'In Africa, AIDS has a Woman's Face:' Implications for Socio-economic Development of sub-Saharan Region.

by

Martina Duskova
BA (hons), University of Huddersfield, Great Britain, 2006
MSc, University of Salford, Great Britain, 2007

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Name: **Martina Duskova**

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Supervisory Committee:

Chair: **Dr. John Harriss**
Professor of International Studies

Dr. Andre Gerolymatos
Senior Supervisor
Professor of History and International Studies

Dr. Michael Howard
Supervisor
Professor of International Studies

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ABSTRACT

This paper aims to explore how the HIV/AIDS epidemic affects the socio-economic development of the sub-Saharan region, and to explain the importance and benefits of a gendered approach in the battle against the disease. As heterosexual intercourse represents the major route of the spread of the virus, sexual behaviour and its determinants in form of the societal norms and pressures are outlined, and ways in which this fuels the epidemic are explained. Possible approaches and ways how to tackle the disease and increase the chances of more effective prevention to halt its spread are discussed. The great need to focus on women in prevention efforts has been widely recognized. This paper however suggests that effective HIV/AIDS programs should equally target the region's women, men, and the elderly and the youth in order to succeed in the battle against the disease and set the region on the path of development.

Keywords: HIV/AIDS; sub-Saharan Africa; gender; development

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TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

Sub-Saharan Africa is the poorest region in the world, and is hit the hardest by the HIV/AIDS epidemic. Millions of people are affected every year, and millions die due to AIDS each year. The disease is increasingly being recognised as one of the major impediments for economic growth and development of the region.

A greater proportion of women is, for a number of reasons, affected than men. The implications of this for the region and its socio-economic development are substantial, considering the crucial role women – 'the backbone of Africa' - play in the societies and, ultimately, in the development of countries: women are those who keep families together, nourish them and secure that their basic needs are met. It is typically women providing care for the sick; the role of women in countries' crucial public sectors such as education or health care is also significant. The gendered face of the disease weakens families, communities, and ultimately states. It impacts development, security and democracy. As Kofi Annan stated, 'if we want to save Africa, we would do well to focus on saving Africa's women' (Annan, 2002).

The importance of targeting women in order to deal with the disease and its spread is something that has been recognized for years. However, any such

help is largely ineffective if men are not included in the efforts, and this is something slowly being acknowledged by international and local aid initiatives. There is still a lag between the rhetoric and action, and appropriate programs addressing both genders still seem to be rather scarce.

This paper suggests that the focus needs to be on transforming the gender power balance so that *women* are not economically and socially disadvantaged to men and are able to make decisions about their lives. The focus should be on *men* and the determinants of their behaviour which often lead them to risky encounters and encourages the inequitable relationships with women. The African *youth* has to be included in these efforts, too, as they form a substantial proportion in many countries across the region, and are Africa's next generation and the core of its potential. Finally, it is necessary to help the *elderly*, most typically women, burdened with care for the rising number of orphans, to secure their well being and to strengthen the future prospects for the development of the region.

The paper is divided into six chapters. The following chapter outlines the basic facts about the disease, such as its origins or transmission routes. Chapter 3 focuses on the sub-Saharan region, and offers possible explanations for the 'woman's face' of the disease, ranging from women's biology to their status across a number of African societies. Chapter 4 provides a general overview of the implications of the disease for the sub-Saharan region, and examines these

from several different perspectives, all of which are crucial elements in countries' development and growth: households, firms, and governments. Ways how the nation's democracy and security might be impacted by the epidemic are also outlined, together with the macroeconomic ramifications. Chapter 5, followed by a conclusion, offers possible courses of action in order to tackle the disease and mitigate its impacts on the region's development, and suggests what areas needs to be focused on in the gendered response to the epidemic.

CHAPTER 2: BASIC FACTS ABOUT THE EPIDEMIC

The HIV/AIDS epidemic is extremely dynamic, and no country remains unaffected. 'HIV is unique in recent human history in its rapid spread, its extent and the depth of its impact' (Hankins, Stanecki, Ghys and Marais, 2006, p.20). Given its magnitude and the severity of its consequences, it is not only a health threat: it has strong economic, social, cultural and political implications. AIDS must be understood as a social and economic problem which severely affects the chances for the region's development. The disease, predicted to reach total death toll of 70 million by 2020, is silently killing more people than any war.

The world has struggled to effectively respond to the disease ever since its significance has been recognized. The aims and strategies to tackle it have been largely fragmented, significantly under-resourced, and the dangers of the epidemic were widely unrecognized. Now, almost three decades later, the world is left with almost 20 million people dead, 40 million living with HIV, and the virus spreading with a frightening pace of around 5 million new infections a year (UNAIDS, 2005).

There are several characteristics that distinguish the current epidemic from other deadly diseases: it is mildly infectious, slow-acting, incurable, and fatal

(Iliffe, 2006). First evidence of the human immunodeficiency virus (HIV) that causes the acquired immune deficiency syndrome (AIDS) was identified in 1959 in Kinshasa by an American researcher studying malaria. This suggests the likely origin of this disease in the region of Western Africa (Illife, 2006).

Another reason for believing that HIV originated in western equatorial Africa is that it most likely resulted from the transmission of the related simian immunodeficiency virus (SIV), an infection of African monkeys. Such transmission of a disease from animals to humans is nothing uncommon, as several other infectious diseases are contracted this way, including plague, yellow fever, or Creutzfeldt-Jakob's Disease. It is possible that the HIV virus was, as the African forest was penetrated by men, contracted by blood in the course of hunting. As Iliffe (2006) noted: 'AIDS is a by-product of the human mastering of the natural environment that has been the core of African history' (Iliffe, 2006, p.6).

There are two forms of the disease: HIV-1, responsible for the global AIDS epidemic, and HIV-2, which is less infectious and generally limited to West African coast. Both of them are have several subgroups. When testing procedures for HIV became available in the 1980s and first cases of AIDS were diagnosed, the disease begun to be recognized as a medical condition (UN, 2004).

The virus was able to spread amongst societies and entire countries through migration. The development of medical services also played its role - vaccination and treatment with improperly sterilized syringes contributed to the transfer, also because it took a long time for the epidemic to become visible due to its slow manifestation. The improved infrastructure network with increased mobility of workers such as truck drivers and miners, coupled with rapid urbanization, helped the virus to travel. During the late 1970s and early 1980s it spread extensively also throughout the US, Europe, and Australasia (Hubley, 2002).

The total population estimated to be living with HIV in 2007 on the planet was slightly more than 33 million. The rates of infection are concentrated disproportionately within the world's regions. Sub-Saharan Africa is the one most severely affected by HIV/AIDS epidemic. According to Iliffe (2006), 'Africa had the worst epidemic because it had the first epidemic' (Iliffe, 2006, p.158). In 2007 in this region alone, the estimated number of people with HIV reached to 22.5 million. Around 2 million were newly affected, and almost the same number of them died (UNAIDS, 2007).

The disease affects gender disproportionately - 58 per cent of the infected are women. Although the ratio might seem insignificant, the implications for African societies are far reaching, given the status and role women have across the region.

The development of anti-retroviral drugs has been one of the major breakthroughs in the fight against HIV/AIDS. Thanks to these, AIDS no longer has to be a fatal illness, and under the right conditions, HIV can be a chronically manageable infection (Walker, Reid and Cornell, 2004). But the availability of drugs has changed the infection from fatal to chronic only in those countries whose population can afford them, which means that this treatment is largely unavailable to vast majority of HIV-positive people in the poorest parts of the world.

