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Rethinking Gender within the Context of the Global HIV/AIDS Epidemic

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ABSTRACT

Gender roles and relations powerfully influence the course and impact of the HIV/AIDS epidemic. Gender-related factors shape the extent to which men, women, boys and girls are vulnerable to HIV infection; the ways in which AIDS affects them; and the kinds of responses that are feasible in different communities and societies. Within the African context, gender inequalities are a major driving force behind the AIDS epidemic and yet there has existed a tendency for societies to socially construct HIV/AIDS as a woman's disease. This view has, for the most part, depicted women as mainly responsible for the spread of the epidemic. This paper debates this position arguing that the rationale utilised to construct HIV/AIDS as a woman's disease has been misplaced and, therefore, is misleading. It presents the view that HIV/AIDS is a woman's as well as a man's disease. The epidemic is also considered to be a global concern. Although men are presented as driving the epidemic because of their privileged status in society, it is acknowledged that the only way to fight the epidemic is by involving both men and women as well as adopting a global approach.

Umbuzo wokuthi amazwi abesifazana engenyulwa kanjani embalini ungakhaya sengathi ngumbuzo omdala kwabanye abantu, kodwa uma sikhangelwa umumo wokucwayisiswa kwembali kweleZimbabwe, lombuzo lokhu uqakathekile kakhululu. Lokhu kubangelwa yikuthi inguduzi zembali yalalilizwe kungakafiki abamhlophe kazizange zizihluphe ngodingisisa ngemisebenzi, amazwi lemibono yabesifazana ezingwalweni abazilobayo. Abesifazana abathintwa lakulezo ngwalo zembali yeZimbabwe kuhlenganiselwa lalezo ezilotshwe ngalezinsuku. Lokhu kutsho ukuthi inxenywe yoluntu lweZimbabwe aluthintwa lakancane kuzingwalo zembali le. Lolugwadlwana lujonge ukucubungula iziji ezimayelana lokungazwakali kwamazwi abesifazana kumbali yesizwe, kunye lokwethula amaqhinga angasetshenziswa ukuze kubuthwe amazwi kanye lokuqakatheka kwabesifazana embalini yesizwe seZimbabwe kungakafiki abelungu. Nxa lolugwadlwana lubukeka njalo luzwakala sengathi lugxile kabanzi kumibono yokuhlaziya imbali, lokhu kungenxa yenjula yodala olumayelana lokudingisisa imbali yabesifazana jikelele. Ngempela, imizamo yokudingisisa ngembali yabesifazana kufanele iqale ngo kuzwisisa izindlela ezijulileyo zo kwembiwa kwembali yabesifazana.

INTRODUCTION

Gender is an important factor in the quality of life and access to health services. Because of their subordinate position to men, women have limited control over their health. For instance, dependency on male partners for decisions on contraceptive practice puts them at serious risk. In addition, women are poorer than men and this frustrates their efforts to protect and promote

their health and that of their children. These conditions also apply within the context of the HIV/AIDS epidemic. The different attributes and roles societies assign to males and females profoundly affect their ability to protect themselves against HIV/AIDS and cope with its impact. Reversing the spread of HIV, therefore, demands that women's rights are realized and that women are empowered in all spheres of life. However, this should not be done at the expense of men. That is, men should not be left behind in whatever strategies and programmes employed in the fight against the epidemic. In addition to a gendered approach, the fight against the spread of the virus requires a global approach especially with regard to accessibility to treatment such as antiretroviral therapy (ARV).

This paper debates the subject of gender within the context of the HIV/AIDS pandemic. It presents the core argument that HIV/AIDS has been wrongly construed as a woman's problem on the grounds that women are most vulnerable to infection on account of social and biological factors; they play a leading role in HIV/AIDS programmes; and that they shoulder the burden of caring for the infected in African societies. It is argued that, HIV/AIDS also qualifies to be considered a man's problem. Men play a leading role in the transmission of the virus; HIV is primarily transmitted through sex between men and women. Since men have more sexual partners than women and also tend to control the frequency and form of intercourse, it is their behaviour which determines how quickly, and to whom, the virus is transmitted. Men also control/dominate the major social, economic and even political structures that are central to its prevention. In light of the foregoing, HIV/AIDS is both a woman's as well as a man's disease and the fight against the HIV/AIDS epidemic requires the concerted efforts of both sexes. In fact, given their privileged position in society, men must play a central role in stemming down the rate of infection rather than continue to be excluded from most programmes related to the epidemic.

