

The Relationship between the Spread of HIV/AIDS and Inequality in Africa

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HIV/AIDS poses a serious threat to public health around the globe; the World Health Organisation estimates that in 2007 there were more than 30 million people living with HIV/AIDS worldwide, and an estimated 2 million deaths as a direct result of the disease[i]. Of those deaths, the majority occurred on the African continent, with some 1.5 million[ii] African fatalities attributed to disease in the same year. Africa has suffered from the ravages of HIV/AIDS for decades and attempts at containing and eradicating the disease have been many in number; there are however groups within African society that are often ignored by modern AIDS prevention strategies. African women and men who have sex with men (MSM) are both at an increased risk of contracting HIV, yet due to their unequal social, political and economic standing, fail to be reached by mainstream intervention strategies.

This essay will illustrate the very real link between the inequality of women and MSM and the spread of HIV/AIDS within these two communities. The data used will be drawn from a number of internationally respected research organisations, such as amfAR – the Institute for AIDS Research, and from leading experts in the field of HIV/AIDS in Africa. I will make use of a combination of primary and secondary sources to support the assertion that HIV/AIDS prevalence rates are so high amongst African females and MSM due to their unequal standing, treatment and representation in African civil and political society. The essay will conclude that more needs to be done, particularly by African governments, to address the specific problems of HIV/AIDS prevention within the female and MSM populations and also to address the inequalities that exacerbate the problem of transmission to these groups. Based on the evidence presented in the essay I will finally make recommendations on how these inequalities can be reduced and suggest strategies to decrease the resulting disproportionate prevalence of HIV/AIDS.

As mentioned this essay will discuss two groups who are 'unequal'. It is important to understand what is meant by the term 'unequal' and 'inequality'. This essay understands the meaning to be those groups or individuals in society who are not viewed and treated as socially equal in society, law, and family life; this includes those who are not equal in terms of economics, politics and civil and human rights. Often discussions of the African AIDS epidemic have deemed inequality to be the north/south economic divide, however for the purpose of this essay it is not the wider economic inequality that will be addressed; it will be the smaller scale gender and sexuality inequalities that will be discussed in this essay.

Women represent 61% of adults living with HIV/AIDS in sub-Saharan Africa compared to 46% of adults worldwide[iii]. Women are at an elevated risk of infection in sub-Saharan Africa and this is being fuelled by socio-economic subordination. Gender inequality poses a major obstacle in both HIV/AIDS prevention and treatment of women in Africa. Carolyn Baylies explains women are particularly vulnerable to HIV infection because of the relations between men and women; she explains that 'gender relations configure with sexual behaviour and economic security' and these factors 'underlie women's particular vulnerability'[iv]. In this section I will explore the reasons why women's inequality contributes to their susceptibility to HIV infection.

Gender relations play a role in women's economic security; this role often takes the form of vulnerable, economically dependent women relying on men, often older men, for financial security. At first glance one may not realise the underlying problems this poses for women, but women who are dependent on men for their finance often have a

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subordinate standing in the relationship as a result. This position of subordination can be further exaggerated by cultural disparities in the social standings of males and females; also religion in some parts of Africa, such as Nigeria's predominantly Muslim north where Sharia law is implemented, has been used as a means to oppress women and prevent their financial advancement. Dependence on males makes it harder for women to insist upon safer sex relations, such as condom use, and also hinders a female partner's ability to negotiate their husband's behaviour outside of the relationship.[v] Brooke Schoepf explains that 'working class wives express powerlessness in the face of what they know, assume, or suspect to be their husbands' multiple partners'[vi]. Male infidelity is quite common in many parts of sub-Saharan Africa, as can be drug use, and both of these factors place the male, but crucially the female (who is very often unaware of their partner's 'extra-marital' activities) at an increased risk of HIV infection. In Ghana, for example, married women are almost 3 times more likely to be HIV positive than single women.[vii] This demonstrates a fundamental flaw in some traditional policies which have promoted abstinence until marriage, such as the United States' AIDS efforts in Africa, as an effective way of HIV/AIDS prevention.[viii]