There is a number of ways HIV can be contracted, the most common of which is sexual transmission, followed by diffusion through blood routes, mother-to-child transmission or contraction via oral routes (Hubley, 2002). It is believed that HIV spreads more easily from male to female in terms of sexual encounters (Hubley, 2002). Women also tend to be infected by blood routes such as transfusion due to childbirth. Mother-to-child transmission is another major way how the virus can spread, and nine out of ten babies infected through their mother are in Africa (Hubley, 2002).

Although the prevention against transmission is relatively simple, there is a wide range of obstacles to it. One of them is the stigma attached to the disease. AIDS was long believed to be a disease of homosexuals and drug users, as it was widespread among these marginalized groups throughout the 1980s. It also implies promiscuity (Hubley, 2002). Furthermore, the fact that the

disease is sexually transmitted evokes cultural taboos, fears and beliefs about sex. Societal and cultural norms present substantial barriers to prevention, and the subordinate status of women across a number of impoverished societies limits their choices and fuels the disease further.

The HIV/AIDS epidemic has a widespread reach, and its impact is yet to unfold. With no country in the world remaining untouched by the disease or its consequences, the world is facing an unprecedented challenge.

CHAPTER 3: HIV/AIDS AND SUB-SAHARAN AFRICA

3.1 Overview of the problem

The character of the epidemic has changed, and the balance of infection had shifted: between men and women, richer and poorer. Sub-Saharan Africa, although it has 10 per cent of the world's population, is home to two-thirds of all people living with HIV. Its prevalence climbs to 7.4 per cent (Hankins, Stanecki, Ghys and Marais, 2006). The number of the infected has been relatively stable in general, but this does not mean that the epidemic has come to a halt. On the contrary: it can suggest that approximately the same numbers of people are being newly infected with the virus as are dying of AIDS. And although percentage prevalence has stabilized, continuing new infections (even at a reduced rate) contribute to the estimated number of persons living with HIV, 33.2 million, being greater than ever before.

In 2007, the estimated number of all deaths due to AIDS was 2.1 million; 76 per cent of these occurred in sub-Saharan Africa. According to Iliffe (2006), the epidemic had reached only 'the end of the beginning', and the experts warned that the worst was still to come, predicting that it would reach its peak between 2050 and 2060.

Why sub-Saharan Africa is suffering the most? Multiple reasons for this can be pointed out. According to Stillwaggon (2006), it is no coincidence that the highest HIV rates and highest rates in new infections are in impoverished countries, which already face a range of other challenges. Poverty encourages risk-taking behaviour, makes people more vulnerable to the disease, and creates riskier environment. The author identified two ways in which social and economic conditions contribute to the spread of HIV. First, poverty severely limits people's choices. For example, policies aimed at prevention mainly using information, education or provision of condoms can only be effective if people possess the power to make decisions about their lives. Secondly, poverty seriously affects health and makes people more vulnerable to diseases. Malnourished people, suffering with infections and parasites, are prone to be infected with HIV as well as other infections. The lack of access to prevention and treatment services with lack of care facilities, their poor equipment or not enough staff only worsens the situation. Moreover, less developed or corrupt institutions of civil and social protection can be discriminating, and the lack of protection further marginalizes poor people, making them even more vulnerable.

Apart from this, the African continent was the one where the virus spread the earliest and the most rapidly, leaving more people exposed to the infection for longer period of time than in the rest of the world, until awareness arose and prevention and treatment were determined. The status of women in the region and the lack of attention they have received in the prevention aims has also been

one of the key determinants of the epidemic's spread, coupled with stigma attached to the AIDS, which is often regarded as 'woman's disease' (Fleshman, 2004).

Hankins, Stanecki, Ghys and Marais (2006) noted that there is no single 'African' epidemic. 'The epidemics in Africa are diverse, in terms of both their scale and the pace at which they are evolving' (Hankins, Stanecki, Ghys and Marais, 2006, p.23). The epidemic is not homogeneous – some countries suffer higher infection rates than others, and variations occur also at country levels. One trend is becoming stunningly clear though: increasing proportion of those living with HIV are women.

3.2 The gendered disease: why a woman's face?

The HIV/AIDS disease has entered its third decade. Sub-Saharan Africa is home to two-thirds of the world's HIV-infected population (Fleshman, 2004). But only relatively recently have the governments and international community begun to realize that 'not only does the global struggle against AIDS have an African face, it is increasingly the face of an African woman' (Fleshman, 2004). Although women make up half of those infected with HIV worldwide, in Africa, women are affected disproportionately.

The implications for the region's development are far reaching. As AIDS is eroding the health of young and productive women, the skills, experience and networks which keep the families and communities going are becoming disrupted. Of all Africans between the ages of 15 to 49 who are HIV-positive, women make up 58 per cent; from the age group of 15 to 24, 75 per cent are women (Fleshman, 2004). This poses a serious question with even more serious consequences: are young women in Africa an 'endangered species'? What implications is this going to have for the region's future and development?

It is becoming clearer than ever that an urgent action to tackle the soaring numbers of infection among women is desperately needed. But first, to be able consider the consequences and determine the action, another question needs to be answered: what makes women more vulnerable to the infection?

3.2.1 Biology

There are a number of reasons why the disease affects women in particular. One of them is their biology. HIV spreads more easily from male to female and women are more susceptible to be infected by the immunodeficiency virus than men are: Mutangadura (2001) believes that women are 2 to 4 times more likely to be infected by HIV positive men during an unprotected intercourse than men. It is the women's reproductive systems that make them more inclined to be infected by the virus, and this is especially true in the case of young women

whose bodies are still developing. Furthermore, while circumcision in males actually reduces the chances for them of being infected, the opposite is true for women (Hubley, 2002).

Although the major route of transmission is heterosexual intercourse, blood routes also represent a way both sexes can be infected. Women tend to be infected by blood routes because they are more likely to receive transfusion e.g. due to childbirth, which heightens their chances of being infected by contaminated blood or improperly sterilized syringes. The widespread skin piercing activities in some societies like facial markings or piercing of body parts are among the ways women in particular can contract the virus.

3.2.2 Socio-economic and cultural conditions

One of the major determinants of the gendered nature of the disease are the region's socio-cultural conditions, coupled with the poor economic situation of a majority of sub-Saharan countries, and the status of women across African societies. Despite the important role women have in the everyday life of the families and communities, such as crops and food production, and despite being recognized as the nourishers of Africa, they are largely subordinate to men. This creates significantly unfavourable conditions for women and their prevention efforts, especially when the major HIV prevention strategies are abstinence, faithfulness and condom use, which are almost entirely beyond their control.

Richmond and Gestrin (1998) rightly noted that 'Africa may be a man's world, but women are the glue that binds it together' (Richmond and Gestrin, 1998, p.42). Amidst the transformation of the character of the continent, the role of African women is a constant, and their physical and spiritual strengths are remarkable. In traditional societies of the past, men were hunters and warriors; women were the home keepers and child bearers. While the role of most men has changed since, women still bear the traditional responsibilities, coupled with a whole range of additional ones: they fetch water and firewood, grow crops, take care of the household and its members. When they move to cities, they still perform the tasks considered traditional for women, while also working in factories or offices.

