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## **Gender Issues in HIV/AIDS Epidemiology in Sub-Saharan Africa**

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### **Abstract**

#### **English:**

The patriarchal nature of African societies continues to shape women's sexual behavior in the region. This in turn accounts for the high prevalence of HIV/AIDS among women in sub-Saharan Africa. Of the several factors implicated in the unequal prevalence of the disease among women in Africa, economic dependency/feminization of poverty, unequal distribution of sexual power (sexual violence and coercion), limited educational opportunities and lack of political will, continue to dominate the literature (Robinson, 2004; Dunkle, et al., 2004; Martin and Curtis, 2004; Eaton, et al., 2003; Mill and Anarfi, 2002). While programmatic and financial initiatives have increased significantly in the third decade of the epidemic, the international community must do more to reverse the trend of the epidemic in sub-Saharan Africa. Leaders of sub-Saharan nations must show a new determination to coordinate available HIV/AIDS related programs so that afflicted individuals voluntarily participate. Culturally relevant (gender biased) public health education in the region is implied.

Keywords: sub-Saharan Africa, women, culture, socioeconomics, HIV/AIDS.

### **Introduction**

The spread of HIV/AIDS in sub-Saharan Africa remains a global public health challenge with an estimated 30 million Africans now living with the disease. Women bear a disproportionate burden of the infected as they constitute 58% of the disease cluster in the region. Adolescent girls are 3 – 4 times more likely to be infected compared to their male counterparts (UNAIDS, 2003; Tabi and Frimpong, 2003). The patriarchal nature of African societies continues to shape women's sexual behavior in the region. This in turn accounts for the high prevalence of HIV/AIDS among women in sub-Saharan Africa.

Of the several factors implicated in the unequal prevalence of the disease among women in Africa, economic dependency/feminization of poverty, unequal distribution of sexual power (sexual violence and coercion), limited educational opportunities and lack of political will, continue to dominate the literature (Robinson, 2004; Dunkle, et al., 2004; Martin and Curtis, 2004; Eaton, et al., 2003; Mill and Anarfi, 2002). The extent to which these factors fuel the spread of the disease in sub-Saharan Africa must continue to dominate public discourse. Also, although it can be argued that the third decade of this pandemic has witnessed an increase in programmatic, socioeconomic and policy initiatives among African nations and donor countries,

some basic questions would appear pertinent at this time. Is the international community doing enough to reverse the spread of this contagion in sub-Saharan Africa? How determined are African leaders to coordinate available national and international resources in the battle against HIV/AIDS in the region? Most importantly, what strategies can African leaders formulate in order to effectively address the disproportionate prevalence of the disease among women? These issues constitute the major thrust of this article.

### **Culture and Gender Roles**

Culture as a set of guidelines acquired from infancy tells the individual how to think, feel, perceive and act either as a male or female. Helman (2001) notes, “The division of human society into two gender cultures is one of the basic elements of social structure, and an important part of the symbolic system of any particular society.” (p. 110).

This would illustrate the culturally accepted double standards in patterns of behavior between the genders in many cultures. Women are expected to maintain their purity and not bring shame on their husband and family. A man’s honor in some societies may well lie on how well the women in his life conduct themselves. For example, among the Muslim Swahilis in Mombasa, Kenya, women are expected to be dependent on men. It is the responsibility of men in this society to provide for and therefore control women and children. Similar pattern of male domination has been reported in Mediterranean societies where premarital/extramarital affairs define masculinity (Ibid, p.110). In South Africa, cultural influences in the spread of HIV/AIDS among women include the fact that “young men claim ownership of their sexual partners.” (Eaton, et al. 2003). These men feel justified to have sex on demand including the use of force in a romantic relationship. Thus the patterns of behavior rooted in gender cultures especially in less industrialized societies become significant in the high prevalence of sexually transmitted diseases among women. These societies would be considered patriarchal and understanding their role in the spread of HIV/AIDS is important in any effective intervention program.

### **Patriarchy and HIV/AIDS**

The relationship between patriarchy and gender roles has been widely discussed in the literature (Parish, 2001; Tabi and Fripong, 2003; Martin and Sandra, 2004).

African societies are patriarchal (Airhihenbuwa, 1995), with some ethnic traditions requiring female pre-marital chastity while others require women to prove premarital virility by having babies (Schoepf, 1991). Girls are therefore socialized from very young ages to play subordinate roles. Girls that are socialized this way would then grow up as desirable women for marriage. They could be rewarded by their families for enhancing family honor and image. Thus years of “hand-me-down” conditioning of women have accounted for gender inequality in the region. In the era of HIV/AIDS, this power imbalance between the sexes carries a new sense of urgency. Women have become especially susceptible to the disease as a result of their limited power in

sexual encounters. In one estimate, 6 – 11% of young women aged 15 – 24 years were HIV positive compared to 3 – 6% of their male counterparts (Tabi and Frimpong, 2003). Any intervention program designed to reduce the high incidence of HIV/AIDS among women in the region must first address socioeconomic and cultural issues in addition to political will. The role of the international community in poverty alleviation programs as well as HIV/AIDS control in the region is also pertinent.