The recognition of women's vulnerability to HIV/AIDS has led to women being the target of many HIV/AIDS prevention programmes. We argue that such programmes in themselves are insufficient as women cannot protect themselves unless men also do so. We share the views of the World Health Organisation (WHO) which clearly favours a more gendered approach to the problem. According to the WHO (1994), the response to AIDS must be gender-based because unequal gender relations are driving the epidemic, women are disproportionately affected by the epidemic and clinical management has been based primarily on research undertaken on men. The definition of gender roles influences the ways that men and women are vulnerable to HIV transmission and mediates the impact of living with HIV/AIDS. Gender issues are also linked directly to the efficiency and sustainability of HIV/AIDS interventions.

THE HIV/AIDS EPIDEMIC: AN OVERVIEW

HIV/AIDS is a global epidemic that has affected the entire world particularly the developing countries (Jackson, 2002). Jackson (2002) likened the disease to the bubonic plague of the middle ages in Europe that had killed many people. Echoing similar sentiments, Fieldman and Miller (1998) consider the disease as having caused widespread pain and concern than any other medical

catastrophe in the 20th century. According to them, the epidemic has had a devastating effect on the whole world, destroying national development and widening the gap between rich and poor nations.

Globally, there are about 42 million people living with HIV/AIDS today and the number is expected to go up (UNAIDS/WHO.AIDS, 2002). Of those infected 38.6 million are adults while the remaining 3.4 are children. The numbers of infected females is estimated to be 19.2 million while that of males is 18.4 millions. Amongst the newly infected individuals as per the end of the year 2002 were about 4.2 million adults (out of which 2 million are women, 1.4 million are men and about 800 000 children below 15 years). The number of people who had died as a result of HIV/AIDS ailments as per the end of the year 2002 was 3.1 million. The most recent UNAIDS/WHO estimates show that, in 2003 alone, 5 million people were newly infected with HIV (UNAIDS 2004a). The developing countries are most affected by the epidemic. It is estimated that 90 percent of the people living with the virus are found in developing countries. Out of the 5 million newly infected cases in 2003, more than 95 percent occurred in developing countries (UNAIDS 2004a). The number is expected to grow even further as infection rates continue to rise in countries where poverty, poor health care systems and limited resources for prevention and care fuel the spread of the virus.

The HIV/AIDS epidemic is not evenly spread over the developing countries (UNAIDS 2004a). Although numbers are rising steeply in Asia, the epidemic is worst in Africa where the human toll and suffering due to disease is quite enormous and HIV/AIDS has become by far the leading cause of death in the continent. In particular, sub-Saharan Africa is one of the worst hit regions in the world. Of the 42 million people living with HIV in 2002, 26.6 million were found in the region (UNAIDS 2002). The region is home to only over one tenth of the world's population but houses almost two-thirds of all people living with HIV (UNAIDS 2003). In 2003 an estimated three million people became newly infected with the virus in the region and 2.2 million are said to have died from the disease. The death figure represented 75 percent of the three million AIDS deaths globally that year (UNAIDS, 2004a). Even within the African continent itself, the infection rates are not evenly spread. During the early 1980s, countries in Western and Eastern Africa were predominantly affected but now it is in Southern Africa where the epidemic is more severe (UNAIDS, 2004a).

In the world in general and in sub-Saharan Africa in particular, women are the worst affected group by the HIV/AIDS epidemic. Initially men outnumbered women among people infected with HIV. In 1998, they comprised 41 percent of the adults living with HIV. However, today nearly 50 percent of adults living with HIV globally are women and the majority of them are in sub-Saharan Africa (UNAIDS, 2004b). According to data released by UNAIDS (2004a), at the end of 2003 an estimated 25 million adults and children were living with HIV in Sub-Saharan Africa; of these, women accounted for 52 percent.