A significant link between the spread of the infection and the status of women in African societies has been recognized (UNAIDS, 2005). There might be differences among countries which need to be taken into consideration. However, some generalization valid for majority of sub-Saharan societies could be made. Stillwaggon (2006) expressed that 'legal systems in many countries perpetuate the inferior economic and social status of women. While gender inequality is a worldwide problem, it is aggravated in those countries in which women have no rights to property' (Stillwaggon, 2006, p.55). Although women are primarily those who support the children and family usually through agricultural activities, they typically lack rights to land, which are granted to their fathers or husbands. The inheritance rights, favouring men, make women even

more dependent on them and their role and duties often limit their access to education. These women, rather than risking abandonment which would mean leaving their children without support, engage in risky sexual behaviour with their husbands. Women's limited power means that they are not in a position to make decisions often even about themselves. Research showed that throughout Africa, the virus is widespread among monogamous married women. However, given their status, they are not in a position to neither abstain, nor demand the use of condom from their unfaithful partners or ask for their fidelity (Richmond and Gestrin, 1998).

This different, socially determined status of genders in the society shapes the pattern of their behaviour. Men use sex as a means of control; as a matter of authority, notion of having power over women. The often experienced violence towards women is an expression of dominance and control extended by men. The role and behaviour of women, determined early in their lives by their upbringing, emphasise submissiveness to men with the aim to please them (Walker, Reid and Cornell, 2004). Moreover, young men, as well as young women, believe in biologically determined male sexuality, which in their eyes justifies men's right to have multiple partners and use violence when woman is reluctant or shy. As research revealed, South African teenagers believe that rape is not when a girl says no to sexual intercourse. The study indicated that boys do not recognize 'no' as an option for girls, claiming that 'they should not have any say in that matter at all' (Walker, Reid and Cornell, 2004, p.32).

There is a considerable link between the high infection rates among young women and their sexual relationships with older men, the so-called 'sugar daddies.' This kind of 'inter-generational' relationship which, in its nature, is not too far from prostitution, although some authors such as Hunter (2002) prefer the term 'transactional sex', is most typically done in exchange for money or gifts, and is a major driver of the epidemic in some areas such as Southern Africa. It is a deadly cycle, as the infection spreads from older men to young girls, who then infect their young boyfriends, who then keep spreading the virus to other young girls they start seeing later. It is not necessarily poverty that drives young girls into the hands of older lovers. As Hunter (2002) suggested, there is a difference between rural and urban areas regarding the purpose why girls engage in this activity: in case of rural areas the primary driver is subsistence; in urban areas, however, the major driver for transactional sex is consumption, as girls seek material possessions ranging from clothes to cell phones.

According to Stillwaggon (2006), the gender power imbalance may be part of the reason why, after more than two decades of AIDS prevention programs based on education and information, no significant success has occurred. Despite the rising awareness of the causes of the infection and the availability of condoms in many African countries, the infection rates in places such as Botswana continue to grow. The 'behaviour has not changed because the chief determinants of that behaviour are economic and social, not informational' (Stillwaggon, 2006, p.56).

3.2.3 Stigma

Walker, Reid and Cornell (2004) noted that AIDS has increasingly become a battle of ideas. This leads to another important determinant of the spread of the virus and a significant brake to its prevention: stigma. Initially, the disease spread among homosexual men in the developed world; nowadays, the disease is crippling the poorest parts of the world, destroying lives and damaging countries' potential for economic growth. One thing remains common though: the affected people are still marginalized and stigmatized. As early as 1987, Jonathan Mann, a WHO's Global Programme on AIDS director, identified three distinct epidemics: HIV infection, the AIDS epidemic itself, and HIV/AIDS stigma, which he described as potentially the most explosive of the three (UNAIDS, 2005).

Stigma has been the disease's companion ever since the epidemic began. It generates unfavourable attitudes and policies toward people perceived to have HIV/AIDS, as well as to their loved ones, and even whole communities. The resulting prejudice, discrediting and discrimination only strengthen existing social inequalities, and fuel the disease's spread. Coupled with poverty and large prevalence of the epidemic in the region, stigma and denial have deadly consequences. While people are aware of the disease, they do not see themselves as being at risk. Fear, as well as associations of AIDS with sex, disease and death, and with behaviours that are perceived illegal, forbidden or taboo, further stigmatize the disease and help spread the virus. Lack of

awareness and knowledge about HIV also play its role. Stigma and denial occur not only on individual, but also on institutional level (de Waal, 2006).

The difficulty with stigma lies within deeply rooted cultural values and religious beliefs, which are extremely hard to change or influence and the subordinate status of women across a number of impoverished societies is fuelling the stigma and spread of the virus. Women are often believed to be the vectors of the infection; many think it is a 'woman's disease'.

HIV related stigma then prevents many from negotiating safer sex, seeking information and assistance, taking an HIV test, informing partners about their status or seeking treatment. Pregnant women might avoid HIV testing, and transmit the virus to the newborn child. HIV positive mothers may knowingly expose their babies to the virus through breastfeeding, in an aim not to arouse suspicion of their HIV status (Brown, Trujillo and Macintyre, 2001).

These community pressures are enormous and often also psychologically damaging. The burden of externally imposed stigma is often worsened by an internalized stigma: an inner struggle when 'personhood and illness have completely fused' (Stein, 2003). Such combined strains upon an individual can result in a downward spiral of fatalism, self-loathing, and isolation from others. And by shaming the affected people, the only ones who could credibly speak for

HIV prevention, stigma only worsens the epidemic, condemning more and more people to suffering and death.

As has been discussed, there are numerous issues that make women more vulnerable to contracting the deadly virus. One of them could also be the conflicts ravaging a number of African countries which exacerbate women's vulnerability, especially when violence is widespread and gang rape is used as a weapon. The mass migration and displacement of population during and after conflicts and wars is also encouraging the spread of the infection (Human Security Report, 2005).

However, the major contributor to the spread of the virus is the socio-economic and cultural setting of the countries. 'HIV/AIDS epidemic is fuelled by existing inequalities' (Seeley, Grellier and Barnett, 2004, p.88). Addressing the gender inequity is an essential part of stopping the HIV/AIDS epidemic from spreading and increasing the chances for the region's development.

However, despite the recognized vulnerability of women in terms of contracting the virus, the role of men in the spread of the disease also needs to be examined. Are they mostly to blame for its current state or are they actually victims themselves? What determines their behaviour that drives them to risky situations? These need to be explained so that their position in the HIV/AIDS epidemic can be determined, understood and addressed.

3.3 Men and the disease

As has been suggested, gender inequalities and sexuality are the major factors in the spread of HIV. While the heterosexual transmission of HIV might only be one of the many aspects of the epidemic, it has been recognized as one of the most significant ones, contributing the most to the rapid spread of the disease (Gupta, 2000).

The status men enjoy across the majority of African societies enables them to control the circumstances of intercourse, typically resulting in unprotected sex. Gupta (2000) believes that 'the global AIDS epidemic is driven by men,' as they have more opportunities to contract and transmit the virus.

Men are typically seen as the ones fuelling the epidemic. However, closer attention should be paid to the determinants leading to their risky behaviour. Men themselves can actually be regarded as victims to the significant pressures and expectations of a society in terms of their masculinity and the concepts and behaviours associated with it. Their status and the social power they enjoy put them also in a position of vulnerability in terms of HIV. The societal norms expect men to be dominant, masculine, and encourage risk-taking behaviour. Walker, Reid and Cornell (2004) outlined the common aspects of masculinity in sub-Saharan societies as follows: 'masculinity [is seen] as rather fragile, provisional, something to be won, and then defended, something under a constant threat of

loss,' and is often connected with unrealistic expectations and pressures (Walker, Reid and Cornell, 2004, p.26).