One contributory factor in the lack of economic advancement of women in Africa is a lack of, or a restriction to, education for young women and girls. Reasons for this lack of education range from the cultural and religious subordination of women explained earlier to the need for some families to exploit their daughters as a 'wage-earner'[ix] due to economic hardship. For families facing extreme economic difficulties taking a daughter out of education and employing her in activity which will result in financial benefit seems a better option than keeping their daughters in school. This lack of education is a contributing reason for the economic disparity for women due to decreased employability, but there is also a more direct impact on the prevention of HIV/AIDS. For many young women the only access they are exposed to about HIV prevention techniques is at school; in the best schools girls are taught about a range of effective prevention methods and some schools, such as in South Africa, support the distribution of complimentary safe sex products such as male and female condoms.[x] By excluding young women from this education many remain ignorant about the risks of HIV/AIDS and some believe a number of popular myths[1] which circulate in many remote, rural and therefore often impoverished regions of Africa.[xi]

The female public health fallout from the economic disadvantages faced by women in Africa is wide ranging. A combination of the lack of education explained earlier and the resulting economic insecurity can force women to take desperate measures to fund their daily lives. For some women the only way of securing their financial future for themselves, and sometimes their children, is by engaging in seriously dangerous risk-taking behaviour such as prostitution.[xii] Female sex workers are at an increased risk of contracting the virus due, in part, to the number of sexual partners they have; very high HIV prevalence rates amongst this group have been observed in both Kenya and Uganda.[xiii]^[xiv] Female sex workers face a range of heightened risk factors other than simply that they engage in sexual activity with a large number males, these factors can include the sex worker's priorities being financial gain and not their personal health, thus a resulting complacency with regard to safer sex and also the difficulty in negotiating the use of condoms with male clients. Their transmission risk is increased due to their susceptibility to forced and violent sex. A South African study found that male clients were more likely to behave aggressively towards the woman if condom use was suggested, which made women fearful of suggesting safer sex.[xv]

Female sex workers are not the only group of women who are at an increased risk of violence and forced sex. Gender based violence (GBV) represents a threat to women throughout the African continent, and the threat poses risks of HIV transmission for women. GBV can increase a woman's risk of contracting HIV significantly because of the biological factors which make female sex organs vulnerable to violent or forced sexual activity.[xvi] There are also socio-political factors that place women at an increased risk of GBV and also of the resulting increase in possibility of HIV infection. One striking case of GBV transmitting HIV on a large scale was seen during the Rwandan genocide of 1994. During the genocide ethnic cleansing by means of forced sex and the use of rape as a weapon of warfare meant a large number of Rwandan women were left infected with HIV. Recent estimates place the proportion of the Rwandan rape victims who are still alive at 70%.[xvii] Due to the spread of prevention myths throughout Africa, some HIV positive men believe they can 'cure' their infection by raping 'baby girls'[xviii], exposing them to HIV infection as well as sexual violence.

As well as the socio-economic factors which place women at a pre-disposition to HIV/AIDS, there is also a significant threat to women's health from the often held view that women are 'child bearers' and as such serve only the vital

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purpose of producing the next generation. Viewing women in this way is not only patronising and restrictive to women but also presents a significant barrier in providing effective targeted prevention techniques. Since the identification of prenatal transmission of HIV/AIDS from mother to child, much of the focus of HIV prevention targeted at women has been the prevention of mother-child infection. By focusing on women simply as mothers, and as thus ignoring women as individual actors that need female specific strategies of intervention, women's needs are often neglected in favour of those of the child. This unequal allocation of resources aimed at preventing disease contraction in children shifts focus from countering the factors which place women at a higher rate of HIV transmission in the first place. [xix]

Because women are traditionally viewed as 'care givers' and not as independent sexual actors, it is often the case that women of child bearing age are expected to try and conceive. This expectation placed on women means that for those who are of child bearing age the use of condoms is unlikely.[xx] This can result in HIV transmission from male to female (and thus resultantly from mother to child), given the extent of unfaithful and drug using male partners discussed earlier. One recent study suggests that four out of five new HIV infections in women resulted from sex with a primary partner[xxi] and the majority of new HIV infections occur among women of child bearing age[xxii]. It is because of the social and cultural pressures placed on women of this age that means that women have very little say in this unprotected sex. Making things worse, many women will not think to get tested as they see little need to due to *their* fidelity, and trust in their partner's; this can result in unnecessary transmission to their child and in some cases, re-infection from their partner, making their illness more severe.

