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Full Length Research Paper

African Diaspora and control of HIV infection due to unsafe medical practices in Africa

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Members of the African Diaspora have been portrayed as defectors, disloyal to their motherland. Such overgeneralized characterizations unfortunately risk clouding a complex reality and masking the positive involvement of a large number of Africans of the Diaspora in African affairs, particularly in the context of the HIV/AIDS crisis. One illustration of this involvement is a pilot project undertaken by US-based members of the African Diaspora in collaboration with one Congolese medical school. Implemented in the Eastern Kasai Province (Democratic Republic of the Congo), the pilot project focused on the training of health care professionals and on the deployment of quality improvement teams to effectively mitigate HIV infection which results from unsafe medical practices. Project aims, design, strategies, and accomplishments are described. Building on this case, arguments are presented to expand the concept of global learning to include capacity development projects, conceived and implemented by the African Diaspora.

Key words: African diaspora, capacity development, control of HIV infection, global learning, health care workers.

INTRODUCTION

As a land of opportunity, America has attracted millions of immigrants. It has also seen a sizeable number of African immigrants, particularly beginning in the 1960s, with the post African colonial era. According to figures available from the U.S. Census Bureau, the overall African-born population of the United States was 881,300 in 2000. According to the American Immigration Law Foundation (2000), “new communities of recent African immigrants have emerged in the United States since the mid-1960s, joining older African American populations in several U.S. urban centers” (2000). When they come to the US, these newcomers pursue various goals. According to American Community Project (2000), some look to create new lives in the U.S. and others plan on using the resources and skills gained to go back and help their countries of origin. When it plays out in actual behaviour to return to Africa and become involved in teaching about African development, this last desire underscores one key aspect of global learning (GL). However, this phenomenon only partially captures the complete range of African immi-grants’ involvement in GL and global development, as it excludes a range of initiatives by a number of African immigrants who have elected to remain in the West while still helping Africa in their own way.

Regardless of their plans (staying in America or returning to Africa), African immigrants generally have wholeheartedly embraced learning and have gained significant higher educational achievements in their host country. According to the Journal of Blacks in Higher Education, African immigrants to the United States are more likely than immigrants from any other region to have a graduate education; they are also more highly educated than any other native-born ethnic group including white Americans. Some 48.9% of all African immigrants hold a college diploma. This is slightly more than the percentage of Asian immigrants to the U.S., nearly double the rate of native- born white Americans, and nearly four times the rate of native-born African Americans.

Having acquired college level knowledge at such a large extent, African immigrants contribute in many ways to the betterment of life in America and in Africa. African communities contribute millions of dollars to the econo-

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mies of Africa by sending money to their family members (Brown University, American Community Project, 2000). According to Nworah (2006), the amount of money remitted by African Diaspora workers - $17 billion per year - is larger than the amount of foreign direct investment in Africa, and rivals official development assistance grants or loans ($25 billion per year). According to Zuckerman (2006), in some African nations, remittance represent as much as 27% of the gross domestic product. According to the UN's Office of the Special Advisor on Africa, the average African migrant living in a developed nation is sending $200 per month home to his or her family.

Sending money is just one dimension of connection to Africa. African immigrants are touched emotionally, socially, and financially by the scourge of HIV that is killing millions of their relatives and acquaintances in Africa. While they are usually ashamed and unwilling to share the details of the cause of these deaths, their strong affinity with and unquestionable compassion for their motherland Africa, leads these African immigrants to organize funerals for their loved ones, send money or even sometimes travel to bury the deceased.

Prompted by their particular circumstances, some have initiated micro-development projects to help Africa; and these projects embrace many areas such as education, agriculture and health care. However, despite the wide range of involvement in development projects targeting Africa, very little is known about their specific contribution both in the mitigation of HIV/AIDS in Africa and in the use of global learning strategies and concepts in the pursuit of their projects. This state of affairs may be due to the lack of assertiveness on the part of African professionals. It may also be due to the restrictive way GL has been defined. After initiating and implementing GL activities, African professionals in the Diaspora do not stand up to advocate their rightful place at the table; hence they risk getting little or no acknowledgment for their legitimate contribution in global learning.