The common (but not exclusive) ways how men in the region 'prove' their manhood include 'having multiple sexual partners, exercising control over women, coercive sex, violence between men, and the use of alcohol and drugs' (Walker, Reid and Cornell, 2004, p.27). Moreover, the emphasis on being self-reliant may prevent them to protect themselves from the infection or seek medical treatment. All of these put boys and men at significant risk.

Men typically do not see themselves at being at risk. Condoms are largely stigmatizing, and are associated with the disease - you want to use a condom because you are sick. The prejudices the HIV/AIDS stigma brings result in fear that women would not want to have sex with them; therefore, they might prefer unsafe sex not to arouse suspicion about their HIV status. It is also a question of rationality over immediate desire, which makes safer sex more complicated. According to Walker, Reid and Cornell (2004), people place more value on the immediate enjoyment, and the future threat of AIDS is less important to them. This can be linked to the region's poverty. The people do not see future for themselves, which, taking into consideration the low life expectancy levels which are gradually falling, is not difficult to understand. As AIDS is not an immediate threat, it only fosters unsafe sex.

In the midst of the poverty and crises the sub-Saharan Africa face, men are often unable to provide for their families. This results in their frustration caused by loss of authority and the eroded traditional notion of masculinity. This might heighten the risk of domestic violence and lead to the disease's spread as men are trying to regain control and power. Furthermore, Walker, Reid and Cornell (2004) pointed out that 'traditional male authority was undermined by colonial authority and apartheid rule' (Walker, Reid and Cornell, 2004, p.33). The authors argued that nowadays women's rights are promoted and men's authority seems to be damaged further. The efforts of international community in terms of tackling the HIV/AIDS epidemic often appears to be further undermining the position of men in their societies. Due to the women empowerment initiatives, men feel that they are not needed anymore (Simoni, 2007).

However, Walker, Reid and Cornell (2004) recognized that there is no single way of being a man. The roles they play in a society differ, and are defined by their relation to others - other men, women, and children. Societal norms influence men's choices, but this can result in both - positive or negative outcomes. The concept of dominant men does not have to necessarily bear a bad connotation: for example, it can mean being responsible for protection and care for the family.

Men are trapped in a web of traditional concepts of masculinity and manhood, which encourage them to engage in risk behaviour. Therefore, their

vulnerability to the disease is heightened, despite and because of their greater power in gender relations (Simoni, 2007). Women might be powerless and vulnerable in the traditional definitions of gender roles, but men seem to have limited power, too, considering the societal pressures stemming from the norms, beliefs and traditions. The need to focus on men and their behaviour has to be recognised. In order to succeed in the fight against the epidemic and ensure the prosperity and growth of African nations, the concerted efforts to combat the disease have to be directed at both: women and men.

CHAPTER 4: IMPLICATIONS FOR THE REGION'S DEVELOPMENT

HIV/AIDS is the leading cause of death in the sub-Saharan region and kills more people than all the wars ravaging it. The epidemic is not African problem: on the contrary. It has increasingly global implications.

An estimated number of 17 million people died in Africa due to HIV related illnesses since the epidemic started, and the number is constantly rising. This is a great human tragedy, which touches every aspect of the continent's life. Beyond the personal loss and the grief of the family, the implications of the vast number of people dead or infected for the region's development are substantial. The structure of economies is being eroded, capacity of institutions undermined, integrity of communities shattered and viability of families strained (Economic Commission for Africa, 2004).

AIDS differs from other diseases which causes are known, effectively treatable and medical science has a long experience in dealing with them. The precise impact of the epidemic on the region is not easy to measure, taking into consideration the disease's long incubation period of approximately 7 to 8 years before the people fall ill. The economic aspect of the disease should be easier to

determine, as a nation's economic development can be understood from the production of firms and households: costs of treating people is measurable in monetary terms; the cost of lost production can also be assessed. In reality, however, the lack of data makes any precise measurements almost impossible, and the information which is available is often surrounded by uncertainty about its interpretation (Quinlan and Whiteside, 2006).

Some things are known for sure though. Sub-Saharan Africa is facing declining standards of living and a disturbingly uncertain future; what has already been achieved in the preceding decades in terms of social and economic development is being eroded, what can be accomplished today is also seriously constrained. The Economic Commission for Africa (2004) went as far as to note that 'in the extreme, the survival of some states may even be called into question' (Economic Commission for Africa, 2004, p.1).

There are several areas where the impacts of the disease are being most severely felt, and they are discussed in the following sections, together with the implications for the region's development.

4.1 Demographic changes

With almost 30 million people living with HIV in Africa, and the significant proportion of adult HIV prevalence of 20 per cent and greater in many countries

across the region, the population changes are inevitable, and in some places are already obvious (Economic Commission for Africa, 2004). The death toll due to AIDS is expected to rise, with a peak predicted to be at the end of the decade, indicating that the worst impact of the disease is yet to come.

AIDS is already having a devastating influence on African societies. Most notable is the drop in life expectancy, which has fallen to a pre-1960 level, something that is unprecedented in nowadays world. The hard gained positive child survival trends are being reversed. Seven countries in the region have life expectancy below 40 years, a staggering number, which would have been considerably higher without AIDS. As proportion of women affected is greater than men, and they die at a younger age, there will be more men left within the most productive age groups, who would have to deal with the household duties and the care for children, and who would most likely seek younger partners and contribute further to the spread of the disease (Simoni, 2007).

HIV/AIDS is responsible for stopping and in some cases reversing the successes reached in health and mortality rates, in a sharp contrast to the trends experienced by the developed countries. The epidemic has a major impact on mortality: in those African countries where the HIV prevalence is greater than 20 per cent (e.g. Botswana, Swaziland, Zimbabwe, South Africa), 'more than 20 years of life expectancy at birth have already been lost to the epidemic, and this effect is expected to intensify in the future' (UN, 2004, p.14). There is a significant

gender dimension to this: by 2020-2025, in Africa's hardest hit countries, whilst male life expectancy is projected to be 48 per cent lower than it would have been had AIDS not existed, female life expectancy is predicted to be staggering 60 per cent lower. This 'population chimney' means fewer young female would be available, which might result in greater tensions and gender-based violence, or, on the other hand, in greater flexibility of choices for women (Poku, 2005). Nevertheless, the decreasing number of women will result in changes in the household structures, with more child and elderly-headed households, and some households dissolving completely.

Population size and growth are also severely affected. By 2025, it is predicted that the population in Botswana and Zimbabwe, given their significant HIV rates, would be 40 per cent lower than it would have been without AIDS.

As the epidemic is taking its tall among the most productive segment of the population - young adults between 15 and 49 years of age, the income generation and care giving is seriously restrained, and the implications of this are profound: households, labour force, food production and the well-being of societies are substantially constrained. The infant and under five mortality further limits the prospects of the countries, as they are robbed of their future human capital. The constantly rising number of orphans is predicted to aggravate inequalities.

The ramifications of the changing population structure with the numbers of children and elderly increasing and the most productive segment of population diminishing are not entirely clear yet. The predictions for the region, however, are daunting: standards of living are declining, the capacity for personal and social achievement is substantially limited, governments' tax base is considerably shrinking, and what has already been secured over the past decades is being eroded. The disease 'is distorting the very fabric of everyday life on the continent, with profound implications for both social and economic development for succeeding generations' (Economic Commission for Africa, 2004, p.4).