The next 'unequal' group that this essay will address is men who have sex with men (MSM). MSM HIV transmission is not a new phenomenon, in fact some of the first recorded deaths from what is now termed AIDS were in a gay men, one suggested name for the syndrome being GRID (Gay Related Immune Deficiency Syndrome)[xxiii]. MSM is a term used to encompass all males who engage in same-sex sexual activity; this includes more than simply gay and bisexual men, it includes male sex workers, transgender people and those who self-identify as heterosexual who may have wives or female partners[xxiv]. Reliable data collection from heterosexual and transgender MSM can be difficult to obtain due to lack of acknowledgement of their sexual activities and recognition of gender status for transgender males.

Lessons learned from the HIV/AIDS epidemic in the Western world show that MSM are at a higher biological risk of infection, primarily due to biological factors such as the nature of MSM sexual activities, but also because of social stigma. The Naz Foundation recognises 'discrimination against men who have sex with men...increases such person's vulnerability to the risk of HIV infection.'[xxv] Worrying trends in HIV transmission can also be seen in the developing world, and there is little evidence to suggest that this trend is in anyway new. Rather, there is evidence to suggest that the spread of HIV amongst MSM presents itself as a serious and growing problem. For example five African countries appear in the top ten countries worldwide with the highest HIV prevalence rate among MSM; Kenya for example has a prevalence rate of 43% the highest in the world, compared to an infection rate of 6% nationally[xxvi]. This is however, a problem that is not being universally or comprehensively addressed within Africa.

One of the major contributory factors in the MSM HIV/AIDS epidemic in Africa is much the same as the factors that saw the MSM populations of the developed world rise disproportionately; a lack of targeted education and prevention strategies. Traditional mainstream prevention techniques focus on other transmission routes which exclude homosexual sexual activities. One reason that MSM specific HIV/AIDS education is so scarce on the continent is that a large number of African states[2] criminalise same-sex relations between males, thus leading to an absence of state-sponsored MSM targeted programmes. AmfAR, in their report into universal HIV access for MSM, explain that 'institutionalised homophobia and criminalisation of homosexuality facilitate the spread of HIV' by 'severely hindering' targeted prevention efforts[xxvii]. When one considers the practical effects on HIV transmission of what the International Lesbian and Gay Association (ILGA) calls 'state sponsored homophobia', there is a clear link to high levels of MSM HIV transmission. This barrier to HIV/AIDS prevention initiatives can be seen in Zambia treatment for gay and bisexual men It is not just the domestic homophobia preventing these specific interventions; some international state donors and NGOs can place pre-conditions on how their aid donations should be spent which can prevent a targeted allocation of resources. An example of these pre-conditions is the United States HIV/AIDS prevention programmes which places specific emphasis on abstinence-only educational initiatives.

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In addition to this, because of the reluctance of MSM to self-identify as gay or bisexual, they can often alienate themselves from the health initiatives targeted at those specific groups. As mentioned earlier not all MSM *are* gay or bisexual, and that group along with the gay and bisexual men who chose not to identify as such for their own security often deny their own risk of contracting the virus.[xxviii] These denials come from those MSM who perhaps recognise the targeted initiatives for gay and bisexual men and they chose to ignore them; equally these men may not see any campaigns targeted at men who are not gay but who engage in same-sex activity thus conclude that there is no personal risk of infection. These attitudes of reluctance and denial can often stem from the fear and risks that accompany stigma of gay and bisexual men but also stigma targeted at any male who has contracted HIV from sex with another man.[xxix] This can cause increasingly unfortunate problems because though on the face of things there may appear to be targeted MSM HIV/AIDS initiatives in some African countries such as Senegal[xxx], but because of the engrained social stigmas and fears there is the possibility that a somewhat 'underground' community of MSM is being ignored.