OBJECTIVES, METHODS AND RATIONALE

Objectives

This paper features an HIV prevention program pursued by US-based members of the African Diaspora and targeting the reduction of HIV infection due to unsafe medical practices in the Eastern Kasai province (DRC). Its objective is to shed some light on the role the African Diaspora has been playing to facilitate human capacity development and the proper provision of medical care in Africa. Moreover, building on this case, the paper argues in favour of the recognition that this pilot and other capacity development projects conceived and implement-ed by the African Diaspora contribute to global learning.

Research methods

To achieve these objectives, qualitative and quantitative techniques have been used: participant-observation, documentary research and quantitative methods based on primary sources. The two researchers are of African origins and have a cumulative experience of about 30 years in the Diaspora; they have travelled a great deal and have encountered many other Africans in many countries, particularly in the United States. They have seized the opportunities afforded by these encounters to engage other Africans in conversations around issues of HIV infection, deaths due to AIDS and poor quality of health care in Africa. Having intimate familiarity with other members of African Diaspora in the United States and elsewhere, they have been able to observe various members of this group and capture their discourse and actions in relation to HIV/AIDS that is affecting Africa.

In the context of the initiation, both during and after the execution of the original project (being featured in this study), they have reviewed a range of documents to acquaint themselves with the unfolding of the global response to HIV and with the debate regarding the two competing HIV infection transmission paradigms. Finally, they have surveyed health care workers in the DRC in February 2005, March 2006, and May 2007 to capture and then analyze primary data on (1) demographics; (2) attitudes towards and knowledge of HIV; (3) practices regarding nosocomial HIV/AIDS infection; (4) practices related to sexual transmission of HIV/AIDS; (5) know-ledge and use of antibiotics and anti-retroviral drugs; (6) use of needles and sharps and experience with needle stick injuries; (7) exposure to blood and body fluids, and blood transfusion practices; and (8) participation in and overall evaluation of infection control continuing educa-tion and quality improvement activities.

The questionnaire was initially formulated in English and then translated to French as the later is the official language in the DRC. Both English and French versions of the questionnaire were reviewed and approved by the Institutional Review Board of the Northern Illinois University in August 2004. These protocols were also reviewed and approved by the Congolese Ministry of Health. Because of the composition of the research team and of the scope of this description (case study), this paper should not be perceived as an evaluation of the overall experience of members of the African Diaspora, but more as an insider's examination of: the issues revolving around HIV infection as experienced within the African Diaspora; as a reflection on the efforts pursued in a limited pilot study; and the challenges that still remain to achieve effective medical care, that does not increase the risk of aquring the HIV infection in Eastern Kasai province and elsewhere in the DRC and Africa.

Rationale of the study

This paper addresses a global issue (HIV/AIDS) and focuses on an overlooked category of actors, viewing them mostly in their soft role of facilitators of learning and transmission of crucial information and knowledge for the mitigation of HIV due to unsafe medical care. In the context of the escalating AIDS epidemic, there has been a noted tendency to critically assess the ability of various stakeholders to discharge their responsibilities. In this vein, African states, governments of industrialized nations, pharmaceutical firms and international donors have all received their share of blame for what has been perceived variously on their respective parts as passivity and lack of vision, insensitivity and bureaucratic delays in approving new HIV drugs, greed and overly protection of patent rights at the expense of human lives in poor countries, subjugation of African states to the shackles of neopatrimonialism (Behrman, 2004; Crew, 2002; Lewis, 2007; Patterson and Ciaminis, 2005 a,b,c).

However, among all these "culprits", African states have received a significant share of the blame, with the majority of them depicted as inefficient, corrupt and illegitimate actors without any real capacity to create strong institutions to develop and implement ef-

fective national HIV policies and to play as equals to other Western players in the international arena (Patterson and Ciaminis, 2005). Taking advantage of the crippling effect of these overwhelming characterizations levelled against African states, numerous international donors have entered Africa under the label of benefactors. They have emerged in Africa where, without the official mission of replacing the so-called failed states, they nevertheless have brought badly needed resources, have created structures for utilization of their mana and have crafted policies that both government agencies and private organizations in the host countries are expected to comply with.