Considering all these, it might not be that difficult to understand why the prevention activities and programs might fall short of people's interest: with such a short life to live, is it really surprising that the people might not be concerned about their future?

4.2 Macroeconomic implications

The disease has to be seen in its entire complexity when evaluating the scope of its consequences. As Quinlan and Whiteside (2006) noted, 'AIDS has the potential to push economies into decline and then keep them there,' and once the economic decline begins, it is not easy to reverse (Quinlan and Whiteside, 2006, p.41).

It has been suggested that the continent's per capita growth is 0.7 per cent lower than it would have been without AIDS (Quinlan and Whiteside, 2006). However, there is a considerable number of other variables influencing the outcomes of an economy, making it almost impossible to determine the impact of AIDS alone. African countries have to deal with a whole range of challenges, including draughts or conflicts, which influences the outcomes of the economies. There is a lack of agreement among researchers 'about the extent of the effects on national economies that are directly attributable to the HIV/AIDS epidemic' (UN, 2004, p.89).

Zaba, Whiteside and Boerma (2004) believed that whereas the impact of the disease on economic growth might be significant in the long term, at a given time it is small, and there is a number of other influences impacting growth to a greater extent, such as prices of oil, or political instability. The authors argued that although the gross domestic product of a country might decrease, per capita income might go up in what they called a 'perverse effect' of when the wealth is, due to AIDS related deaths, divided among less people, and therefore increasing the welfare of the community.

The Economic Commission for Africa (2004) asserted that the classical economic models in the 1990s revealed that the disease would have minor effects on macroeconomic performance despite the pace of new infections and the rising death toll. Similarly, newer models, considering the dynamics and

different variables of the epidemic, also suggest the impact would be modest. However, it needs to borne in mind that the continent is yet to fully feel the impacts of the AIDS due to its long incubation period. The predictions of the World Bank (2003) are more daunting, suggesting that the long-term economic impacts of the disease on the region are going to be much more severe than predicted to date. Focusing on human capital, in a model applied to the case of South Africa, the World Bank report (2003) pointed out the reasons why economic growth is likely to be severely impacted: the existing human capital is widely being depleted, especially that of young adults; death of parents and the subsequent loss of income destroys mechanisms necessary for investment in children and young people; poorly educated adults are then less likely to invest in their children's education, and the coming generations' welfare is thus impacted.

The outcomes of macroeconomic studies might be uncertain, but the interest in them is rising, and the reason for this might be that the scale and magnitude of the epidemic is considerably worse than predicted in early 1990s. The disease changes demography in the worst affected areas such as South Africa, where mortality rates have doubled due to AIDS (Quinlan and Whiteside, 2006).

According to the World Health Organization (2001), although not sufficient on its own, good health is a necessary condition for economic growth, and advance in public health, disease control and improved nutrition support

economic take-off. If these are not in place, poor societies face severe barriers to economic progress. Most remarkably, the organization stated that 'a typical statistical estimate suggests that each 10 % improvement in life expectancy at birth (...) is associated with a rise in economic growth of at least 0.3 to 0.4 percentage points per year, holding other growth factors constant'. It is important to realize that in the developed world, typical life expectancy at birth reaches to 75 years for men and 81 for women and is rising; in sub-Saharan Africa, the number is 49 for men and 52 for women, and is falling. 'Thus the difference in growth will be about 11.6 percentage points per year, and this will cumulate rapidly. In short, health status seem to explain an important part of the difference in economic growth rates, even after controlling for standard macroeconomic variables' (WHO, 2001, p.24).

However, it must not be forgotten what the United Nations recognized almost a decade ago: 'the real wealth of a nation is its people. And the purpose of development is to create an enabling environment for people to enjoy long, healthy and creative lives' (UNDP, 1999, p.1).

4.3 Households

According to Quinlan and Whiteside (2006), recent research has shown that there 'is a close relationship between a household being affected with HIV and its subsequent impoverishment' (Quinlan and Whiteside, 2006, p.83). It is on

the household level that the epidemic is most severely felt. Families are left with emotional and economic hardship, as the death of a breadwinner exacerbates poverty, and family faces disintegration. In Zimbabwe, for example, the adult rate of HIV is 26 per cent. Although the proportion of men and women infections is roughly equal, women are infected at younger age of 19 to 29 years, whereas for men the peak is 30 to 39 years (Mutangadura, 2001). The death toll for women is highest in their most productive age, depleting country of its potential and leaving great number of orphans. When a female adult dies, the implications for the household are far reaching. As Mutangadura (2001) pointed out, 'women exhibit certain nurturing and allocative behaviours that enhance the food and nutrition security of the entire household and of children in particular' (Mutangadura, 2001, p.7). This indicates that when she dies, the well-being of the household deteriorates. In many rural areas, women are in majority as men migrated to cities or mines for work. When there is a high HIV/AIDS prevalence, the resulting morbidity and mortality in the community might endanger the rural livelihood of such communities.

Furthermore, a study conducted in Tanzania revealed that a death of a woman in household is negatively related to school enrolment of all children in the household. The child is often taken from school to replace the missing member of family either in the household chores or to perform income generating activities. No such association was found when a male died. As Mutangadura (2001) remarked, 'withdrawing children from school is a short-term strategy that

has permanent effects that could make it difficult to reduce poverty in the longer term', as human capital is key to development (Mutangadura, 2001, p.8).

The AIDS related deaths are associated with increased probability of household dissolution and child migration (Zaba, Whiteside and Boerma, 2004). The rising number of orphans, estimated to be in the range between 13 to 15 million, places substantial strains on the family and the whole community. A study conducted in a number of sub-Saharan countries revealed that a large proportion of orphans do not stay with the original family after a death of their mother. Most typically they are looked after by a grandparent. As elderly people often lack the education, opportunity and energy to earn decent income, and frequently have to deal with emotional stress connected with the burden of care, the child's welfare is negatively affected, and with it the country's prospects for development (Poku, 2005). Rising inequalities in a society are likely to occur as the increasing number of orphans does not have the same opportunities as other children growing up with their parents.

As a greater proportion of the region's families have to deal with the disease and the costs and strains associated with caring for a sick member, they are struggling to extend a helping hand to others in need. The inter-household relationships between the families, communities, friends, relatives, and neighbours have been traditionally and widely utilized in assisting those in social, economic or psychological need, and this has been based on mutual trust and

reciprocity (Mutangadura, 2001). The basis of the extended family, a long standing tradition in the African societies, the informal social support mechanism, is increasingly being eroded and help is being more difficult to obtain, as the HIV/AIDS related morbidity and mortality place enormous strains on affected households ranging from lack of money to personal overcommittment.

As a greater number of women is affected than men, the implications for the region are significant. It is primarily women who keep the societies going, and their work represents a foundation of rural communities. Women play crucial role in development. When they are fully involved, benefits are immediate: families are healthier, income, savings, and investment increase. What is true for the basic core of every society - family - extends to the whole community and country (Annan, 2002). As AIDS is eroding the health of women, the skills, experience and networks which keep the families and communities going are becoming disrupted, too. If they are not infected themselves, they usually care for their sick relatives, thus reducing the time devoted to agricultural or income generating activities. If a family member dies, the financial burden increases, regarding the often overwhelming funeral costs and lost income. If she dies, the household can collapse completely. Children in particular are likely to be affected, the elder ones being taken from school to do housework or generate income. Then, these children, most likely to be girls, lacking education and opportunities, will be less likely to protect themselves from contracting HIV.

