HEALTH / GENDER STUDIES

HIV/AIDS and Health Inequalities in Sub-Saharan Africa: Trends and Dimensions

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Abstract
This paper focuses on the interface between the HIV/AIDS pandemic and health inequalities in Sub-Saharan Africa, with an inbuilt assumption that the health inequality situation in African nation states exacerbates, and therefore forestalls meaningful efforts towards the control of HIV/AIDS spread in sub-Saharan Africa. The paper therefore articulates the situation of HIV/AIDS pandemic in various African sub-regions, the context of health inequality among various population and social groups in the continent, and the efforts of government and non-governmental agencies in the provision of HIV/AIDS preventive and cares programmemes. It therefore assesses how equitable these programmemes are in the general population, which provides an understanding of the relative impact of health and social inequality on HIV/AIDS preventive and care/management initiatives, especially the procurement and use of anti-retroviral drugs

Introduction
HIV/AIDS is a life-threatening but preventable disease affecting millions of women and men in our society, it is a health and social catastrophe of genocidal proportion that has the capacity to roll back the gains of our democracy and to make our democratic rights meaningless. HIV/AIDS has emerged as one of the most serious diseases facing the developing world especially the countries of Africa with consequences that reach far beyond the health sector. In the first decades after independence, African countries invested in health care, which lead to average life expectancy in sub-Saharan Africa (SSA) to rise from 39.9 years in 1960 to 50.6 years in 1995. Now however, life expectancies in many African countries are dropping driven by HIV/AIDS and a resurgence of malaria and tuberculosis among other infectious diseases. Almost 2.5 million Africans died of AIDS in the year 2000(UNAIDS, 2001) and has caused a cumulative total of about 20 million deaths since the start of the epidemic (Ajakaiye, 2002). UNAIDS reported an estimated 3.4 million new infections in 2001, and estimated that some 28 million Africans are currently living with HIV. Some 50 million people would have died on HIV/AIDS before the end of the present decade. And assuming that about five people within each immediate family are affected for every person who dies, some 250 million Africans will be closely affected by HI/AIDS within 10 years (Ajakaiye, 2002)

The spread of HIV/AIDS in the continent has prompted many governments of member countries in Africa, and other international organizations towards designing effective

means of combating the scourge. Unfortunately, most of these countries are among the poorest in the world without viable economic conditions. What obtains in most African countries is economic stagnation and depletion, which leads to the incapability of the governments to take care of their population. Observation shows that the capacity of various governments to serve their citizens is among the prominent causes of the epidemic, as budgets shrink and civil servants are killed by AIDS. In Botswana for instance, the government will loose 20 percent of public revenue by 2010 because of AIDS. In Kenya, death due to AIDS accounts for up to three out of every four deaths in the Police Force (Ajakaiye, 2002). In trying to cope with the enormous economic wastage due to HIV/AIDS, African governments could not help it but to keep all time low budgetary allocation directed towards the prevention and care of HIV/AIDS epidemic in the continent in spite of the magnitude of the epidemic in the continent. FHI (2000) reported that, although sub-Saharan Africa has two thirds of the word's HIV infections and about 84 percent of its AIDS death, the region accounts for just 3 percent of global AIDS spending.

Whatever be the case, there is need for African nation states government to step up action towards the control of the epidemic in the continent due to its more devastating economic and social consequences. If the situation were left as it is presently, there would be a time when most African countries would not have any money left for other needs. This fear is made obvious following the estimates of the direct costs per case of HIV infection in two African countries, Zaire and Tanzania where Over et. al. (1988) employed three types of labour to derive an economic measure of healthy life years lost in both countries. They found that the cost of the HIV infection far outweighs the average annual income in these countries.