Whereas they have been applauded for their willingness to step in and to provide a variable amount of resources, international donors have also been severely criticized for the unintended consequences of their presence and interventions in Africa such as the ability to "limit creativity and independence" and "contribute to the continuation of the neopatrimonial state" (Patterson and Haven, 2005; van de Wale, 2005, 2001).

In consideration of the aforementioned negative externalities of HIV policies and programs in Africa, one may well get a clue as to why the sexual transmission orthodoxy paradigm of HIV/AIDS is the most predominant policy in the African health care landscape (Bukonda and Disashi, 2007a). This state of affairs is particularly disturbing given the accumulation of reports suggesting that HIV infection in Africa may be coming more from unsafe medical care than from unsafe sexual trans-mission (Brewer et al., 2003; Gisselquist and Potterat, 2003; Gisselquist et al., 2003; Reefer, 2000).

The foregoing propositions clearly underscore the need for prevention programs that fight against HIV infection due to unsafe medical care in Africa, an area in which the majority of African states have miserably failed. The members of the African Diaspora who have proper expertise can play a remedial, yet challenging role, particularly when one considers the long history and established prestige of the major agencies that are key proponents of the HIV transmission orthodoxy. These propositions also serve as a justification of the nosocomial HIV infection control in Eastern Kasai (NHICEK) project, which these two researchers, who have a cumulative experience of approximately thirty years as members of the African Diaspora, developed and implemented with financial backing from the United States Agency for International Development (USAID) through the Association Liaison Office for University Cooperation in Development (now Higher Education for Development or HED).

NOSOCOMIAL HIV INFECTION CONTROL IN EASTERN KASAI (NHICEK)

The idea to develop NHICEK was initiated by an active member of the Congolese Diaspora, also a faculty member at an American University. This was a response to a call for grant proposals released in the spring of 2003 by Higher Education for Development (HED), then the Association Liaison Office for University Cooperation in Development (ALO). He contacted and enlisted the collaboration of a colleague based at an African University. The proposal was crafted in 2003 according to and in order to meet the stipulations of the funding agency. Editing support was provided by the NIU Office of Sponsored Projects. Submitted in September 2003, the proposal underwent external blind review. Notification of the selection and award was received in April 2004. Under this initiative, the School of Allied Health Professions at the Northern Illinois University (NIU) was brought into collaboration with the University of Mbuji Mayi's School of Medicine in the DRC to implement a two-year long partnership initiative.

Mission and goals

The partnership was entrusted with the mission of: (1) training and establishing a core group of trainers/ facilitators in the area of infection control and HIV prevention; (2) training health care workers in two pilot health zones in HIV mitigation, teamwork, and quality improvement; (3) establishing and coaching quality improvement teams in these two pilot health zones; (4) measuring and improving infection control and HIV mitigation related knowledge, attitudes, and behaviors among health zones (HZs) personnel in the Eastern Kasai province of the DRC; and (5) using the results of the evaluation of project's processes and outcomes to instruct health policy making on effective strategies to establish infection control quality improvement teams and mitigate iatrogenic HIV infection in resource constrained countries.

Project activities

This project relied on the introduction of specific continuing education (CE) and quality teams (QTs) or quality improvement teams (QITs) as recognized means for organizational improvement and productivity (Crosby, 1980; Dobyns and Crawford-Mason, 1991; Houle, 1980). A number of members of the African Diaspora in the United States were involved because of their professional expertise deemed relevant in the pursuit of project objectives.

Project stages

Activities were implemented in six stages. During its initial stage (start-up: April – June 2004), an Advisory Committee and a Listserv for Project Staff were set up. Moreover, research protocols were finalized.

