses made them experts who have knowledge of the disease, while the patient is "ignorant". The medical professionals, especially the doctors, believe that antiretroviral drugs; condoms, circumcision etc are the solutions for the prevention of the disease while the nurses had a more social orientation to the prevention of the HIV/AIDS.

In the overall conclusion table below, I compare the responses of the different groups in Ajegunle, which will be compared and contrasted with organisations that have intervened in HIV prevention in Nigeria.

Table 3 showing overall conclusion of responses by subject position

Subject position	Fatalism/Hopelessness	Medical model	Protectionist discourse
Knowledge of HIV	Yes	Yes,	Yes,
Risk of HIV/AIDS	Yes, scarcity of condoms,	Yes condom	Distrust
Risk Assessment and behaviour	Risky behaviour	Ignorance	Errant and promiscuity
Prevention of HIV	Abstinence, Condoms, herbs	Medical solution (HIV-test, antiretroviral drugs, microbicides, abstinence, circumcision of male child,	HIV testing, Abstinence, be faithful to partner, reproductive health and women's rights,

Source: Ajegunle interview response 2015

The Ajegunle discourse on HIV/AIDS prevention in Nigeria has captured the sometimes-paradoxical relationships that exist between respondents in the groups, their subject positioning, social interaction and the role that gender had played in their social location. The discourses also indicate that people at the grassroots know about AIDS/HIV, and its transmission even if they do not always trust the message, but their interactive power relationships (sex workers and married women, especially), shows that they are constrained by cultural and other factors, and cannot always take effective prevention action. The grassroots discourses were holistic and, unlike most of the organisational discourse raised the issue of primary prevention- the social and cultural issues, which militated against prevention- notably poverty and its effects, issues around women's rights and the use of traditional cultural healing as they affect the sex workers and their clients, married women and their husbands, and the people's attitudes to Western medical solutions.

Discussion of both Ajegunle and Organisational Discourses

Prevention Perspectives- Organisations and Ajegunle

Efforts aimed at reducing the spread of the HIV disease are at the core of many AIDS response strategies in Nigeria- with a focus on antiretroviral drugs, condom use and awareness creation [secondary and tertiary prevention]. The prevention activities of the GOs and LNGOs also use Information Education and Communication (IEC) to address behaviour change so that people can act on the knowledge of the disease. The general assumption is that information and knowledge of HIV/AIDS will make people take precautionary measures that will not make them susceptible to HIV infection. Preventive education activities such as promotion of abstinence, behaviour change, and condom use, and antiretroviral drugs are undertaken in greater proportion by the LNGOs at the grassroots levels. The majority of the organisations seem to increasingly adopt abstinence as an approach, due to pressure from the INGOs, apparently because of their ideological/moral shift in prevention[6]. The GOs and LNGOs are also using Western preventive approach of technical medical solutions, but most prevention interventions from the GOs have relied on giving information about HIV transmission and behaviour change.

In contrast, the people of Ajegunle community already had an understanding of HIV/AIDS causes and, the risk behaviours associated with its transmission. Generally also they knew the specific practices that make

[6] However, the faith-based organisations (FBOs) such as the Saint Charles Catholic Group and the Ajegunle Baptist Church have been using abstinence as their main focus of prevention before the shift.

its prevention possible, but could not act on them, reportedly due to lack of power engendered by factors - such as poverty, cultural belief, domestic violence etc.

The main prevention effort in Ajegunle has come from the LNGOs who get their funding support from the INGOs and GOs and work directly with the grassroots individuals and communities. The interaction and decision making here is top-down. The antiretroviral drugs, information, education, and communication and in some cases condoms have been viewed as the basis for prevention at this level as dictated by the organisations [INGOs and GOs] that sponsor them. The local emphasis at the grassroots reflects the salience of structural issues such as domestic violence, poverty, and women's rights even though they understand the risks associated with the disease. Thus, the situations establish the case for primary prevention since the whole effort in Ajegunle both secondary and tertiary preventions has not made any difference.