### **Female Poverty, Economic Dependency and HIV/AIDS**

Several social, economic, cultural and political factors account for African women's dependence on men and their consequent vulnerability to HIV/AIDS.

In African societies, the desire by men to have many children and women to validate their marriage through multiparity (having borne more than one child), have been implicated in the spread of this contagion (Moyo and Mbizvo, 2004). In these societies, marital fidelity is questionable since the relationships are usually not mutually monogamous. Moyo and colleague reiterate the fact that "... in Zimbabwe, women may be under pressure from their spouses or sex partners not only to reproduce, but to also achieve a desired number of surviving children." (Ibid, p. 10). In their assessment of the quality of sexual partnership reporting in rural Tanzania, Nnko and colleagues noted that while 40% of married men reported having non-marital partners, only 3% of married women engaged in this habit (Nnko, et al., 2004).

It is clear that even though marriage could protect spouses from sexually transmitted diseases, this can only be true if both spouses enjoy equal power in their marital relationship. Compared to Western countries, women in traditional African societies lack the power to deny sex to their spouses even when they can prove instances of marital infidelity in their relationship. In a study in Zimbabwe, it was noted that majority of the HIV-positive women were actually infected by their spouses (UNAIDS, 2003). Even more revealing is that in a survey of a group of rural women in Sierra Leone, one half actually believed that their spouses had a right to beat them. They also admitted that it is the woman's obligation to have sex with her spouse on demand even if she was not interested (Ibid). Females head most of the impoverished households in sub-Saharan Africa (Cohen, 1992). In the face of increasing needs, these women would likely engage in transactional sexual activities either occasionally or as professional commercial sex workers, thereby promoting a vicious cycle in the spread of HIV/AIDS.

### **Access to Condoms**

In their Millennium Development Goals, the United Nations has identified condom use as well as education in combating the spread of HIV/AIDS (Robinson, 2004). Yet several studies would suggest limited availability and usage of this important weapon against HIV transmission in sub-Saharan Africa (Eaton, et al., 2002; Volk and Koopman, 2001; Adih and Alexander, 1999). These studies present sociocultural, economic and religious barriers in the limited condom use in the

region. For example, in their study of “Health information sources for Kenyan adolescents ...,” Pratt, et al. (2000) note that religion is the most frequently cited factor influencing teenage pregnancy and consequently sexually transmitted diseases (STDs) such as HIV/AIDS in that country. Christianity is the dominant religion in Kenya with 30 % of the population claiming to be Catholics. The conservative Protestant and Catholic religions openly preach against the use of any barrier methods in sexual encounters among their members. The result is that women members as the most vulnerable population are denied opportunities for sex education including use of condoms to prevent sexually transmitted diseases (Pratt, et al. 2000). In their response to the Declaration of Commitment on HIV/AIDS adopted by consensus at a special session of the United Nations General Assembly in June, 2001, The Vatican notes that “The Holy See’s support for a new commitment to fight AIDS does not include a change in its moral position on the use of condoms as a means of preventing H.I.V infection ....” (United Nations General Assembly, 2001). Christianity remains the dominant religion in sub-Saharan Africa.

On the other breadth, several young people harbor a number of misconceptions and negative attitudes about how sexually transmitted diseases such as HIV are spread. In his (2002) survey of HIV/AIDS knowledge and attitudes among secondary school students in Nigeria, this writer found that of 100 respondents, 60% admitted that none or few of their friends used condoms in sexual encounters. Ladner, et al. (2002), also noted similar limited condom use pattern among students in rural Zimbabwe. Akande, (1994) reported a high incidence of risky sexual behavior among students in Zimbabwe and Nigeria in spite of adequate knowledge levels. Nearly 30% of 1400 students surveyed admitted to never using condoms. However condom use increased significantly with free access to them. Most of the non-users are women whose sex partners discourage barrier methods of any kind in sexual encounters (De Bruyn, 1992). In situations where younger women are economically dependent on older men, they lack the negotiating power to insist on condom use during sexual encounters (Schoepf, 1993). This only exacerbates the rate of vulnerability of women to HIV/AIDS in the region.