During its second stage (July –September, 2004), a training program for trainers/facilitators of Infection Control and Quality improvement teams (QITs) was developed. Five Congolese medical doctors were brought to the U.S. to be exposed to the culture and practices of infection control and to be trained as infection control facilitators. They spent two weeks in Northern Illinois (November 2004) and participated in 5 training modules. Lectures were delivered by faculty members selected from NIU and other institutions such as DesMoines University Medical College, Joint Commission International and Kishwaukee Community Hospitals. Some of the lectures by two faculty members who are members of the Congolese Diaspora were presented in Tshiluba, one of the main national languages of the Democratic Republic of the Congo. Lectures were complemented by tours

of infection control departments at two area hospitals. During these tours, participants were introduced to infection control techniques used by host hospitals. Questions and answers sessions were held at the end of each module. At the conclusion of their training, draft infection control plans and ten training modules were developed. These modules are made of a series of eight modules on infection control (IC) training program and another series of two training modules related to quality improvement principles and team creation, dynamics and effectiveness.

The third stage was devoted to collection of primary data in order to assess baseline measures of knowledge, attitudes, and practices related to nosocomial HIV infection control and other variables of interest. The fourth stage was the actual delivery of the planned capacity development intervention in two of the four study health zones. During the fifth stage, collection and consolidation of follow-up data with baseline data to explore any change brought about by the project were pursued. The conduct of this exercise has enabled our team to get a series of positive results as well as a number of insignificant findings. Details can be found in the final report of the project. Findings were disseminated during the sixth stage. In this vein, seven presentations have been made at various local, national and international conferences. One manuscript has been published (Bukonda and Disashi, 2007b) and another is in press.

Accomplishments

They can be appreciated in various ways. Because of space constraints and of the global learning perspective, it will suffice to list the number of participants trained in the Eastern Kasai province under each module:

234 health workers were trained in “General HIV infection and mitigation strategies”;
120 health workers in “Quality Improvement Theory and Principles”;
118 health workers in “Building quality improvement teams for HIV infection prevention”;
50 health workers in “Understanding and preventing vertical HIV transmission”;
50 health workers in “Blood transfusion, operating rooms, and HIV infection control strategies”;
112 health workers in “Injection process, needle stick and HIV infection prevention strategies”;
116 health workers in “Use of antibiotics and anti-retroviral medicines and infection control”;
80 health workers in “Infection control in infectious diseases and intensive care departments”;
80 health workers in “HIV infection control in physician offices and rural health Centers” and;
50 health workers in “HIV testing and infection control in clinical laboratories”.

GLOBAL LEARNING: EXPANDING THE CONCEPTUAL SCOPE

In line with the conception and implementation of NHICEK, the concept of GL emerges as a central theme. This concept was defined by Hovland (2005) as a process that helps students:

(a) gain a deep, comparative knowledge of the world’s peoples and problems; (b) explore the historical legacies that have created the dynamics and tensions of the world; (c) develop intercultural competencies so they can move across boundaries and unfamiliar territory and see the world from multiple perspectives; (d) sustain difficult conversations in the face of highly emotional and perhaps uncongenial differences; (e) understand—and perhaps redefine— democratic principles and practices within a global context; (f) engage in practical work with fundamental issues that affect communities not yet well served by their societies; and (g) believe that their actions and ideas will influence the world in which they live.

This conceptualization is rich, but it is unrealistic in its first aim of enabling students to “gain deep, comparative knowledge of the world’s peoples and problems.” In our opinion such deep, comparative knowledge is unattainable and irrelevant. Additionally, by focusing on a Western concept of democracy and on democratic principles that have proved practically elusive to many world citizens and by dubitatively considering their redefinition, this conceptualization has exposed its ethnocentricity and has failed to recognize other widespread political experiences such as dictatorships and autocracies which have been at work with the backing of the most powerful nations of the world. Such widespread political experiences maybe, also need some better understanding and some effective refinements by GL students to give way to better forms of dictatorial governance under which a significant number of currently oppressed and disenfranchised peoples could finally become unshackled and attain better access to HIV medicines and clean medical care settings and practices. Finally, it will suffice to point that this conceptualization represents unfortunately a *de facto* exclusion of meaningful international initiatives undertaken by members of the African Diaspora and aimed at improving human capacity within health care systems in developing countries to address HIV/AIDS. Hovland’s definition of GL focuses specifically on students or learners and shies away from major global issues such as poverty alleviation and HIV morbidity and mortality.