Contrasting Organisational Discourse and Ajegunle Responses

Clearly the medically oriented secondary and tertiary preventions foci of the organizations are in contrast with those of Ajegunle community where there is poverty, cultural and power gaps. Sex workers are powerless to make street youth (their sex partners) use condoms because they need the money and would not like to lose their customers, and may not insist on condom use at the time. They also blame each other for spreading the disease in the community. The ordinary married men and married women also struggle to come in terms with high-risk behaviour as married men (husband) exonerate themselves as the source of the disease in the family, and blame it on the infidelity lifestyle of the women, while the women blame it on the sexual excesses of their husbands outside matrimonial homes. The women also blamed the prevalence of AIDS in the community on the culture of the people- as they lack the power to say no to sex when their husbands demands it even during seeming ill-health- as against condom use, which some husbands often reject its use, especially with their wife.

The social position of the HIV organisations that work in Nigeria and the responses from the grassroots people in Ajegunle community have shown that both the organisations and the grassroots people talk-past each other [have different ideology] on HIV prevention, which suggests that effective prevention action is being severely inhibited. It is suggested here that it is a matter of power.

The conceptualisation of Steven Lukes (1974) is useful to examine the operation of power in this instance. He argues that for us to have a full understanding of power, we need to see it in terms of three dimensions – structural conditions, agenda setting, and actual decision-making. If we apply these to the stakeholders in this study his three dimensions of power can be presented as follows:

1. Structural power [INGOs]
2. Agenda setting [GOs and LNGOs]; and
3. Decision-making [Grassroots people].

So the INGOs, (through funding) create the conditions under, which the GOs and the LNGOs set their agendas for HIV/Aids prevention, while the actual decisions on preventive behaviour are made by the grassroots people of Ajegunle community [sex workers, clients of sex workers and the married men and women. In short, the structural power of the INGOs dictates preventive action within Nigeria (the preventive agenda of the GOs and then down to the LNGOs). This does not seem to be related directly to the situation of those at the bottom of the heap where decisions about preventive behaviour are being made. This is where the street youth/clients of sex workers or husbands exercise power over sex workers or wives indicating the general powerlessness, especially dependent women and those at the bottom of the heap in Ajegunle community and those most at risk to HIV and Aids pandemic.

The relationship between power and knowledge of HIV/AIDS and its prevention is crucial to this discourse. The fundamental basis of power (Rowlands, 1997) according to Lukes is that power distorts knowledge by wrapping or distorting the truth in a direction that is beneficial to the specific interests of the dominant group

(Hughes, 2002). This explains why clients of sex workers [street youth] who possess [the financial] power often use direct force, and coercion on sex workers during interaction- to the detriment of the sex worker's interest or decision, especially when the issue of condom use is raised. The husbands of ordinary married woman also manipulate them against their decision because they lack power to say no to the man even when he is infected with sexual transmitted diseases (STDs).

Moreover, the culture in Ajegunle works against married women in terms of sexual relationships with their husband, since the woman is seen as the property of the man [husband], and cannot say no to sex when demanded. Traditionally, in Nigeria, it is an abomination for a woman to say no to sex if the husband demands it (Iyiani, 2000). It is believed to be sacri-religious, and the duty of the woman to adhere to the sexual desire of the husband. This situation of patriarchy has serious implications for the reproductive health rights of the woman, especially in the face of HIV/AIDS pandemic. However, the situation is condemnable since any form of sexual coercion is rape. And rape is about power, which is inhumanity against mankind, not sex.

The third, structural, dimension of Lukes' view of power, explores how power shapes preferences via values, norms, and ideologies (Aldrich et al, 2001). Thus all social interaction involves power in relation to the social position of the people because ideas operate behind the language of people's value system and action. This is why the topology of power within the organisations that prevent HIV/AIDS in Nigeria, and their action, ideas or values, especially the INGOs are grounded in social and technical medical discourse that are meant to direct the positions of the GOs and the LNGOs to suit the ideologies of the INGOs since they have the authority, and power to provide the support fund that is needed by the GOs, and the LNGOs for HIV reduction.