Relative to men, women are more vulnerable to HIV infection due to their biological make up and

also due to the cultural, social, and economic status that society imposes on them. Unlike men and boys, women and adolescent girls are biologically more susceptible to sexually transmitted infections, including HIV. They also often lack power to negotiate the terms of sexual relations and economically dependent on men. Women also comprise the majority of the poor in sub-Saharan Africa and are the main victims of hunger and armed conflict. HIV/AIDS is most susceptible to the most vulnerable human beings and is said to thrive where there exists conflict, hunger and poverty.

HIV/AIDS: A WOMAN'S OR A MAN'S EPIDEMIC?

The main argument presented by this paper is that society has tended to feminise HIV/AIDS utilising what may be judged to be the wrong rationale to dismiss it as a women's problem. Although, initially perceived as a health problem requiring a medical solution, over the years HIV/AIDS has emerged to become a multifaceted problem with social, economic, political and legal dimensions. At the social level studies (see e.g., Macdonald, 1996; Lesetedi, 1997; Tembo, 2001) have revealed an association between gender and HIV/AIDS. While the disease itself is a health issue, the epidemic has been elevated to a gender issue pertaining to women and inequity in society. More specifically, the debate surrounding the spread of HIV/AIDS has depicted women not only as one of the most vulnerable groups in our society but also as being mainly responsible for its spread.

An outcome of the feminisation of HIV/AIDS has been the stigmatisation, discrimination against and (negative) stereotyping of women within the context of the epidemic which is tantamount to blaming the victim (Mukamaambo, Lesetedi and Mulinge, 2001). At the heart of the stigma of AIDS lies shame - the perception that those with the virus have done something wrong. On the other hand, discrimination exists when those infected, or suspected to be infected, with HIV are singled out and handled differently or treated in an unequal manner relative to those who are not (Mukamaambo, Lesetedi and Mulinge, 2001). Where it exists, community members act hostile towards those infected with HIV/AIDS or towards their families. Although both males and females may be victims of stigmatisation and discrimination, the consequences are more severe for women relative to men. Women risk being assaulted and even removed from the house once their status become public knowledge. This occurs even in cases where the women have been infected by their spouses (World Health Organisation/UNAIDS Joint Programme on HIV/AIDS, 1998). The rate of abandonment by especially spouses is also likely to be higher among women relative to men. Assaults and other forms of maltreatment or abuse of women who are infected with HIV/AIDS no doubt constitutes a violation of some of their basic human rights.

HIV/AIDS AS A WOMAN'S PROBLEM

One is bound to pose the question, "Is HIV/AIDS truly a women's epidemic?" A simple, but logical and well-balanced, answer to this question would be one that incorporates both a 'yes' and a 'no' category in its responses. Such answer would allow for arguments for and against the

construction of HIV/AIDS as a woman's problem. In addition, it would provide an opportunity to bring in the male species to assume their responsibility in the spread and entrenchment of the epidemic. At the realm of 'yes', there are indeed certain respects in which the HIV/AIDS epidemic can be termed a women's problem. These include women's vulnerability to infection, women's caring responsibilities, women's overall better response to the HIV/AIDS epidemic, the targeting of women many HIV/AIDS prevention campaigns, and the women's need to prove their womanhood through motherhood. A more detailed discussion of each of these factors ensues hereafter commencing with vulnerability to infection.

Women's Vulnerability to Infection

Women's vulnerability to HIV infection appears to be the dominant factor that qualifies the HIV/AIDS epidemic for consideration as a women's problem (Tembo, 2001). Women are most vulnerable to infection with the virus. HIV/AIDS infections are increasing most rapidly among women, who contract the virus primarily through sex with an infected male partner. In addition, women tend to be slow to come forward to receive medical treatment because they consider their own health needs after the needs of their family members (Bury, 1994). Thus, the epidemic has become a major threat to women all over the world.