Implicitly, the prevention and care for HIV/AIDS is an enormous task, and expensive business for governments, let alone the individuals. Poorer and developing countries are experiencing faster explosion of the epidemic, while the developing countries are having decline in the numbers, irrespective of the historical antecedents showing that HIV/AIDS was identified concurrently in North America, the Caribbean and East Africa in 1978 (FHI, 2000). For individuals in Africa, especially the poor, HIV/AIDS remains a colossus capable of penetrating their families, groups and all aspects of life. Critical observations and commentaries demonstrate without much doubt that there is a relationship between HIV/AIDS epidemic and poverty situation, amidst other social and cultural environment characteristics (Folayan and Folabi; 2003, Obioha, 2008). Among the poor, the struggle to survive everyday overshadows attention and concern about the scourge. Poverty translated in depriving people of access to health facilities, schools, and media also limits their access to information and education on HIV/AIDS. The harsh economic condition often pushes families, often unaware of the risks, to send children into the workforce or to hand them over to recruiters promising jobs in a distant place where, unprotected they might be force into sexual abuse. According to Ajakaiye (2002), when HIV/AIDS appears in an already impoverished household there are limited means for response, the mortality rate is high, the impact is severe and the pressure and pain of poverty increases.

This discourse assumes that even though HIV/AIDS affects the non-poor, the effect on the poor is obviously more pronounced due to factors such as unequal access to health care . The notion that there is unequal distribution of health or health inequalities in Africa is not an understatement of what obtains in reality. This condition relegates the poor to

the background in the course for the scramble for health care, which further worsens the control of any disease in the general population, especially the infections ones. It is against this background that this paper assumes that the health inequality situation in African nation states acerbates, and therefore forestalls meaningful efforts towards the control of HIV/AIDS spread in Africa. The main focus of this paper therefore is to examine the interface between the HIV/AIDS pandemic and health inequalities in Africa. Specifically the discourse revolves round and presents the situation of HIV/AIDS pandemic in Africa, the context of health inequality, the efforts of government and non-governmental agencies in the provision of HIV/AIDS preventive and care programmemes, interrogates the impact of inequalities and how equitable various programmemes could be in the general public considering the social dichotomous categories.

Over View of HIV/AIDS Situation in Sub-Sahara Africa

Sub-Saharan Africa remains the region most heavily affected by HIV worldwide, accounting for two thirds (67%) of all people living with HIV and for three quarters (75%) of AIDS deaths in 2007. An estimated 1.9 million (1.6–2.1 million) people were newly infected with HIV in sub-Saharan Africa in 2007, bringing to 22 million (20.5–23.6 million) the number of people living with HIV.

At present, the statistics on the prevalence of HIV/AIDS in the continent of Africa is still controversial. In some quarters, it is believed that the given statistics produced by western sponsored projects is "demononizing", purposely to ridicule Africa, while for some other schools of thought the statistics reflects what obtains in reality. Yet, for others, it is still underestimated and uncertain. For Adomako Ampofo (1999), relative to North America and Europe, estimates on the incidence of AIDS in Africa are still uncertain, due to the methodology employed. The World Health Organisation (WHO) routinely collects statistics on AIDS cases through voluntary reporting by national authorities. WHO believes that the total number of cases reported in Africa is under reported and estimates the number based on public health surveillance data and the use of an AIDs – estimation model. For instance, as of December 1992, WHO estimated a cumulative total of 2.5 million AIDS cases worldwide (compared to 612,000 reported) with a disproportionate 71 percent believed to have occurred in Africa (United Nations, 1994). Many African researchers and physicians, however, believed this to be an over statement and overestimation of African case (Latham, 1993). Certainly, as the scenario suggests, the AIDS situation in Africa calls for concerted action, however, for a continent where 'diagnosed' individuals have later been reported as having been 'cured', the data must therefore be read with some caution (Adomako Ampofo, 1999). Whatever is the case and our chosen point of interpretation, the spread of HIV/AIDS is continually in increase, as it is the case in Nigeria, South Africa, and Botswana among others. Even though the reading of the magnitude of increase may differ, recent picture and figures on HIV/AIDS epidemic in Africa still point to the fast growing rate of the epidemic. The epidemic is climbing higher than previously believed in the developing countries of the world including Africa. New data in the UNAIDS report on the Global HIV/AIDS epidemic (2001) indicates that theories that the epidemic might "level off" in heavily affected countries, due to a decline in the pool of people at risk, are being disproved as the epidemic continues to expand even in countries that already had extremely higher HIV prevalence, with prevalence rate in adults now exceeding 20 percent

in five countries of Africa (Odumosu, 2002).

