# The Challenge of AIDS in African Society

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According to the Joint United Nations Program on HIV and AIDS (UNAIDS), the estimated number of Human immunodeficiency virus (HIV) cases in Sub-Saharan Africa was 22.5 million in 2009 (UNAIDS 2010:20). If HIV is not treated, it can develop into Acquired Immune Deficiency Syndrome (AIDS). This syndrome deteriorates the immune system making the person susceptible to acquiring infectious diseases and possibly death. This essay analyses the challenges that this virus brings into Africa. Firstly, it examines the impact at household level focusing on food production, orphans and poverty. It questions the relevance of poverty in the proliferation of HIV/AIDS. Secondly, it analyzes the causes for why women are the most affected by this disease and how these causes also represent a challenge for Africa. Thirdly, why a society with low education and low awareness of AIDS can be a breeding place for HIV will be considered. Consequently, the impact of HIV on the health system is scrutinised to emphasise the exposure of the society to other health challenges with a weakened health system. Finally, the economic and political impact of HIV is analysed focusing on the difficult position in which the low- and mid-income country governments are embedded domestically and internationally. This questions whether HIV is single challenge for Africa or instead is underpinned by other challenges that augment its impact.

In Sub-Saharan Africa, the estimated number of newly HIV infected women in 2009 was 1 million (UNAIDS 2010:131). This represents an important challenge for the household if HIV mothers are not treated. In Sub-Saharan Africa, there is only 40% coverage of women on antiretroviral therapy (ART) and it is estimated that there are 5,800,000 women in need of ART (WHO 2010:58). Untreated mothers may die creating a serious burden for the household and the community as someone would need to take care of the orphans. The number of orphans has increased globally from an estimated number of 14.6 million in 2005 to 16.6 million in 2009 of which 90% of these live in Sub-Saharan Africa (UNAIDS 2010:112). This may deteriorate the social conditions of the communities and families bearing this burden (Poku N.2005:93). The household could be affected in different ways. Firstly, if another household takes care of these children, this will extend the number of its members without increasing its power to produce money or food for the extended members of the household (Barnett T. et al 2006:222). Secondly, if this extended household needed more people to support the household income, orphans or other children of the household would need to work to support it (Barnett T. et al 2006:222). Children may withdraw from the schools in order to work in the household or in activities that generate income (Barnett T. et al 2006:220). This may deteriorate the level of formal education within the household. Thirdly, the children may take the role of a carer for the rest of the family in case there is no other adult able to be responsible for the orphans (Barnett T. et al 2006:223). Therefore, the possibilities for social promotion and to improve their social conditions may be diminished. In theses circumstances, the impact of HIV/AIDS on women and households may represent a serious challenge for poor communities in Africa. So, HIV can drive people to poverty. On the other hand, poverty can create a milieu with socio-economic constraints that result in women being unable to sustain themselves potentially looking to commercial sex as a way to survive (Poku N.2005:93). This opens up the possibility that poverty can be a cause for HIV infection in the same way that HIV/AIDS can create poverty. Thus, poverty can increase women's susceptibility to HIV infection making women more vulnerable to the disease. In this case, poverty may represent a serious challenge to Africa and HIV aggravates the problem.

In Sub-Saharan Africa, 13 women become infected from every 10 men infected (UNAIDS 2010:130). Women's poor social conditions can place themselves in a difficult position to negotiate safe sex practices. A study in Nigeria showed that poverty and lack of means to obtain food compelled 35% of female sex workers to join to sex trade and

to engage in unprotected sex with costumers (UNAIDS 2010:76). It can be said that poverty and food insecurity disempowered women to prevent HIV infection. Thus, women's disempowerment can facilitate the spread of HIV. Empowerment approaches to negotiating safer sex practices might be a solution to overcoming HIV. However, according to the AIDS, Security and Conflict Initiative (ASCI) "These empowerment approaches underestimate the deeply entrenched and socially underwritten power relations based upon systems of patriarchy, ethnic and power relations that have developed over centuries" (de Waal A. et al 2010:32). Patriarchy, disempowerment and power relations can also explain the fact that 60-80% of African HIV infected women had one partner but were not able to either negotiate safe sex with their partners or to prevent them from having additional sexual contacts (Barnett T. et al 2006:199). Women are embedded in social structures where they may have a disadvantaged position in preventing HIV infection. In this case, patriarchy and disempowerment may explain the propensity for women to be more vulnerable to HIV than men in Africa. It can be said that HIV does not only represent a challenge in Africa but patriarchy and women's disempowerment are challenges as well.

In Africa, the coverage of people living with HIV who had received an HIV test and their test results varies from 5% to 68%, in several national population surveys during 2004–2009 with most of the countries having less than 45% coverage (WHO 2010:19). This demonstrates the poor coverage of HIV testing in some countries in Africa, and indicates a low awareness of the potential HIV status in the population. This lack of awareness increases the risk within the population if they undertake behaviours such as unprotected sexual intercourse or sharing intravenous needles. Education can have an important role in preventing the spread of HIV. The low testing coverage and the increase in the number of new cases annually indicates that the population remains not fully aware of AIDS. According to UNAIDS "Less than half of young people living in 15 of the 25 countries with the highest HIV prevalence can correctly answer five basic questions about HIV and its transmission (these include Botswana, Burundi, Cameroon, Central African Republic, Chad, Congo, Cote d'Ivoire, Guinea-Bissau, Kenya, Malawi, Nigeria, South Africa, Togo, United Republic of Tanzania and Zambia)" (UNAIDS 2010:68). Poor levels of education among the population and inadequate structures for creating awareness may create an environment susceptible for the spread of HIV infection. In this case, the spread of HIV evidences that poor education levels among the population aggravates the situation.