Men can contract HIV from women and women from men. This mostly happens through vaginal intercourse, but can also happen through anal intercourse and occasionally through oral intercourse. The factors that make women the population at greater risk of infection range from biological to social and cultural factors (Esu-Williams, 1994). Biologically women more vulnerable to HIV infection than their male counterparts because the virus is more concentrated in vaginal fluids. This makes it more likely for infected men to pass on the disease to women than the other way round. The vagina offers more area than the penis and its mucous membrane absorbs HIV more easily. It is also likely to have minute ruptures through which the virus can enter the bloodstream. In general, relative to men, women are twice as likely to contract HIV through vaginal intercourse with an infected partner. In addition, it has been recognised that the large service area of the female genitalia increases the efficiency of transmission of the virus from males to females (Tembo, 2001). What puts women at even greater risk, however, is that they tend to have sexual relationship with older men, who already have had more partners and are more likely to be carriers of HIV/AIDS than younger men. Women are also vulnerable socially to HIV/AIDS because they have been socialised to be sexually submissive.

The low economic status of women in many developing nations renders them more vulnerable to HIV infection. Although poverty affects everyone in these countries, women tend to be more disadvantaged (Tembo, 2001). On average, relative to men, women have fewer economic options, own much less than half the world's property, and earn much less than half of global income. They also dominate the categories of the unemployed and low-income earners. Furthermore, there are fewer women than men in higher paid jobs and there are more women than men in lower paid jobs (Tembo, 2001). According to Tembo (2001) low education standards among women results in them occupying low paying jobs. Despite positive action by the Government, fewer

girls receive a full education than do boys. The low economic status of women undermines their capacity to control their sexual encounters and relationships. Whether or not they are aware of it, poverty, unemployment, and poor pay often lure or force women into high-risk short-term or long-term sexual relationships which place them and their partners at risk of HIV transmission. For instance, these conditions may expose them to unsafe sexual practices such as forced and unprotected sex, wife inheritance and commercial sex work.

A host of cultural and societal practices also tend to entrench women's greater vulnerability to HIV/AIDS infection (Macdonald, 1996; Tembo, 2001). According to Tembo (2001), for example, risk taking and vulnerability to infection for women are increased by norms that make it inappropriate for women to be knowledgeable about sexuality or to suggest condom use. Violence against women is another practice with a cultural overtone which exposes women to infection with HIV. Most violence directed toward females occurs within the family and increases women's vulnerability to infection. Certain forms of family violence are sexual in orientation and predispose women to HIV infection. A study conducted by Community Information Empowerment and Transparency (CIET) Africa (cited in GENDER-AIDS, 2002) found that cultural values support sexual violence in South Africa, while laws against rape often are not enforced. For instance, the underlying cause of all rape is deeply rooted in cultural values that legitimise men's ready sexual access to and control over women, by women's accession to those values, and by a failure of law enforcement. In some countries such as Botswana, South Africa and Swaziland, where HIV/AIDS is prevalent, the sexual abuse of young girls, including babies, by older men is thought to be partly a consequence of what has come to be referred to as the 'virgin myth' or 'virgin cleansing'. This refers to the belief among men that raping a virgin will cure AIDS (GENDER-AIDS, 2002).

The effect of cultural factors is reinforced by the low social status of women in many developing nations. Women's vulnerability to HIV infection is further compounded by their lack of empowerment against prejudicial cultural and traditional practices in sexual and reproductive matters and relationships ((Macdonald, 1996). Coupled with their low status in society, the lack of empowerment renders women incapable of controlling their sexual encounters and relationships. Avoiding HIV and/or STD infections often is more problematic for women than for men. For instance, condoms provide good protection against HIV infection and other STDS when used correctly and consistently during sexual intercourse. But condom use ultimately requires the consent and co-operation of the male partner, and women cannot always successfully negotiate their use. Abstinence, the only fairly safe measure against HIV/STD infection, is not always an option for women, since non-consensual sex is an all-too-common reality.

Women's Caring Responsibilities

A second major manifestation of HIV/AIDS as a women's problem rests with the caring responsibilities that they must shoulder in most societies. Overall, studies have clearly shown that women bear the brunt of the HIV/STD burden because of the multiple roles they play in the family as well as in society as a whole (Lesetedi, 1999; Tembo, 2001). The epidemic affects

every aspect of women's lives whether they are infected themselves or other members of their family are infected. As mothers, women are the main formal and informal carers of the sick in society. Most societies rely on women to be voluntary caregivers for their families. As such, the burden of care (looking after the sick) usually falls on them. Should any close member of the family fall sick, the responsibility for care rests with women. Some women even discourage men from offering care. It should be noted that women's caring duties are in addition to other responsibilities that they have in the household; at times they combine the role of family care with that of breadwinners. As the AIDS epidemic grows, the girl child also feels the impact of caring for the sick. More often than not, girls are the first to be pulled out of school to help with household duties and income generation in order to cope with the tasks of caring for siblings and ill parents (Lesetedi, 1999).