Another relatively more comprehensive definition was formulated by Rimmington et al. (2003) who portrayed GL as “the combination of global reach and global perspectives to produce a global graduate.” This formulation was further refined by openly associating GL with the “use of modern communications technologies” and “inter-

action of learners living in diverse geographic locations with different cultural backgrounds." For Rimmington et al. (2003), the aim of GL is to "produce the global graduate", a graduate capable of exhibiting "the requisite commu-nication and team work skills for successfully achieving learning outcomes in a global context plus the attributes required by accreditation bodies in their chosen program". While they have the merits of attempting to elucidate a new concept, not only do these two definitions give a content or essence to the GL concept, but they also somehow convey the intent that had preceded their formulation (Okoli, 2008). In both cases, one can detect the setting in which these formulators navigate and in which they draw their key reference terms. The foregoing is said particularly in reference to a noticed tendency in both definitions to explicitly confine the world of GL to students or learners who pursue formal learning, are concerned about meeting "accreditation requirements" in their chosen programs and who expect "formal graduation" in the traditional meaning of this term. Such prescriptions, in our opinion, are peripheral and unnecessarily limitative. The essence of GL, as established by the content of these two definitions, could be characterized as the product of imaginary (artificial) attributes instead of being the product of real (intrinsic) attributes.

Taken as such, these formulations leave outside of the domain of GL, a wide range of learning topics, learning activities and learners. Hence, by electing to illustrate their formulation with a reference to the spread of democracy, these descriptors leave outside in the cold learning activities covering subject matters of great health interest such as "emerging infectious diseases", "culture of infection control", and "delegation of HIV treatment roles to health paraprofessionals." These very important subjects are just emerging or reemerging and they have not yet been molded into formal academic programs in many parts of the world. Dissemination, promotion and incorporation of such infection control knowledge and practices in various human activities represent positive steps in the betterment of global welfare particularly when one considers the magnitude of morbidity and mortality due to preventable infection with HIV, hepatitis, and other infectious diseases standing at the front line. Also left in the dark would be potential learners who, after acquiring their right of entry into existing trades years ago, are already part of the workforce. Because of significant advancement and sophistication in technology since their formal graduation, these older graduates also stand to benefit from learning. When given access to learning opportunities on burning issues of professional and societal interest, these learners - who do not necessarily expect formal graduation or formal validation from accrediting bodies - stand to enhance the quality of their work performance and to enable their communities to reap evident direct and indirect benefits such as avoidance of iatrogenic infection, shorter lengths of hospital stay, and protection from HIV and other infectious diseases coming through exposure to blood and other body fluids. Given these reasons, we view GL more broadly as a human endeavor that focuses on facilitating/ achieving learning in the global context with the learning process under consideration targeting issues of global concerns, using as much as possible advanced communication strategies to facilitate the learning process, and having potential ramifications and impact on the welfare of a large segment of the world population. Under this view, global learning is seen as addressing issues of global interest, in a global context, and through interaction with other learners and trainers with different or with similar cultural backgrounds. While of great interest and utility for traditional learners or students in classroom settings, formal graduation and official accreditation are not deemed *sine qua non* conditions of GL.

CONCLUSION AND RECOMMENDATIONS

Acquired immune deficiency syndrome (AIDS) is a global human tragedy that has caused countless infections, sufferings and deaths, particularly in Africa. According to UNAIDS (2008), "the overall number of people living with HIV has increased as a result of the ongoing number of new infections each year and the beneficial effects of more widely available antiretroviral therapy". The UNAIDS' report also reveals that "Sub-Saharan Africa remains most heavily affected by HIV, accounting for 67% of all people living with HIV and for 72% of AIDS deaths in 2007".

According to Lewis (2007), Africa alone has more than 1.4 million orphans. The devastation caused by HIV had remained relatively invisible for a long time (Behrman, 2004) before galvanizing the attention of world leaders in the last ten years or so and prompting, *inter alia*, the creation of a brand new global mitigation structure (UNAIDS/WHO, 2006) and the implementation of diverse approaches to curb HIV infection.