So this paper argues that medicalist discourse around ignorance as was stated by the medical doctors in this study is too simple. For HIV/AIDS prevention to be effective there is need to relate the prevention approach to the felt-needs of the people, especially the most vulnerable, as this is where prevention stands or falls. There is therefore an urgent need to close the gap between the views of the organisations and the people at the grassroots. Therefore, there is need to confront power- both with respect to structural power, resources (money, cultural values etc) and power within social and sexual interaction. In this context, it requires linking top-down and bottom-up perspectives under the framework of empowerment [transformational distribution of power], and participation[7] (Tembo, 2003). So the concepts of interventions and participation are the forms in which the perspectives of the INGOs and the people respectively [top down and bottom-up] are brought together to an empowerment agenda, for transformational HIV prevention. Linking bottom-up perspectives of the people in relation to each other (grassroots) and in relation to the top-down nature of strategies of the INGOs will potentially empower both the local organisations and the community by making them much more accountable and directed by the needs of the people. It will also close the gap between the agendas set and the actual conditions of decision-making for vulnerable people.

Rationale for Primary Prevention in Ajegunle- using Community Development Approach

Prevention programmes, especially from the point of INGOs and GOs have shown that prevention does not work except if the prevention is planned and managed with the support of the people themselves in relation to their culture (UNAIDS, 2000). Footnote: For example, in countries that have implemented quick, 'well-planned efforts' with support from political leaders and grassroots community organisations, including sex education in schools, treatment of STDs (sexually transmitted diseases), and widely promoted condom use, HIV prevalence has been kept consistently low and has even decreased (UNAIDS, 2000) unlike where the grassroots communities are not involved. It is the primary level of community involvement and

[7] Participation in this case is the mechanism through which the social position of the people and their diverse livelihood, are brought into the empowerment agenda- that is formed through linking top down and bottom perspectives.

empowerment, which seems important if HIV prevention is to work, be embedded and successful in the longer term.

This may involve challenging the cultural norms, which prevent people from acting upon information about safer sex (including the norms internalised inside people's heads), but also focus on the power and resource issues, which make it difficult for them to assert their wish for safer sex (Mayo, 2000).

I suggest- building capacity of the organisations and institutions that people at the grassroots will use and relate them in order to participate in community decisions and solutions, especially in HIV/AIDS reduction. This can take place by building intermediate local level organisations as arenas where this interaction and negotiations can take place. It will also serve as capacity building of local level community organisations. Building the intermediate local level organisation will create room for interplay between empowerment and capacity building as grassroots people and NGOs work together in HIV/AIDS prevention project.

Systematically, the synergy of linking top down and bottom-up perspectives suggests a greater strength where the powers of the organisations and the grassroots people will emerge and reflect the local conditions of the people while embracing the international concepts. Linking unique initiatives from the grassroots that identify community AIDS issues and, the organisations' [INGOs] perspectives will help to streamline multisectoral partnership that can address the grassroots prevention needs of the community. This is why the study suggests that capacity building[8] will enhance the coordination [interactions and power balance] between the various actors both at the top and the bottom- so that they can strengthen information sharing, and integrate their various perspectives on HIV prevention. In this form, the discourse is about change that is based on integration learning (Eade, 1997), which must (however) be rooted in information since information helps to reduce uncertainty (Tembo, 2003) that surrounds HIV/AIDS, especially power.

Conclusion

Discourses of both organizations and the Ajegunle grassroots people have shown that the INGOs frame their interventions in the context of their ideologies and use it to influence the wider political and economic environment of prevention both for the GOs, LNGOs and for the ordinary men and women in the community. However, understanding the realities faced by the most vulnerable people and the nature, and extent of social transactions, and interaction- between female sex worker and the street youth, married men and their wives- has shown how the pressures associated with their social position, social location and power has created a gap that has made the sex workers and married women often powerless to effect HIV prevention. Similarly, it is interesting to note how changes or shift in ideology from the wider world- on the part of the INGOs is influencing the nature of LNGOS interventions before they get to the community. Arguably, the powerlessness of both the local organisations and the people is based on the fact that they lack the strength to act or achieve HIV prevention on their own even when they have the necessary knowledge in their head. The LNGO's arguably can only help effectively with this task by involving the local community in the development of its preventive programmes. The task seems to be to build the community capacity for such cooperation to take place.

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[8] Capacity building is an enabling process where people can both determine and achieve their objectives.

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