All over the world, available fact sheets suggest that the spread of HIV/AIDS has exceeded the worst projections by far. As at 1998, 34 million people in the world were living with HIV/AIDS and one third of these are young people between the ages of 10 and 24. The epidemic continues to grow as 16,000 people worldwide become newly infected each day. Fourteen million adults and children have already lost their lives to this devastation disease, and the death toll rises each year (UNAIDS 1998e). At present, the latest information indicates that, an estimated 33 million people (30.3 – 36.1 million) were living with HIV in 2007 throughout the globe. Women account for half of all HIV infections—this percentage has remained stable for the past several years. There were 2.7 million (2.2 – 3.2 million) new HIV infections and 2 million (1.8 – 2.3 million) AIDS-related deaths in the same year 2007(UNAIDS, 2008). This shows that the rate of new HIV infections has fallen in several countries, but globally these favourable trends are at least partially offset by increases in new infections in other countries.

The African situation is gruesome, where deaths due to HIV/AIDS is likely to surpass the 20 million Europeans killed by the plague epidemic of 1347-1351 (Decosas and Adrien, 1999), if proper care is not taken to control the epidemic. At present time, it is from African continent that we have the country with highest number of infected adults in the World. With an estimated 5.5 million [4.9 million–6.1 million] people living with HIV (UNAIDS, 2006), South Africa is the country with the largest number of infections in the world. Sub-Saharan Africa has two thirds (67%) of all people living with HIV worldwide. An estimated 370 000 (330 000 – 410 000) children (younger than 15) became infected with HIV in 2007. The total number of children living with HIV has increased from 1.6 million (1.4 – 2.1 million) in 2001 to 2 million (1.9 – 2.3 million) in 2007, out of which almost 90% live in sub-Saharan Africa (UNAIDS, 2008).

Regional Estimates and Distribution

Sub-Saharan Africa's epidemics vary significantly from country to country, with most appearing to have stabilized, although often at very high levels, particularly in Southern Africa. The nine countries in Southern Africa continue to bear a disproportionate share of the global AIDS burden as about 35% of HIV infections and 38% of AIDS deaths in 2007 happened there (UNAIDS, 2008).

Drawing a comparison with regional distribution of the epidemic might make some revelations. In Southern African region, HIV prevalence rate has risen to alarming levels where data reveals levels of more than 30% in several areas. The scale and trends of the epidemics in the region vary considerably, with southern Africa most affected. In 2007, this sub region accounted for almost a third (32%) of all new HIV infections and AIDS-related deaths globally, with national adult HIV prevalence exceeding 15% in eight countries in 2005 (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe). Nowhere else in the continent has national adult HIV prevalence reached such levels. However, there is evidence of slight declines in the epidemics of some countries (notably Zimbabwe), while the epidemics in most of the rest of the subregion have either reached or are approaching a plateau. Only in Mozambique have the latest HIV data (from 2005) shown an increase in prevalence over the previous surveillance data set (UNAIDS,

2007). In Swaziland for instance, HIV prevalence in 2000 from sample of antenatal clinic patients ranged from 32.2% to 34.5% in urban and rural areas respectively. In Botswana and South Africa's Kwa Zulu – Natal province, the prevalence rates were 43.9% and 35%; and 36.2% respectively.