### **Gender and Healthcare Seeking Behavior**

Gender inequity in health care remains another factor in the disproportionate burden of HIV/AIDS among women in sub-Saharan Africa. Women are less likely to seek health care or be cared for in health care settings compared to men. Socioeconomic status and low literacy are major factors influencing this outcome. Low literacy rates tend to hamper women’s knowledge about prevention strategies. Many women in the region are less likely to benefit from anti - HIV/AIDS campaigns channeled through the print media. Radios and televisions are owned mostly by men. Women in rural settings are worse off (De Bruyn, 1992). Women are more likely to delay seeking health care either because symptoms were not considered severe, had disappeared or for lack of money. Even when women sought care, they were more likely than their male counterparts to turn to public health care facilities where marginal care is the norm (Voeten, 2004). Even more troubling is the strong belief system in African societies. Most believe in the power of traditional healers to make people ill or well. This is manifest in the high

patronage of sub-Saharan Africans to traditional healers.

A study of traditional healers' practices and the spread of HIV/AIDS in south eastern Nigeria revealed a troubling HIV transmission risk among these healers. Reuse of unsterilized needles and cross contamination with patients' body fluids were practices among Nigerian traditional healers of greatest public health concern. Sixty percent of Nigerians patronize traditional healers (Peters, 2004). The power of suggestion by traditional healers to their patrons often delays prompt appropriate medical intervention. Also, the use of one blunt instrument on several clients in their practices constitutes a major factor in the spread of HIV/AIDS in sub-Saharan Africa (Ibid). With limited resources, women become most vulnerable to these hazardous alternative remedies.

### **Mother to Child Transmission**

The above issue has serious implication for mother-to-child transmission (MTCT). Over 1900 infants are estimated to be infected with HIV daily, primarily through MTCT in sub-Saharan Africa. Among pregnant women in sub-Saharan Africa, the HIV seroprevalence rate is over 30 percent (Shetty and Maldonado, 2003). Although significant advances have been made in the prevention of MTCT in the past decade, these benefits are not fully available to resource poor countries especially sub-Saharan region. In addition to cost, ignorance, low literacy rates, patronage of ethnomedical practitioners remains a challenge. As noted above, since over one-half of people in the region patronize alternative remedies, pregnant women are likely to either be infected while being treated for other ailments or would be unwilling to visit regular post-natal facilities. This in turn would result in missed opportunities to learn about preventing MTCT. Among the barriers to low HIV serostatus disclosure rate among women in sub-Saharan Africa are accusations of infidelity by their spouses, abandonment, discrimination and violence. Women attending free standing antenatal clinics are more likely to reveal their HIV serostatus (Medley, et al., 2004). This would promote early treatment and a reduction in MTCT.

### **Sexual Violence and Coercion**

Sexual violence and coercion of women in sub-Saharan Africa and the implication for HIV transmission have been reported in earlier studies (De Bryun, et al. 1992; Schoepf, 1993). More recently, similar observations have been documented (Tabi and Frimpong, 2003; Parish, 2003). Even more current studies continue to associate intimate partner violence and high levels of male control in a woman's current relationship with HIV seropositivity (Dunkle, et al. 2004). The authors warn that women with violent or controlling male partners remain at increased risk of HIV infection. They argue for social discourse and effective intervention strategies on the relationship between masculinity, intimate partner violence, male dominance in relationships, and their implications for high HIV prevalence among women in sub-Saharan Africa (p. 1415).

In patriarchal societies of Africa, the above suggestion would constitute a feat that could challenge the very core of African masculinity. On the other hand, it also strongly suggests the

need to examine ways that males from traditional African societies could be enticed to become part of the solution. It is safe to argue that faced with the grim statistics about high morbidity and mortality rates of their female mates (from AIDS) in the region and the implication for quality of life of both genders, African males will see the need to embark in some behavior change. In the same vein, other traditional practices such as female genital mutilations, forced marriages and early pregnancies which compromise the quality of life for women and young girls in the region must be addressed. The reasons for genital mutilations have been documented. They mostly center on the same theme of gender control that dates back in time (Henrion, 2003).

### **Governance and Political Will**

It is the responsibility of governments to protect its most vulnerable citizens from health hazards. In the era of HIV/AIDS, governments in sub-Saharan Africa with the highest prevalence of this disease must do more to protect women. These governments must show leadership in educational intervention programs that target women and their male partners in order to reduce risky behaviors which otherwise subject women to this contagion. A clear public policy focusing on condom availability/proper usage, pre-natal HIV testing/prompt treatment in order to reduce MTCT, abstinence education and a variety of socioeconomic incentives should be considered a good investment by the leadership of sub-Saharan nations in the war against HIV/AIDS.