4.4 Firms and governments

The economic impact of the disease is remarkable especially on the micro level. Some AIDS advocates believe companies have to respond immediately to the challenges of the epidemic: their executives need to react because the disease will increase the costs of labour, decrease productivity and affect markets and competitiveness. Zaba, Whiteside and Boerma (2004) believed that the amount of foreign direct investment flow into the region have decreased as a reaction to the disease and its implications. Governments have to respond because economic growth is affected, there is less money to spend, and people are dissatisfied (Quinlan and Whiteside, 2006).

As AIDS is taking its toll on the most productive segment of the population, this seriously affects the country's tax base and reduces its ability to finance public expenditures, which includes health services or education. The World Bank (2003) in one of its reports suggested an increase of taxes to gain resources to finance the prevention and treatment programs. However, Quinlan and Whiteside (2006) noted that such proposals 'challenge governments to consider the revival of 'welfare state' policies and the reorientation of national budget allocations towards more social spending in a world driven by market forces' (Quinlan and Whiteside, 2006, p.41).

Most educational and civil service institutions suffer from loss of workers such as teachers, the majority of whom are women. In Zambia, a third of newly trained teachers in 2001 died to HIV-related disease. The skills and knowledge are lost and the costs of training new workers, and especially coupled with the risks of being infected and dying at a young age, are considerable. As a result of the depletion of staff, countries' service delivery standards plummet, which leads to deteriorating levels of services delivered and poses a risk to development as a result of decreasing literacy levels, reduced capacity to prevent and treat HIV/AIDS, and increased inequality in social, economic and gender terms. Public health is affected, food security threatened, competitiveness reduced, rule of law impacted, state capacity lowered.

The costs of the epidemic burden health systems and the already tight national budgets. The circle of poverty and misery with underfinanced sectors crucial for the economy and its people may create dissatisfaction among the country's citizens, which can lead to crime and may pose a threat to country's democracy and security, as support of governments deteriorates and tensions increase (Chirambo, 2007).

4.5 Democracy and security

HIV is not only a development challenge, but it also got on the international agenda as a security issue despite the existing disparity of opinions

whether the disease should be regarded as threat in these terms or not (Quinlan and Whiteside, 2006).

It has been acknowledged that HIV/AIDS places substantial strains on society and its institutions necessary to maintain democracy. These include most notably the parliament, judiciaries and schools. Furthermore, de Waal (2005) suggested that the epidemic as well as the international responses to it is changing the structure of international governance, as countries are growing significantly dependent on international assistance. The author then outlined numerous reasons why HIV/AIDS might jeopardise some aspects of democracy: he argued that AIDS can serve as a justification for repressive measures in the name of public health. It can lead to exhaustion and withdrawal from public life, which would reduce voter turnout, and this can have potential negative impacts on the level of democracy. The great proportion of youth – especially men, can be a risk factor in an environment with high unemployment, particularly when coupled with poverty, which can lead to high levels of criminal activity and threaten country's political stability. Due to the excessive deaths of young women, the disease results in substantial gender imbalance, unprecedented since the slave trade. This change in demography then severely affects their status and endangers democracy; however, de Waal (2005) noted that this is an area where further research is needed. Some suggested that men will seek younger sexual partners and wives, for which there already is evidence. A pro natalist attitude may become dominant, reducing women to wives and, primarily,

mothers. An optimistic thought is that women, with the rising scarcity of them, will become more valued.

The shortening life expectancy associated with the disease erodes human capital and might endanger democratic governance, as experienced civil service personnel is lost and the complexity and continuity of the institutional arrangements are disrupted, increasing the vulnerability to alternative thoughts. The loss of human resources adversely affects the quality of services which is most notable in crucial areas such as health, education, agriculture, justice, police, or parliament. As has already been suggested, these sectors are then less efficient due to the increased absenteeism and staff turnover, and the poor services delivered undermine development efforts. Another potential threat to democracy might be a death of a respected political leader, which might result in political crisis. Furthermore, the stigma frequently attached to AIDS might lead to attractiveness of extremist ideologies.

Substantial funds are dedicated to the disease's treatment; however, the access to it is largely inequitable, which might generate resentment and tensions. There can also be pressures to redirect the much needed capital to other crucial and largely underfunded sectors such as education.

Finally, the region's increasing dependence on international aid for AIDS programs can impact the notion of national sovereignty. Democracies in African

countries, especially those with the legacies of colonialism, are being undermined in the eyes of many when decisions about national policies are made with international creditors and donors behind closed doors, and there is a growing reliance on international aid to sustain African institutions and to keep its sick alive. According to de Waal (2005), 'the dependence is (...) deep, broad, intimate and indefinite,' and the future implications of this needs to be carefully assessed, as it represents a challenge for both the states themselves as well as the international community.

The disease affects strategically important population in terms of national security: soldiers and peacekeepers. The HIV prevalence among soldiers in many African countries is higher than the rates among the general population, and is the leading cause of death in some countries' militaries (Feldbaum, Lee and Patel, 2006). The impact on the strategic capabilities of armies is complex and includes loss of highly trained and experienced personnel, who are expensive to replace. The high turnover of soldiers is affecting the training of the new ones, as well as undermining the soldiers' morale. The lower availability of healthy men may affect the country's ability to protect its interests. On the other hand, some expressed that countries' offensive military plans might be halted as an effect of the disease, leading some countries to turn to non-military ways of promoting their interests. However, no empirical evidence to support this exists yet.

The security of women is particularly affected. The epidemic exacerbates existing social problems, and women are exposed to higher risk in conflict situations for a number of reasons: sexual violence with the use of rape as weapon can occur; the breakdown in social structure and legal protection, the eroding health infrastructure, lost economic opportunities, education and skills training, and the presence of the military and peacekeeping forces are all increasing women's insecurity (Kristoffersson, 2000).

The epidemic has gradually shifted from the low politics of public health into the high politics of national security, as the link, although still under-researched, is increasingly being recognized. De Waal (2005) concluded that, however little empirical evidence there might be yet to support it given the disease's complexity and the amount of time before the impacts fully unfold, 'AIDS is bad news for democracy on many fronts. It causes numerous stresses: demographic, economic, and institutional and it generates global inequity (...). HIV/AIDS is adding a new dimension to the fragility of many states, especially in sub-Saharan Africa.'

CHAPTER 5: ACTION

The increasing number of people being infected with HIV and those dying to its related diseases has a substantial impact on every aspect of the people's lives, their families, communities, and whole nations. Prevention is a crucial part in the efforts to break the vicious circle of disease, poverty and misery and give the region and its people a chance for development and growth. However, it is often overlooked: as de Waal (2005) expressed, 'prevention is a concern for everyone, but a priority for no-one.'

It is important to make the HIV prevention accessible for everyone. Crucial however is to ensure that the constraints to use the prevention methods are removed. The first step to overcome these is to understand, discuss and challenge the ways in which gender and sexual inequality fuels the epidemic. Over the past several years, there has been a change in the rhetoric on HIV/AIDS, as the importance and role of gender in fuelling the pandemic has been recognized. However, the action is still significantly lacking behind the talk. Gupta (2000) pointed out that it is not difficult to see the links between gender, sexuality and the disease, but how to address these issues in order to ensure an effective response to the spread of the epidemic remains a burning question (Gupta, 2000).

The author then recognized three groups of programs aimed at HIV/AIDS prevention in relation to gender. The gender-neutral 'do no harm' approach is not specifically targeted at either of the sexes, such as the 'be faithful' messages. The problem with such programs is that they do not recognize the specific needs of women, which should be reflected in greater social support or the availability of female councillors. This approach can thus be ineffective by failing to respond to individual's gender-specific needs, but, as the author recognized, at least does no harm.