In most of the comparatively smaller epidemics in West and Central Africa, adult national HIV prevalence has remained stable overall. However, signs of declining HIV prevalence are evident in an increasing number of countries (notably Côte d'Ivoire, Mali and urban Burkina Faso). The trend in West African countries has not been too high when compared with the South African situation, but national adult prevalence rates already passed 5% mark in many countries including Nigeria with 5.8 % prevalence rate in year 2000. Nigeria still has the largest epidemic in this sub region. Although the percentage of adults infected with HIV is estimated at 3.9% (Federal Ministry of Health Nigeria, 2006) in 2005 is smaller than many other sub-Saharan African countries (notably in East and southern Africa), the country's large population means that almost 3 million (1.7 million–4.2 million) Nigerians were living with HIV in 2005, second in number globally only to South Africa (UNAIDS, 2006).

The situation in East Africa is encouraging, and serves as a model for other African sub-regions. In this sub region, some of the countries with previous high infection rate of HIV/AIDS are experiencing down ward arc in prevalence rates, especially in Uganda, which is the first African country to have subdued a major HIV/AIDS epidemic. Surveillance records show that HIV prevalence in pregnant women in urban areas has fallen for eight years in a row, from as high as 29.5% in 1992 to 11.25% in 2000 (Odumosu, 2002). However, researchers discovered that the downturn in the prevalence rate is not unconnected with concerted effort and focus on information, education and communication; and decentralized programmemes that reach down to village level; with evidence of increasing use of condom in most cities. Quite different from other regions, the trend of HIV/AIDS infection has not been all that high in North Africa. However, Odumosu noted that the visible trend is also towards increasing HIV infection rates, though still at very low levels. The existing surveillance systems have been criticized as being inadequate, with high probabilities of denials in these countries, which were one of the initial problems, faced by most African countries where the epidemic is currently very high.

From the regional analysis, the HIV/AIDS infection rate and trend tends to be on increase in Southern Africa and West Africa, though at a slow rate in the latter and on decrease in some places of East Africa. South African sub-region statistically remains the area with highest rate of infection, while the North African region is the least infected. More general picture of the prevalence rate in selected African countries is shown in table 1 below.

Table: 1 HIV/AIDS Prevalence Rate for Selected Countries

Variable	Botswana	Zimbabwe	Zambia	Kenya	Cameroon	Uganda	Nigeria
HIV Prevalence	38.8	33.7	21.5	15.0	11.8	5.0	5.8
Adult and Children	330,000	2,300,000	1,200,000	2,500,000	920,000	600,000	350,000
Orphans	69,000	980,000	570,000	890,000	210,000	880,000	1,000,000
Deaths	26,000	200,000	120,000	190,000	53,000	84,000	170,000

Source: UNAIDS/WHO Epidemiological Fact Sheet, 2002

Consequences of HIV/AIDS in Sub- Sahara Africa

HIV/AIDS is now the leading cause of death in sub-Saharan Africa and the fourth-biggest killer globally. The epidemic has cut life expectancy by more than 10 years in several nations. It is not just a public health problem but also one that has far reaching consequences to all social sectors and to development itself once generalized. It can decimate the workforce, create large numbers of orphans, excerbate poverty and inequality and put tremendous pressure on health and social services. Annual basic care and treatment for a person with AIDS, even without antiretroviral drugs (ARV), can cost as much as 2-3 times per capita gross domestic product (GDP) in the poorest countries. Already, HIV/AIDS causes a measurable fall in annual per capita growth in the hardest-hit countries of sub-Saharan Africa and threats to reverse their development achievements of the last 50 years. As citizens of poor countries we recognize the fact that HIV/AIDS is a disease of inequality and maginalistion whereby the vulnerability arises out of a combination of poverty, unequal access to basic needs and resources, oppressive cultures and traditions, and the absence of adequate health-care and information.