It is not uncommon for women to sacrifice their careers and for girl children to forgo their right to education to care for terminally ill patients (UNICEF, 2004). Even where care is institutionalised, the burden still falls on women. That is, women usually assume greater responsibility than men for caring for the sick, at home or in hospital. For instance, in recognition of the fact that the health sector cannot cope with the rising numbers of the sick, Governments in some countries have formally adopted the home-based care concept for AIDS patients. This is a well-intentioned programme that aims to alleviate the increasing congestion in hospitals caused by patients suffering from AIDS and other HIV related illnesses. The programme has shifted the burden of care to women who provide home based care; in almost all the cases home care means woman care. The expectation of women to provide most of the care for people with HIV infection and AIDS, in addition to their usual tasks, results in high stress. Such stress is compounded when the women become ill themselves often with no one to care for them.

Women's Better Response to the HIV/AIDS Epidemic

The tendency to view HIV/AIDS as a woman's problem may also be an offshoot of the fact that women with HIV often respond better than men in the same situation (Esu-Williams, 1994). Women are more visible than men in the total HIV/AIDS situation. It is women who are the strongest links in our communities and commit themselves to dealing with HIV head-on. The communities rely on women to take the initiative when it comes to crises such as HIV/AIDS. Being the strong pillars of communities, women provide social support and welfare to all members of the society. In many parts of the world women have initiated most AIDS programmes. These campaigns have enabled some women to protect themselves and have raised wider awareness, energising community responses to HIV/AIDS. They have also tended to shift responsibility for action onto women's shoulders thus creating the impression that HIV/AIDS is a women's problem. Unlike men, who tend to lose heart easily, withdraw from circulation, keep away from their friends and die much faster than women when diagnosed with HIV, women tend to support each other and share their problems much more. Men with HIV lose their status within the community when they come to know they have the disease; they tend to confine the problem within themselves. Women are also more likely than men to undergo HIV testing because of pregnancy. As such, they tend to be over-represented in official HIV/AIDS statistics.

The Targeting of Women by HIV/AIDS Prevention Campaigns

Another basis for the feminisation of HIV/AIDS has been the targeting of women to the exclusion of men by many HIV/AIDS prevention campaigns (Esu-Williams, 1994). This has occurred because many countries follow the example of family planning programmes that have targeted women at the exclusion of men and also due to the fact that it is relatively easy to reach large groups of women especially pregnant women in antenatal clinics. Such trends have tended to create the wrong impression that HIV/AIDS is a woman's problem. In addition, the basis for most HIV/AIDS statistics in most developing countries has been periodical Sentinel Surveillance Surveys that mainly cover women attending antenatal clinics. Even well meaning programmes like the Prevention of Mother to Child Transmission (PMCT) of HIV have elevated the construction of HIV/AIDS as a woman's problem. The programme puts the interest of the unborn child before that of the mother by focusing exclusively on the unborn child and showing no interest at all on the mother herself. As underlined by Patton (1994: 89), these programmes portray women mainly as transmitters of the virus rather than as victims of the epidemic.

Women's Need to Prove Womanhood through Motherhood

A final way through which the HIV/AIDS epidemic may be constructed as a woman's problem pertains to motherhood. This can be viewed from two dimensions. First, society pressurises women to prove their womanhood by bearing children. Motherhood is perceived as the ultimate validation of womanhood (Macdonald, 1994). This, in some sense and cases, undermines the capacity for women to protect themselves from infection utilising the few readily available methods such as using condoms. Second, not only are women more liable to contract HIV, but they may pass the virus to their future children. A pregnant woman who is HIV positive may transmit the virus to her baby in the womb. Transmission can also occur during birth or from breast milk (Patton, 1994). The child may later develop AIDS. Women are also discriminated against when trying to access care and support when they are HIV-positive. In many countries, men are more likely than women to be admitted to health facilities (Esu-Williams, 1994). Family resources are more likely to be devoted to buying medication and arranging care for ill males than females.