In those countries where there is political will and government commitment to controlling HIV transmission, significant decline in incidence (including among women) has been noted. Uganda in East Africa continues to be applauded for their government's unequivocal commitment to the control of HIV (Ghys, et al., 2002, Wax, 2003). Women in Uganda would appear less burdened with the disease compared to their counterparts in sub-Saharan Africa. Some leaders in sub-Saharan Africa are yet to fully commit resources to the prevention of MTCT. For example, President Mbeki of South Africa ignited a political fire over the link between HIV and AIDS arguing that the two were not linked. Actually, it was only after the Constitutional Court of South Africa ordered him to make antiretroviral drug, nevirapine, available to pregnant women in order to prevent mother-to-child transmission did he fully assume the needed leadership role (Fassin and Schneider, 2003). This is also indicative of lethargy and denial among leaders in the region that contributed to the high incidence and mortality from the disease.

Zambia and recently Botswana are also showing some progress albeit painfully slow. Several African leaders have also begun to show commitment by having the president of their countries preside directly on HIV/AIDS commissions. Burkina Faso, Burundi, Congo, Ethiopia, Ghana, Kenya, Mozambique, Niger, and Nigeria are examples of countries whose Presidents and Prime Ministers have shown commitment at the highest level of leadership by directly presiding over HIV/AIDS commissions (UNAIDS, 2003). It is clear that commitment at the highest level of leadership among nations in Africa is part of the recipe needed to begin reversing the HIV/AIDS trends in the region. Such commitment must address the disproportionate burden and those factors that place women at the highest level of susceptibility to HIV in sub-Saharan Africa.

## **International Commitment**

Although the international community waited too long to mobilize resources to fight HIV/AIDS in sub-Saharan Africa, it is heartening to see increasing commitment from many industrialized nations of the world. The international community now sees HIV/AIDS affliction as a civil rights issue. Thanks to the development of antiretroviral regimes, AIDS can easily be transformed into a manageable chronic disease. Thus in the third decade of this pandemic, there is reason for cautious optimism. However, the role played by the international community especially the affluent countries in making these life saving drugs available in sub-Saharan Africa is of particular significance at this time. Again, these programs must target socioeconomic and political vulnerabilities of women in the region.

Several programs targeted at sub-Saharan Africa, if sustained and simplified, will continue to make a difference. For example, commitment of \$15 billion dollars over the next five years by the United States government towards the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria has been hailed by the international community as an effort in the right direction. However, the program appears to be punctuated with a lot of public relations gesture as only \$200 million a year is actually dedicated to the HIV/AIDS, TB and Malaria control program. The program has already become mired in bureaucratic and partisan red tape with its abstinence and pro-life stance (Wise, 2003). Similarly, the World Health Organization has engaged on an ambitious program of providing 3 million people (living with AIDS) anti-retroviral treatment by the end of this year. The WHO calls this initiative “3 by 5 plan.” In collaboration with multilateral institutions, governments and individuals such as the World Bank, The Global Fund to Fight AIDS, Tuberculosis and Malaria, President Bush’s \$15 billion pledge, the Bill and Melinda Gates Foundation, as well as other Non governmental Organizations, the WHO hopes to reverse Africa’s HIV/AIDS epidemic (Fleck, 2004). To what extent women will benefit from these initiatives given their limited socioeconomic and political leverage remains an open question.

Similarly, former President Bill Clinton has brokered a landmark AIDS deal aimed at making ARVs available to poorer countries. He hopes to make life saving drugs available to 2 million people by the year 2008. Through his efforts, countries such as Canada, Ireland, and Great Britain among others have contributed to the initiative. Ireland has already committed \$58 million to Mozambique while Britain hopes to donate 320 million pounds by the year 2006. Furthermore, Britain plans to place the HIV/AIDS epidemic at the center of the G-8 and European Union agenda in 2005 (IBPD, 2004). These are the types of initiatives needed in order to begin reversing the HIV/AIDS trend in sub-Saharan Africa. Similarly, nations in the region that are severely afflicted by the pandemic must show commitment by ensuring coordination of these programs with particular emphasis on women. The need for afflicted nations in the region to vigorously engage in public health education as well as voluntary testing, now assumes additional urgency as international initiatives targeted at the region increase. This would help to identify those individuals, especially women for intervention at the stage of susceptibility.



## **Conclusion**

It is clear that the HIV/AIDS pandemic in sub-Saharan Africa is driven by poverty. It is also clear that the war on HIV/AIDS in the region will not be won until socioeconomic constraints and gender subordination in these nations have been addressed. The education of men about women's status must take center stage throughout the region. Poverty reduction (especially among women heads of households) through international initiatives similar to the ones described above as well as debt relief and/or forgiveness must constitute part of the intervention program. Increased literacy of women but in particular young girls is very essential to controlling the disproportionate burden of the contagion among women in the region. Human development that focuses on health education and skills development (especially for girls and women) must underlie any intervention program to influence the spread of HIV/AIDS in sub-Saharan Africa.

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