A basic assumption which is a common believe is that the HIV/AIDS epidemic affects the capacity of the economy to produce by reducing the quality of labour input with the adverse effects to the national economy being enormous and multifold manifesting in lower productivity, lower savings, rise in prices of factors of production, among others (Moshi 1999). Apart from the economic consequences, there are social effects mainly on the perception of the illness in the society. In Nigeria for instance, HIV/AIDS has been treated as a moral rather than a medical issue, especially the way in which the disease has been described and classified, reflecting the same social cultural prejudices that made the disease shameful in the first place (Barnett and Blackie, 1992). Known cases of HIV/AIDS are stigmatized by the society in which they live. Features common to the stigma include identifying the person concerned in terms of the stigmatizing attributes, which in turn overrides other characteristics and social roles. The stigma spread to the whole person and "spoils" the person's identity, devalues the person and leads to discrimination and outright rejection, all of which result in reduced opportunities (Goffman, 1963), self worth and contribution to the over all development of the society.

The Context of Health Inequalities in Sub-Sahara Africa

Provision and access to health facilities and services is one of the major problems in most African countries today, which also impacts on the HIV/AIDS situation. Health as generally defined by WHO implies a state of well-being of an individual, group of people or society, which could be practically negative or positive denoting unhealthy and healthy conditions respectively. But the question in most human societies has focused on the pattern of distribution of this condition, which could be described as equitable or inequitable/unequal. Health inequality as a condition could be perceived from two main different dimensions- affordability and availability of these services, and also inequality on knowledge as demonstrated by Gunn et al (1988). In Africa, health inequalities seem to cut across many countries with few exceptions. Using Nigeria as a case study, with regard to availability of health care centres, for every 1000 persons, a single health care service centre could not be said to be available to them from 1995 – 1999 (CBN, 1999; NISER, 2001). Further analysis of number of hospital beds and doctors per 1000 persons is much

revealing. There are 1000 persons to less than a bed and a doctor respectively, implying a higher rate of growth of population relative to that of facilities and personnel (Table.2). Within the same period, the table shows a worsening rather than an improving condition on the variables from the computation of the percentage change over the years.

Table 2: Availability of Health Care in Nigeria, 1995-1999

Years under study						Average over Years		Percentage Change		
Indictaor	1995 (Base Years	1996	1997	1998	1999		1996	1997	1998	1999
Doctors/1000	0.27	0.21	0.21	0.2	0.22	0.22	-22.22	-22.22	-25.93	-18.52
Hospital Beds 1000	0.68	0.64	0.61	0.58	0.63	0.63	-05.88	-10.29	-14.71	-5.88

Source: NISER, 2001

In examining the situation more critically, there are rural/urban disparities in the location and availability of health care service to the people. In the rural areas of Nigeria, access to health services is very low, which is further made worse by proximity to, and the quality to road network to the facilities. Other health infrastructure facilities and staff are also disproportionately distributed between the rural and urban sub-population. Over 80 percent of hospital beds (government and private) and much of the public sector health staff are concentrated in the urban areas (World Bank, 1996b). It is also noteworthy that tertiary, and referral systems that provide specialist and teaching services are located in the urban centres, usually at state or provincial headquarters according to the national health care system arrangement in Nigeria and most African countries. Owing to the above, those residing in the urban areas experienced a higher rate of fulfillment in health provisions than their rural counterparts, irrespective of the fact that there was significant change for better in the experience of Nigerians in the rural areas in 1996 (Ajala, et al 2002).

Health inequality also relates to the affordability of health care services as different from the physical access and availability as emphasized above. One thing is for a facility to be available, another thing however the affordability of those facilities and services to the general public especially the poor is an important question. The poor in our society finds it difficult to procure necessary drugs, consult health personnel or even transport him/her to the health care centre because of the deepening poverty situation. Ajala, et al (2002) also showed that the poor compared to the moderately rich and the very rich experienced lower attainment ratio or fulfillment in the health provisions in Nigerian society. Unfortunately, the situation seems to be made worse by consistent under funding of existing health facilities in most parts of our continent, even though the World Bank (1994) urged countries to denote a minimum of five percent of their GDP to the maintenance of the health sector.