HIV/AIDS AS A MAN'S PROBLEM

As pointed out earlier, the HIV/AIDS epidemic is characterised by widespread, deep-rooted bias against women, particularly in the developing world, which have been utilised to reduce it to a women's disease. However, we argue that the epidemic is not just a women's disease but also a men's disease. The HIV/AIDS epidemic can be considered a man's problem as well on several grounds. First, worldwide women may be contracting HIV at a faster rate than men but it is men who drive the epidemic. Men have more sexual partners than do women. As such, they have more opportunities to contract HIV. In addition, contrary to the view advanced through the feminisation of HIV/AIDS that women are the major transmitters of the virus, it could be argued that it is men who are the main transmitters of HIV. Men are involved in almost every case of

sexual transmission of HIV. They are more likely to transmit HIV to female partners through unprotected sex than women are to transmit the same to men. Consistent with this view, Over and Piot (1991) point out that preventing HIV transmission among men (and women) who have many sexual partners has a significantly greater impact on the epidemic than preventing transmission among the general population. That is, an approach which targets people (males) with multiple partners is likely to be more effective than one focusing on the general population.

Certain physical factors make it easier for a man to transmit HIV to a woman than vice versa. In the absence of sexually transmitted infections, a man with HIV has an average chance of one in 500 of passing the virus to a woman in a single act of unprotected vaginal intercourse. The odds of woman-to-man transmission in the same situation are about one in 1 000 (Royce, Sena, Cates, and Cohen, 1997). Also, viral load - the amount of HIV in the blood - is very high during the first few months after an individual contracts the virus. Because a man is more likely than a woman to have sex with another partner soon after contracting HIV, and because the viral load rises in seminal but not vaginal fluid (Royce, et al., 1997), men are more likely to transmit the virus to others during this period. According to Royce et al. (1997), for example, the rapid spread of HIV in the United States and Thailand in the 1980s has been attributed to many people having other sexual partners soon after contracting the virus. The capacity for men to infect women at a higher rate is compounded further by the fact that men are more likely to have multiple sexual partners than are women.

Second, the gender-based inequalities that have contributed to labelling HIV/AIDS a women's disease overlap with other social, cultural, economic and political inequalities and affect both women and men of all ages. Although a variety of factors increase the vulnerability of women and girls to HIV, men and especially young boys, are vulnerable too. The same social norms that prevent women from controlling their bodies or deciding the terms on which they have sex also make men vulnerable to the virus in that it reinforces their lack of understanding of sexual health issues and at the same time encourage promiscuity. This vulnerability is further increased by the likelihood of engaging in abuse of alcohol and other drugs. Thus, whereas the epidemic may be considered to be a woman's problem in light of the fact that women are most vulnerable to being infected with the virus as well as being affected, among others, men do contribute to the entrenchment of the epidemic on account of their privileged position in society and their attitudes toward women and the epidemic in general. Men's behaviour is strongly influenced by perceptions of masculinity. Most cultures expect men to be sexually active, often with more than one partner. Also, attitudes towards risk-taking lead many men to reject condoms as unmanly or consider sexually transmitted infections as no more than an inconvenience.

As pointed out earlier, the feminisation of HIV/AIDS has tended to blame women for transmitting the virus to their unborn children. Conventionally, newborns are said to contract HIV from their mothers, not fathers and in most societies it is not uncommon for a woman to be stigmatised and blamed for passing on the infection to her unborn child. This situation is compounded by well meaning programmes, such as the one responsible for prevention of mother-

to-child transmission, that target HIV-positive expectant women. It could be argued that the terminology 'mother-to-child transmission' alone to some extent invites stigmatisation. It implies that the woman is solely to blame for the infection of the child. Yet, fathers cannot be absolved totally from the responsibility of transmission of HIV to the unborn child. They are equally responsible, and in some cases may be solely responsible, for the transmission of HIV to infants (unborn children) through the mother. A more neutral position would be one that acknowledges the role of both fathers and mothers in the infection of the unborn child. Hence, the emphasis should be on parent-to-child transmission rather than mother-to-child transmission.