Though social and political problems are in themselves a barrier to access to HIV/AIDS treatment and prevention, and though these problems perhaps present the leading (non-biological) cause for MSM HIV transmission, they are also a cause of subsidiary problems. In many African countries, particularly those who criminalise MSM activity, there is very often a denial of the existence of homosexual sexual activity, and sometimes of all forms of anal sex. This has consequences for the health services of these countries, crucially the sexual health services. In most Western countries, such as Australia, it is common for sexual health centres to test for infections that present rectally when testing gay and bisexual men, or indeed any male who has engaged in receptive anal sex.[xxxi] State denials of this kind of activity means that some African testing centres do not test for, and therefore do not treat, those sexually transmitted infections that present rectally.[xxxii] Some of these infections, such as syphilis, can facilitate the transmission of the HIV virus during anal sexual activity. There is a direct link between clinics failing to test for these infections and the spread and subsequent re-infection of HIV in MSM.[xxxiii]

'State sponsored homophobia' can cause health problems that are often over looked or ignored in the developing world. Mental health problems such as depression are common amongst gay and bisexual men, mostly as a direct consequence of the stigma and discrimination they face on a daily basis.[xxxiv] Though these mental health problems can be serious, by themselves they are not fatal; it is the consequences of these problems that prove to be the most deadly. The effects that depression can have on the spread of HIV are perhaps considered minor in relation to other effects but what is often overlooked is how depression can be a cause of much of the risk taking behaviour that puts MSM at risk of HIV infection. Studies have shown that mental health problems including depression can lead to an increase in risk-taking behaviours such as complacency over safe sex, multiple sexual partners, alcohol and drug use and inconsistent condom use.[xxv][xxxv] This combined with a lack of self-worth (which in turn can also lead to a risky behaviours and a lack of concern over health) and a lack of provisions and treatment for mental health problems throughout Africa can prove fatal for Africa's MSM.

The data presented in this essay supports the assertion that both women and MSM are unequal in African society. The conclusion of this data presents mainstream African AIDS prevention policy makers with a problem in how they think about and address the needs of certain communities within African society. There is a wealth of evidence that suggests that both women and MSM are disproportionately affected by the AIDS epidemic and that by ignoring these problems the spread of HIV/AIDS within these groups expands. For women the problems are dominated by their actual and perceived weakness in terms of economic security and social standing; and with MSM they are dominated and exacerbated by criminalisation of same sex relations and the social stigma associated with these sexually restrictive laws. There must also be recognition that whilst individually each of these problems presents a significant threat to female and MSM health, it is the sad truth that often these problems combine together to create an increased threat. To address the particular issues which affect these communities, governments both national and international as well as NGOs need to rethink their approach to HIV/AIDS transmission prevention. Geeta Gupta, in her address to the International AIDS Conference, states that to effectively address the intersection between HIV/AIDS, gender and sexuality requires that interventions should not reinforce damaging gender and sexual stereotypes[xxxvii]. A reduction in the transmission of HIV amongst women and MSM will only be achieved when initiatives dedicated to addressing the socio-cultural factors and evidence-based behavioural, biomedical and social interventions are implemented.[xxxviii] Women must receive the respect they deserve, there is a need for community

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education which addresses the subject of gender subordination; women need to be educated to take HIV precautions themselves and there is a need to be an end to all gender based violence. Specific education initiatives need to be targeted at female sex workers but Africa should learn from lessons in Asia and take care not to label these women as 'disease vectors'[xxxix].

MSM transmissions can be reduced considerably if targeted education exists, which does not assume that all MSM are either gay or bisexual and if stigma associated with same sex relations is eradicated; this can only realistically be achieved if a complete decriminalisation of all homosexual activity takes place and with a comprehensive overhaul in social attitudes towards same sex relationships. Strategies of intervention cannot afford to make the mistakes made in the developed world in addressing HIV/AIDS, particularly amongst MSM, nor can they simply mimic the strategies of the West. Africa's problems are exactly that, they are African, and solutions need to be community driven and specific to the communities of *African* women and *African* men who have sex with men.

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