Within our population, the rural populations have less chances of affording their cost of health care services. This however owes to the preponderance of different degrees of poverty in rural Africa. Following the position of McNamara (1978), rural Africans live in a condition of life where there is malnutrition, illiteracy, diseases, squalid surroundings,

high infant mortality and low life expectancy as to be beneath, and reasonable deficiency of human decency. African rural societies especially live in near total deprivation of certain basic necessities of life, including food and other components necessary in dominant agricultural economy (Ajakaiye and Adeyeye, 2001). Intra country analysis of poverty and inequality shows that poverty situation in the rural Nigeria is greater than what obtains in the urban areas, which may not be different from what happens in other African countries due to their similar historical heritage of colonialism. Colonialism as a root cause of poverty in Africa is predicated on the fact that social and economic differentiation began in a significant way during the colonial period. During this period there was an introduction of some fundamental changes in Africa by creating a group integrated with outside world producing for markets, and a group, which remained subsistence (Obioha and Odumosu, 2002) and invariably poor.

Gender analysis of the access and affordability of health services in African societies demonstrates a relative difference between men and women in this regard. An examination of quality of life of Nigerians in relation to health shows that males experienced higher fulfillment in the utilization of available health-care compared to the females (Ajala, et al 2002). Culturally, in most African societies, especially in the rural and traditional societies, women have limited rights, even over their own health condition. They are less empowered to the extent that the consent of their husbands or male household heads is required before they could consult a doctor. This implies that the health facilities may be there, but the cultural proscriptions may prevent certain groups of the society from making meaningful use of them. Apart from the cultural issues relating to the physical access to the health care centre, what bothers most people from the economic and financial perspective is the level of poverty among women compared to men in African societies. Most women, especially in the rural area of Africa are poor; they have low income and less rewarding occupation. Also they are discriminated against on important economic issues such as inheritance rights and ownership of land and other vital factors of production in most societies (Obioha, 2003). Due to the above disadvantaged position, it becomes obvious that most women could hardly afford the financial cost of their health care.

The above discussion, which focused on the issue of health inequality, has illuminated in some details, the situation of the problem in Africa and Nigeria in particular where most of the statistics were obtained. It is particularly evident that there is heath inequality, which is perceived from the dimension of affordability of cost of care, and physical accessibility or availability of health care facilities or services to individuals. This situation however dates back to the colonial period as Adomako Ampofo(1999) evinced on Cameroon. Then in the early years of colonial medical services, the primary mission of the staff was to protect the health of Europeans, as well as a few African soldiers and civil servants, rather than the health care of the general African population. What is more important to us from these positions is how the various aspects of health inequality relate to HIV/AIDS problem in Africa.

The Impact of Health Inequalities on HIV/AIDS Epidemic in Africa

Due to the uncertainty, spread of HIV/AIDS on the continent has generated a number of studies on different aspects of the problem, which include sexual relations, knowledge-attitude belief, practice and the high-risk groups. The demographic picture of AIDS in

sub-Saharan Africa suggests the complex socio-cultural dimensions of both the disease and sexual relations, which are acknowledged to be primarily responsible for its spread (Ankomah; 1990; Caldwell and Caldwell 1993; Langstone 1989 and Flana et. al 2000). What has been left out in most of the studies in Africa is the role of health inequalities or condition in spread of HIV/AIDS.