A gender-sensitive approach, on the other hand, understands the different needs of the sexes. The development of women-specific policies and projects largely dominated development work in the 1970s and 1980s (Flood, 2007, p.9). Examples of these include providing women with female condoms, as the little bargaining power women have in relation to men was recognized. Despite this, these programs fail to address the underlying issues that form the basis of women's vulnerability to infection; therefore, however necessary such programs might be, they do little to shift the power balance in gender relations. This has been acknowledged and followed by a shift to 'gendered development' approach with focus on gender relations, aiming to restructure male-female power relations, and the past few years have witnessed an emergence of a transformative approach, which aims to alter gender roles and power relations in order to create more equitable relationships. Such innovative strategy joins women as well as men in an effort to redefine gender norms, which appears to

be an effective and sustainable way of how to respond to the gendered disease. However, Gupta (2000) pointed out some of the drawbacks, such as that the current programs can be actually damaging as they encourage harmful gender stereotypes.

To effectively combat the disease, to halt its further spread and to set the region on the path of development and prosperity, the focus needs to be on *women* because of the growing 'feminization' of the epidemic and its implications for the region (Global Coalition on Women and AIDS, 2004); on *men* to curb the spread of the virus and to relief women from the burden the disease places upon them (Fleshman, 2004); on *youth* as they form a substantial proportion in many sub-Saharan countries, represent the countries' potential and their behaviour is more likely to be transformed (Walker, Reid and Cornell, 2004), and on the *elderly*, as the burden of care for the rapidly increasing number of orphaned children falls on their shoulders, meaning that they quite literally have the region's future to a large extent in their hands (Hope, 1999).

The next section discusses the courses of action urgently required in terms of the suggested groups that need to be targeted.

5.1 Women

The magnitude and complexity of the crisis in sub-Saharan Africa needs an attention to be paid to the vulnerabilities of the region's women (Fleshman, 2004). HIV/AIDS and its related diseases is the leading cause of death of young females in the region. This should serve as an important lead in setting the strategies for effective intervention, which has to address the underlying issues that make young women particularly vulnerable, such as the norms that define acceptable behaviour and economic dependency. The notion of their submission to men is ingrained in their early upbringing, and the status of women is one of the major barriers to the prevention efforts.

As the infection is spreading, scientists desperately search for causes and try to develop new programs in response. However, not much can be achieved in terms of prevention if women are not granted more equal status in relation to men. Facing the Future Together report (2004) looked at causes of the high infection rates among women and concluded that both local governments and international community favour men in their design of HIV/AIDS programs. The report further criticised the gender-neutral approach to education concerning the disease, and importantly, its prevention and treatment. It then suggested that only a 'gendered' approach would reduce the infection rates (Facing the Future Together, 2004). There has been a range of initiatives from major international

organizations targeted at women with regard to the disease, however, these have been generally small-scale and have not been effective (Hope, 1999).

There is a great need to implement strategies which would focus on empowering women 'through improved access to health, intensified HIV/AIDS awareness and prevention programs and (...) access to education' (Mutangadura, 2001, p.10). As Seeley, Grellier and Barnett (2004) believed, not only the challenge of women's vulnerability has to be addressed, but the unequal gender relations and the nature of 'development' need to be changed. The programs need to give women an access to information, skills, services, technologies, and encourage their participation in decision-making, as these are all crucial in containing spread of the epidemic and alleviating its impact (Gupta, 2000).

The empowerment of women would secure improved health and well-being of the family, society and ultimately the whole country. The biggest challenge is transforming the beliefs and attitudes influencing behaviour, including the ways girls are brought up - equity needs to be emphasised and preached, replacing the traditional upbringing in belief of subordinance to men. In changing this, however, male participation and support is also crucial.

According to Fleshman (2004), women in Africa have been actively pushing for a change for a long time, which shows that there are efforts of African

women to challenge and change the gender power balance. Their empowerment requires change in beliefs and attitudes, and the cooperation of men is a key to altering the gender dynamics. As Simoni (2007) pointed out, the 'gender inequity is a fundamental factor driving the spread of HIV/AIDS and gender equity is possible only if men support and promote it' (Simoni, 2007, p.27).

5.2 Men

In order to tackle the HIV/AIDS epidemic and alleviate its devastating consequences, the focus of the prevention initiatives should, to a large extent, be on men. The disease might have a woman's face, but behind every woman who is HIV positive or at risk of becoming infected is a man who is HIV positive or at risk.

There is an urgent need for a gendered approach in dealing with the epidemic, which would involve and target both sexes. Some researchers believe that African men get largely ignored in AIDS prevention despite the widely acknowledged fact that men are fuelling the disease (Smith, 2000). There is a lack of policies and programs targeting men, and the existing ones are largely underdeveloped. Men are typically seen as a barrier to effective prevention. Flood (2007) suggested that the current gender inequalities, which are significantly disadvantaging women, might explain the limited resources and efforts devoted to programs targeting men.

When designing prevention strategies aimed at men, several crucial questions needs to be asked beforehand, having in mind that men's choices are often restricted: what determines their behaviour and the choices they make? What influences their decisions? How this makes them vulnerable to contraction and spread of HIV?

The societal pressures and expectations placed upon men mainly in terms of their masculinity are most often the determinants that shape their behaviour. As a result, men are often encouraged to start sex at early age, to have many partners, or show violent behaviour. Failing to appear masculine leads to them being ridiculed, and it is the fear of this shame that drives them to engage in risky behaviour (Wainaina, 2000).

This indicates that the traditional concepts of masculinity have to be challenged and, most importantly, gradually transformed. Masculinity, for example, can bear a whole range of different connotations, and among others calls for protecting one's family or challenging own fears. 'If cultures can promote these images of masculinity, and create new ones, then more men might start doing what they desperately need to do: shoulder responsibility for AIDS' (Schoofs, 1998). The concepts and beliefs need to be challenged, but in a way that would not endanger the relatively fragile notion of manhood and male authority. The men's privileged position should be turned from harming and disempowering women to benefiting them. Men's status and power within

communities should be used to protect them and their women, and to contribute to the battle against the deadly disease. Fostering gender equity would mean better lives for all and would lead to economic development and growth. The understanding of the role of men as an essential component in HIV prevention and treatment needs to be spread widely and policies implemented accordingly on all levels ranging from international to local and individual (UNAIDS, 2000).

There are louder and louder voices calling for men to make a transformation - not only in their beliefs and attitudes, but primarily in what it means to be a man (Schoofs, 1998). Several questions remain though: are the men willing and able to redefine their norms and beliefs and to alter their behaviour? Why would they do so? What are the incentives for change? Would it threaten men's masculinity and power?

There are a number of reasons why men would benefit from more equitable gender relations. Personal well-being is one of them: current gender roles encourage men to engage in risky behaviour, which, among others, takes its toll on their health, and there are other personal costs of conforming to norms of masculinity. Secondly, the quality of life depends largely on the quality of relationships with others. Women are an inseparable part of men's life, and their role in the nourishment and well being of families is crucial. Men's relationship with women - their wives, girlfriends, sisters, daughters, mothers, would improve significantly if the gender power balance was altered, which would very likely

have a substantial and far-reaching positive impact on the quality of men's lives. Next, the community in which men live would benefit, too, and this benefit would stem from women's improved health, flexible labour division, and the decrease in violence. Finally, Flood (2007) pointed out that there is an ethical obligation for men to eliminate the unjust privilege they have.