While in some cases the mother will have contracted the virus from another man, in the majority of cases men indirectly transmit the virus to their child by first transmitting HIV to its mother. Many men only learn they have the virus when a child is diagnosed with AIDS; in such circumstances some men initially deny they have contracted HIV. More often than not they will blame the woman as the one who is infected and not them. Furthermore, just like women have to prove their womanhood through motherhood, in many societies fatherhood is a cultural obligation. Among other reasons, men become fathers to perpetuate the family name and, most important, to provide proof of their virility. Because of such obligations many men pass on HIV to their children through the children's mothers. Yet, little research has been undertaken into the relationship between fatherhood and HIV/AIDS. Many men are unaware that they and/or their female partners have HIV and only discover they have the virus when a child of theirs falls ill with AIDS.

The HIV/AIDS epidemic could also be viewed as a man's problem in light of certain male attitudes that entrench rather than avert or reduce it. According to Esu-Williams (1994), for example, men in positions of power often downplay women's initiatives in HIV prevention. Yet, women are the strongest links (or pillars) of communities and provide social support and welfare to all members as well as lead the way during times of crises such as HIV/AIDS. In many parts of the world AIDS programmes started by women have made important strides in addressing the epidemic. However, policy-makers are often not supportive of women's groups' efforts in fighting HIV/AIDS because they perceive such groups as mainly representing the clamouring for the rights of women. Thus, millions of men and women die because the men who lead our communities are afraid of change, and of yielding or sharing power. In addition, although the debate over the role of men in HIV prevention and how to enable men to change their behaviour is taking place at various levels of many African societies, the discussion of men's sexual behaviour and responsibilities is seen as a priority for society as a whole only in a few countries. There is a general reluctance among men to debate these deeper issues and many societies assume that the solution to HIV prevention can be found within already existing social structures and values. However, the continued escalation of the epidemic suggests that the successful combating of HIV will depend on radical changes to those structures and values, particularly in relation to the role of men and women (Esu-Williams, 1994).

Besides being both a woman's and a man's disease, HIV/AIDS is also a global disease. The

globalisation process has contributed significant to the HIV/AIDS situation in the world today. The epidemic is one of the most costly crises the world has ever experienced; it is estimated that by 2007 the world will need US 20 billion dollars to provide antiretroviral treatment to just 6 million people (UNAIDS, 2004a). However, global disparities clearly exist in the capacity for nations to manage the epidemic. In most developed countries HIV/AIDS is a manageable chronic illness because of access to technology, drugs and the existence of strong social safety nets. Yet, very few nations in the developing world can afford to provide drugs to their citizens. As the gap between the developed and the developing countries widens, serious differences in the ways that states can afford to take care of their citizens are emerging. Existing evidence shows that developing countries have problems in providing antiretroviral treatment and the care for other HIV-related diseases. The World Health Organization estimates that nine out of ten people who urgently need HIV treatment are not being reached. Around five to six million people in developing countries will die in the next two years if they do not receive antiretroviral treatment (UNAIDS, 2004a).

A GENDERED AND GLOBAL APPROACH TO HIV/AIDS PREVENTION

Although prevention efforts in the fight against HIV/AIDS have characterized societies the world over, more still needs to be done considering the growing rates of infection. Experience shows that controlling the epidemic effectively depends on the involvement of all members of society both locally and globally. It goes without saying that women are the strong pillars of any community. They provide welfare to everyone in the community and have been playing a leading role in creating more awareness about this HIV/AIDS to the larger population. However, for prevention programmes to be effective they need support from all people, from government, NGOs and international organisations. In particular, in recognition of the gender inequalities that pervade most African societies, the participation of men is very necessary if the strategies adopted by the fight against the epidemic are to bear fruits. That is, men need to take a leading role in the fight against HIV/AIDS. This requires a re-examination of the traditional gender roles that men play in society. For instance, men take the initiative in sex and they are the deciding factor in the use of contraception. It is necessary that they should take responsibility for their sexual behaviour and recognise the fact that their actions often put women at risk of sexually transmitted infections or unwanted pregnancies. Men are also more likely to transmit HIV to a female partner through repeated unprotected sex than vice versa.