In most African countries, governments have designed various strategies to combat the HIV/AIDS epidemic, but it seems that the programmemes that are put in place are not yielding commensurate returns due to already established inequality in health distribution among citizens. In some countries, however, their government has not been able to make meaningful stride against the epidemic due to poverty. On this note it could be supported from previous reports that the spread of HIV virus is faster and more endemic in poor countries, and among poor people. While the HIV virus affects people of all races, most of those dying of AIDS are black and poor. It is no accident that Africa is the continent most affected by HIV/AIDS, and minorities are most affected within the United States, which reveals the fault lines of deep inequality in the world order. Also in South Africa there are white citizens with AIDS, but HIV incidence varies dramatically across South Africa's social divides. Here as elsewhere, AIDS is a disease of the poor, and the poor are disproportionately black (Farmer, 2001) which makes vulnerability to HIV/AIDS to be linked to poverty, race and structural inequalities.

Programmemes that are in place for HIV/AIDS control include broad based preventive and narrowly arced care and management. Activities within the spectrum of prevention include behavioural change intervention (BCI), public enlightenment, and researches for the purpose of awareness. The care and management options include voluntary counseling and testing to a greater extent than as obtained in the preventive option. Others include, provision of anti-retroviral drugs, and lately the care of the people affected by HIV/AIDS. These programmemes and options are still exclusively within the reach of those with higher access to medical care and facilities. One therefore still wonder whether justice could still be done to the poor in the prevailing but disturbing circumstance of health inequalities in most African countries including Nigeria. With regard to Preventive programmemes, the existing health inequalities in most countries have rendered them practically unworkable or selective in areas where they have worked. Information about the HIV/AIDS does not get to the poor and those in the rural areas as fast and accurate as their counterparts who are either rich or reside in the urban areas. For instance due to health inequality in knowledge and practice, circumcision has been implicated as a risk factor in the transmission of HIV. It is for example argued that sexual intercourse causes lacerations and bleeding in women who have undergone clitordectomy and infibulations thus increasing their risk of infection (Gunn et. al. 1988). Furthermore, in both female and male circumcision, use of instruments during the operation without proper sterilization has been implicated as a possible transmission route.

> "the African countryside and its peoples are some way immune to change, and that cultural practices such as circumcision (or no circumcision) and degrees of sexual permissiveness are fixed for all time. Such aview is not too different from assuming that the populations of the African countryside beat to a kind of heart of darkness" (Conant, 1995;109)

The above scenario may not be associated to rich urban dwellers that are well informed about causative factors of the spread of HIV/AIDS. For instance, general observation shows that while behaviour change is the significant part of the problem in preventing HIV transmission, basic condom availability is still an issue along some parts of the society. Various donor agencies and national departments of health procure millions of condoms, but distribution of these condoms to local health departments is extremely inefficient, leading to large overstock in some areas and shortages in others.

In terms of treatment, care and management, the health inequality factor also poses a great difficulty. The anti-retroviral drugs are very expensive to procure and are not made readily available in all sorts of health care centres except the tertiary institutions of health, which with all indications are not accessible to the poor in the society. This condition has set a limitation on who are more likely to obtain care on HIV treatment services. Besides, the cost of procuring the anti-retroviral drugs is enormous for the low-income earners in most African countries. In South Africa for instance where there is profound poverty and inequality, which is among the highest in the world, more than 40 percent of the entire population and 72 percent of the rural population earn less than US$ 2.50 daily, the richest 10 percent receive 47 percent income, and the poorest 20 percent receive 3 percent of income (FHI, 2000:11) .It is against this observation in South Africa and similarly in other African countries that various countries' government have embarked in subsidizing antiretroviral drugs so that they could be affordable to their infected population.

Against this background, President Thabo Mbeki of South Africa among other African leaders has continually clamoured for reduction in the prices of the anti retroviral drugs because he and his African counterparts could not make AZT universally available for HIV-infected pregnant women due to the heavy burden of debt in their respective countries at present time. They also called for less toxic formulations and evidence of effectiveness of the drugs with strong inspiration call across Africa "let us make our own AZT". The west has vehemently resisted this call for parallel importing and generic production of these products as heretical – patented drugs. Outside Africa, people around the world are challenging the notion that HIV/AIDS treatment is too expensive for Africa and poor regions, which led to worldwide protest that forced drug companies to begin lowering prices and to drop their lawsuit they had tried to, block South Africa's access to cheaper generic drugs. Regrettably, when the government subdizises these drugs and make them available, they are also practically out of the rich of the common man and the poor due to some socially structured barriers in the procurement.