Gupta (2000) noted that the commonly held belief that empowerment of women means disempowerment of men has to be challenged. It is not a zero-sum game. In the longer term, more power to one brings more power to all. Another fear is that the change in gender roles means altering the society's culture, and is in conflict with multiculturalism and diversity. But Gupta (2000) pointed out that what is actually being transformed are the society's customs and practices. As she further added, 'customs and practices that seek to subordinate women and trap men in damaging patterns of sexual behaviour are based on a biased interpretation of culture that serves narrow interests' (Gupta, 2000, p.7). The oppression of rights and freedoms of individuals that promote a circle of illness and death has to be stopped. What more powerful reason can there be for a change?

Men therefore need to be part of programming considerations. Men's traditional authority needs to be taken into account, and males, as an important link in the HIV/AIDS battle, need to be approached with initiatives to challenge the traditional norms which are marginalizing and harming women. The

community would benefit, and men leaders will appreciate that their influence and authority have been acknowledged (Flood, 2007).

Evidence reveals that there are initiatives of men which are aimed at tackling the disease and its spread, and which have recognized gender equity as one of the major obstacles to successful battle with the epidemic. Such initiatives, coming for example from Kenya or Uganda, need to be fostered and build upon, as they help to raise awareness about the disease and its prevention and the role of gender inequalities, as well as it creates new leaders and the much needed role models for boys and men in the community (Gupta, 2000). More of such groups involving both men and women need to be established despite the numerous challenges such as poverty and conflicts.

There is a need to stop blaming men for the spread of the disease, and to understand the determinants of their behaviour. Masculinity embodies both, power and vulnerability, and men have to be recognized 'as both agents of patriarchy and victims of masculinity and attempt [needs to be made] to link masculine privilege with responsibility and accountability' (Simoni, 2007, p.32). The concepts of masculinity need to be redefined. This means challenging the widely held norms and beliefs and transforming them; touching the deeply ingrained values and traditions of societies and cultures, and going into the roots of individuals. It is extremely hard to change, and it requires a joint effort from

societies as well as the men themselves to become an effective and sustainable tool in the battle against the epidemic.

5.3 The elderly

In alleviating the devastating impacts of the disease and increase the chances for the region's development, the focus should increasingly be also on the elderly. Grandmothers are largely burdened with the care for the dramatically rising number of orphans which is predicted to soon reach 13 million in the region. Care is often highly problematic given that their capital, age, health and education constraints limit their income-generating opportunities (Gupta, 2000). While grandparents fostering children is not a new phenomenon, with the increased death rates among young adults there is an urgent need to design and implement supportive programs for the elderly. Various studies have revealed that women's incomes are strongly associated with improvements in children's welfare. This shows the importance of the needs of elderly women being properly addressed, as this would most likely improve the welfare of the children in their household, and in the long run positively impact the future of the whole country. An example of support could be the promotion of informal sectors, such as knitting and sewing activities, provision of training and micro-credit so the women would be able to generate adequate income.

Importantly, help is needed so that the concept of extended family and its benefits are maintained and can continue to mitigate the negative effects of the epidemic on households. The extended family still represents a major support for surviving orphans, but is being significantly unable to cope with the complex constrains the disease brings. The policies need to enhance family coping strategies and should complement macro-economic policies that promote economic growth (UNAIDS, 2000).

5.4 The youth

For sub-Saharan children, the AIDS epidemic has changed the face of childhood. The disease is destroying the old social structures, families are collapsing and more children are left vulnerable, especially where social support mechanisms are not available.

According to Knight, 'there are 1.5 billion people between the ages of 12 and 24 in the world, and 87 per cent of them are growing up in developing countries' (Knight, 2008, p.1). In some of them, for example Uganda, where the life expectancy is 47 years, 56 per cent of its population is younger than 18 (Knight, 2008). This indicates that there indeed is a potential for effectively challenging the disease and mitigate its spread in terms of the coming generations, if the focus is on the children and youth.

There is a need to intervene early and target young boys to foster equitable attitudes and behaviour towards girls. The beliefs girls are taught in their upbringing need to be altered, too. It is in childhood that ideas about gender relations and sexuality are formed, and these should be taken into consideration when designing prevention strategies. Today, boys in the region are typically encouraged to start being sexually active early in their lives, and to have multiple partners. They look up to their predecessors and their behaviour and think why should not they behave the same way? And girls accept this, believing who are they to change that (Walker, Reid and Cornell, 2004). This points out to the importance of role models; grandfathers, fathers, masculine characters; role models from the past are looked up to when the contemporary ones are missing. There is an urgent need for new leaders who could be role models for the African youth.

Transforming the power relations is only a part of the solution, however. More than that is needed if the spread of the disease is to be halted. A study carried out in South Africa indicated that young men would not stop having multiple partners, even if that meant they would contract the virus (Walker, Reid and Cornell, 2004). Apparently, men place more value on presence than future, on immediate enjoyment over future achievement. Is it because they do not see any future for them? And is it really difficult to understand this considering the countries' staggering life expectancy numbers? Someone who has a likely

prospect of dying at the age of 35 will probably be unwilling to invest for the future, in education or savings.

Sub-Saharan Africa needs a promise of a better future so its citizens would be willing to invest in it. People regardless of country they live in need to be able to look to the future and have something to aim for (Barnett and Whiteside, 2006). Therefore, economic growth of the region is crucial.

CHAPTER 6: CONCLUSION

The HIV/AIDS epidemic is a global problem that should unite the world in an intense battle, which, unfortunately, it seems to be constantly loosing. The scale of the problem is unprecedented, and the virus is killing millions of people each year, destroying countries' opportunities for growth.

In reversing the trends in the spread of HIV throughout the region, prevention should be made a top priority. As heterosexual transmission is the major route of contracting the virus, the focus should be on the sexual behaviour of people and its determinants.

Former United Nations Secretary General Kofi Annan stated: 'in Africa, AIDS has a woman's face' (Annan, 2002). The gendered nature of the disease only exacerbates the challenges the region faces. The role of women across African societies is crucial, yet they are largely subordinate to men, economically and socially disadvantaged, and significantly unable to make effective decisions even about their own lives. These constraints, although increasingly being recognized in the prevention efforts, have so far failed to be properly addressed and mitigated.

No prevention strategies are likely to be effective and sustainable if men are not included. Men have been largely condemned as an obstacle to such efforts. The importance of their participation in targeting HIV/AIDS epidemic through changing the gender power balance has to be recognized and effectively acted upon.

It needs to be realized that women might be victims of the societal norms and traditions, but so are men. When the determinants of male behaviour are examined, the power of the masculinity concepts, societal pressures and expectations is revealed. These need to be considered in the approaches aimed at transforming the traditional norms and beliefs, which have to be sensitively implemented.

At the same time, programs have to be designed to lift the burden off the shoulders of the elderly people in terms of care for the ever increasing number of AIDS orphans. Their role needs to be appreciated and properly addressed as they are struggling to provide for the next African generations. These are, together with the youth, the region's future and its chance for ending poverty and ensuring economic growth.

Only a combination of these approaches seem to represent a sustainable means of getting the epidemic under control, reverse its spread and set the region on the path of development. It must not be forgotten that it is up to the

actions taken now whether the many daunting predictions for sub-Saharan Africa will remain just unfulfilled models, or a cruel reality.

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