The view expressed in this paper that HIV/AIDS is both a men's as it is a women's disease suggest that a more effective approach to the epidemic would be one that is not biased toward one sex but treats men and women as being both responsible for the control of the spread of the virus. Such an approach should enable both sexes to protect themselves against HIV infection, to access proper care, and, in general, to cope better with the epidemic (UNAIDS 1999). This raises the question of whether men can be persuaded to change and whether widely held concepts of masculinity will allow men to assume their rightful responsibility in combating the spread of HIV/AIDS. For such to occur, it may demand a radical overhaul in the social structure of our

male-centred societies. In addition, care should be exercised to ensure that the situation does not arise where previous mistakes are repeated by designing programmes that target men at the exclusion of women. The present strategies and programmes employed tend to focus on issues related to women overlooking those concerning men. Women and men can become partners in making change work for them both. For example, informing men about reproductive health, HIV/AIDS, maternity and childcare can increase their support for family planning. Income-generating schemes for women can also include men. In sum, a balanced approach will not only help men and women to communicate and save more women's lives, it will also increase the probability of both sexes protecting themselves, being involved in the fight against the epidemic, and taking ownership of HIV/AIDS programmes.

Since the HIV/AIDS epidemic is part and parcel of the globalisation process, there is a need to invoke a more global approach to the fight against the virus. In addition to raising awareness through education, it is also necessary to prevent people from becoming infected through therapies such as microbicides which offer protection from secondary infections among those already infected by the disease. The globalisation process has made it necessary for organisations and even countries to have contacts with big pharmaceutical companies in order to have access to life prolonging drugs especially anti-retroviral drugs. Although some of these companies have prevented the generic production life saving drugs to make AIDS treatment cheaper and more accessible, there is need to intensify the campaign against such initiatives. The efforts taken of groups such as Treatment Action Campaign (TAC), a South African non-governmental organisation that has managed to mobilize national and international support for the idea of universal access to drugs for people with AIDS (Crenshaw, 2000), must be emulated the world over. The group encouraged the South African government to take the pharmaceutical industry to court and the government won the case.

CONCLUSION

This paper has debates feminisation of HIV/AIDS which has tended to construct the epidemic as a women's problem. It examines the extent to which HIV/AIDS is truly a woman's problem by presenting factors that qualify the epidemic to be a woman's as well as a man's problem. The guiding argument underpinning the debate is that the social construction of HIV/AIDS as a woman's problem in terms of women being mainly responsible for its spread is a rather misleading one. This is the case because it presents a one-sided view of the reality and fails to acknowledge the role that men may play. We argue that both females and males are equally responsible for the problem. HIV/AIDS can be construed as woman's problem on the grounds that women are most vulnerable to infection on strength of social and biological factors; they play a leading role in HIV/AIDS programmes; and shoulder the burden of caring for the infected in our society; among others. On the other hand, the epidemic qualifies to be a man's problem mainly because men play a leading role in the transmission of HIV and also control the major social, economic and even political structures that are pertinent to its prevention.

In lieu of men's privileged position in most African societies and also of their previous exclusion from most programmes related to the epidemic, it is concluded that the overwhelming responsibility of stemming down infection appears to lie with men. Men are not only the driving force behind the epidemic, but also control/dominate the social, economic, and political structures that are central to combating it. In addition, HIV is primarily transmitted through sex between men and women. Since men have more sexual partners than women and also tend to control the frequency and form of intercourse, it is their behaviour which determines how quickly, and to whom, the virus is transmitted. The recognition of women's vulnerability has led to women being the target of many HIV/AIDS prevention programmes. Nevertheless, such programmes in themselves are insufficient because women cannot protect themselves unless men do so as well. It is also necessary to take a global approach to the problem. Developing societies would benefit from the life saving therapies such as microbicides) anti-retroviral drugs that big pharmaceutical companies are able to manufacture. The developed nations have more access to drugs and more effective treatment of the disease although no cure as yet. At the same time these nations would also benefit from the approaches that the developing nations adapt in the fight against the HIV/AIDS epidemic.

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