The devastation also has severe external ramifications and implications as it affects Africans in the Diaspora in many ways. Regardless of their having or not acquired HIV, Africans in the Diaspora face the reality of receiving bad news about relatives, friends and acquaintances who have been diagnosed or who have died of HIV/AIDS in Africa. Given the severity of the scourge in Africa, such sad news are more frequent for them than for any other immigrants and Western citizens. When they are received, these sad news trigger a chain of events such as withdrawing money from one's bank, visiting a Western Union or Money Gram outlet, calling one's relatives to apprise them of the remittance that has just been made to enable access to medicines, organizing funerals or/and sometimes travelling to Africa to attend the fune-rals of their loved ones. As they conduct these acts of social etiquette and of deep social affinity with their kins,

Africans in the Diaspora experience significant uneasiness to explain to their friends and Western colleagues and acquaintances the cause of these frequent deaths. This attitude is guided by prevailing social norms and taboos about dying and about HIV.

Africans in Africa and in the Diaspora still perceive HIV generally, as a disease that promiscuous individuals contract through unsafe sexual activities. This well entrenched belief is reinforced by some church teachings that portray the disease as an indication of decay in sexual morality and God's wrath for those who engage in sexual immorality (Beaubien, 2005; Brethren Revival Fellowship, 1989) . It is also reinforced by the predominant paradigm of HIV transmission that is taught through African health care systems (Bukonda and Disashi, 2007a). This paradigm views sexual activity as the dominant mode of HIV infection and portrays unsafe medical care as a minor concern. This is particularly disturbing given the accumulation of reports suggesting that HIV infection in Africa may be coming more from unsafe medical care than from unsafe sexual transmission (Brewer et al., 2003; Gisselquist and Potterat, 2003; Gisselquist et al., 2003; Reefer, 2000). Despite this evidence, the response and behaviour of Africans in the Diaspora are generally determined by the assumptions of the orthodox view.

Besides facing and addressing at an individual level all these issues brought by HIV in their lives, a number of Africans in the Diaspora have engaged in initiatives aimed at mitigating the magnitude and severity of HIV infection in their countries. With the exception of one pilot project of which the objectives, strategies and accomplishments have just been discussed in this paper (with a focus on reducing HIV infection caused by unclean medical care), we are not aware of any other Africa Diaspora-based HIV initiative that focuses on addressing nosocomial HIV infection in Africa. Unless we are mistaken, all known HIV related initiatives launched and supported by Africans in the Diaspora (e.g. African AIDS Initiative International, Inc., Mobassa Relief Initiative, and the West Africa Project to Combat AIDS and STIs {WAPCAS}) are based on abstinence, faithfulness and use of condoms; they use education, outreach, testing, counseling, and support services to control the spread of the disease and foster behavioral change in lay people while overlooking the widespread use of unclean needles and syringes and the transfusion of untested, potentially HIV-tainted blood to unsuspecting patients in Africa (Simonsen et al., 1996) and; they seek to promote the integration of the growing number of AIDS orphans into their communities and to reduce the stigma attached to the disease.

Despite their significant undertakings, all these initiatives built or not on the sexual orthodoxy paradigm have not yet been formally considered under the light of the global learning (GL) concept. It is believed that all these initiatives more or less have some association with GL conceptualizations developed over the last few years. However, this link has not yet been formally clarified or promoted. Members of the African Diaspora have not yet been sufficiently explored in their role of learners and translators of knowledge into meaningful social initiatives for their countries or of credible players endowed with the capability and the willingness to mitigate the various scourges that befall Africa. Quite unfortunately, their attitude toward the devastation caused by HIV/AIDS in Africa has been fallaciously viewed as a mere combination of silence, denial, sense of powerlessness and passivity (Eboko, 2005). Unfortunately, such negative and largely unwarranted images are likely to propagate and add to whatever pre-HIV/AIDS negative publicity that has been on- going - such as being disloyal and unpatriotic defectors (AllAfrica.com, 2006) - if they are not countered by objective and substantive reports showing African Diaspora's meaningful initiatives and accomplishments in and for Africa. Those Africans in the Diaspora who are engaged in GL projects need to use a higher dose of assertiveness to gain their rightful place in circles where GL issues are explored and where definitions are formulated about the content and framework of GL. In so doing, they will acquire advanced understanding of and contribute their ideas to the overall field of GL. Hopefully they will be welcome to the table instead of being perceived as troublemakers.

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