Conclusions

Global inequalities dictate who can access affordable AIDS prevention and treatment services. It is the responsibility of governments, the UN, the global economy and pharmaceutical companies to ensure that affordable access to HIV/AIDS prevention and treatment is extended to all HIV positive men and women, including the poor and less privileged. However, the context of increasing poverty in Africa places an imperative on government in the continent to act to ensure that ethical and moral choices are made to reduce the poor people's higher risk of HIV infection and mortality. While the poor bear the heavy social burden of the sick and dying, the government is asked to support policy decisions, which include the interests and concerns of the poor. HIV/AIDS research,

health-care and prevention budgets should reflect the poor people's needs and demands an urgent priority.

Based on the above, this paper therefore brings forth a call on men and women's orgnisations, government, the donor sector, AIDS Service organizations and NGO's to work together to create a compassionate and enabling society in which women and men, poor and rich, old and young assert their equal right to life by freely exercising responsible choices for prevention and treatment. The imperative to treat HIV/AIDS as a collective social responsibility requires action and decisions from the whole society and government to bring the pandemic under control and to ensure the survival and longevity of all women, men and children. By promoting a culture of equality, responsibility and choice in relation to HIV/AIDS we believe we can end the poor people's overwhelming, social and economic susceptibility to HIV/AIDS and affirm the right of all people to life and dignity.

What should be done for the Poor to make HIV/AIDS preventive, care and support Services Equitable? As a matter of fact, following our observations from the prevention to the treatment, the poor has little or no opportunity to access the few and expensive available services. :

Tailor behaviour change messages to specific audiences such as groups at high-risk men, women, young people, and especially the poor. Ensure a guaranteed supply of quality male and female condoms, and make them less expensive and affordable for the poor. Perhaps by subsidizing the production and sale. Educate the people, especially the poor on how to avoid STIs, recognize common STI Symptoms and seek treatment where the price is affordable. Ensure the affordability of VCT, especially for the high-risk groups and the poor. Develop a HIV/AIDS treatment and care strategy (including HAART), ensure an adequate supply of drugs, and strengthen the capacity of the health system to provide treatment and care to HIV positive patients). Treatment of opportunistic infections (0Is) should be made affordable, and if possible free. Provide funding and training for communities and NGOs to provide case for and support PLWHA, especially the poor. Strengthen the safety net for poor household affected by AIDS, and including AIDS orphans.

However, on a broad nation based progrmmes, the governments need to act early, increase government commitment, attention, and funding. Each government also needs to create an enabling policy environment and use a multi-sectoral approach with active involvement of all relevant sectors, civil society, NGos, and private entities. But above all these broad strategies, the following policies that would concern and alter the lives of the poor for good should be vigorously pursued.

Integrate HIV/AIDS in poverty reduction strategies. As the relationship between poverty and HIV/AIDS is symbiotic, the integration of HIV/AIDS into national anti-poverty programmemes and development instruments such as PRSPs and HIPC would help ensure the priority of HIV/AIDS control in the development agenda and facilitate actions to mitigate the impact of AIDS on the poor. Address gender inequality. The evidence shows that there are more women getting infected than men in many developing countries. Women now account for 55% of adults living with HIV/AIDS in Sub-Saharan African. Gender inequality is therefore a contributing factor to the epidemic and needs to be addressed in the long term through measures such as improving the rights and education of women. Also rural/urban disparities in health care distribution should be addressed properly. Finally, there is need to develop a good monitoring and evaluation (MandE) and

surveillance system. A realistic MandE plan with clearly-defined input, output, outcome and impact indicators help track the performance of the national AIDS response and evaluate its impact on the epidemic.

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