The number of HIV infected patients has caused a fundamental impact upon on health care systems in Africa. HIV/AIDS care represented 27% of the health care spending in Zimbabwe and 66% in Rwanda in 1995 (Barnett T. et al 2006:199). In these cases, HIV may have two effects on the health system. On the one hand, the excessive workload due to the high number of patients can burn out the staff, and staff absenteeism may become an issue (Poku N.2005:125). On the other hand, health workers can be lost either through death or chronic sickness due to being HIV infected themselves. In Malawi, there was a three-fold increase in the number of staff deaths due to AIDS from 1992 to 2000 (Poku N.2005:126). The deterioration of the health system not only impacts upon the care of HIV, but also upon other diseases. Thus, the role of the public health care system as a care provider could be diminished. This may make it more difficult for non-governmental organisations (NGOs) to handover their HIV treatment programs to the public health care system. According to Matthew Wilhelm-Solomon in his study on Northern Uganda "selected rural health centres with ART provision were supported by different branches of Médecins Sans Frontières (MSF) , which included community support, although these faced staff and supply-line challenges once MSF withdrew" (Wilhelm-Solomon M.2010:17). This would make it very difficult the sustainability of the HIV programs in the long term and the public sector would be dependant on other actors for the provision of HIV care. This would challenge the perspectives for governments to scale up the treatment to improve the coverage. UNAIDS has already stated the inappropriateness of the current infrastructure, systems, and staff to maintain patients' adherence for the actual programs, and also scale up HIV services in Sub-Saharan Africa (UNAIDS 2010:29). The HIV impact represents a serious challenge for health systems and may create a vicious deteriorating cycle that would increase the vulnerability of people to die of HIV/AIDS. In spite of the increase in the number of patients under HIV treatment since 2000, deaths related to AIDS remains high (UNAIDS 2010:29). From the public health perspective, HIV/AIDS can be considered a serious challenge for African society and the public health system.

In Sub-Saharan African countries, the major group of infected patients is women between 15 to 24 years old. The HIV prevalence of this group doubles the prevalence of the male counterpart in Botswana, Zimbabwe. Lesotho, South Africa and Republic of Congo (UNAIDS 2010:131). The prevalence in this particular young age-group may

have an impact on society level. Firstly, life expectancy decreases sharply if they are not treated. For instance, life expectancy in Botswana was 63 years in 1990 according to U.S. Census Bureau Current Projections (Garret L. 2005: 43), while it is 54 years in 2008 according to World Bank indicators (World Bank 2009). Secondly, the birth rate would reduce because women's fertility would be affected due to women's early mortality and the social burden for women as patients and as carers, for instance one study found the fertility rate of HIV infected women was 50% less than non-infected women in Rakai district (Uganda) (Barnett T. et al 2006:187). The demographic changes may be critical for the sustainability of the society because either the total number of members would be diminished or the intergenerational transfer of knowledge would decrease or the society is less able to cope with the HIV burden. It can be noted that HIV can weaken the capability of a society to face future challenges including HIV. On the one hand, HIV can be a factor in unifying society to combat the disease as the development of the numerous civil society activist groups in Uganda or South Africa show. On the other hand, patients can be stigmatised. This stigmatisation can excluded infected people form society and create a division between HIV infected individuals and the rest. For instance "In Rwanda, more than 50% were verbally insulted, 36% physically harassed and 20% physically assaulted, 65% experienced loss of job or income and 88% were denied access to family planning services due to their HIV status" (UNAIDS 2010:124). Social cohesion has a positive role in preventing and coping with an HIV epidemic. The higher the social cohesion, the less vulnerable a society may be to the disease (Barnett T. et al 2006:97). As mentioned before, inequality, disempowerment and poverty can make individuals and societies more vulnerable to acquiring HIV. Therefore, the spread of HIV would depend on how risky an environment is, and the susceptibility and vulnerability of the society to the virus (Barnett T. et al 2006:138). In contrast, if HIV spreads in a society with low social cohesion; it would worsen the social cohesion. This would place these societies in a vicious cycle making it difficult to exit from. In this sense, HIV cannot be considered the single challenge for Africa because it relies on a susceptible environment characterised by low social cohesion, inequality, disempowerment and poverty.

HIV/AIDS represents a challenge to the economy at different levels. At household level, the disease can decrease the capacity of the members of the household to work due to either sick members not being able to work or the carer may needing to look after the sick members. A study in South Africa among rural and urban household showed a 40% to 50% decreased in income in HIV/AIDS affected households in comparison to not affected household (Rau B. 2007:167). At national level, HIV/AIDS morbidity reduces the capacity of the workforce and HIV/AIDS mortality reduces the size of the workforce. A study by the United States Agency for International Development (USAID) showed that gross domestic product (GDP) decreased 2.6% in countries with prevalence rates of 20% or higher (Mc Innes C. 2007:95). According to Mueni wa Muiu and Guy Martin, HIV/AIDS is wrecking havoc in the Sub-Saharan African economies and societies (Mueni W.M. et al 2009:81) However, the African economies were already weak and indebted before and during the epidemic. At community level, agricultural food production remains a major source of income. In Uganda and Ghana, small farmers account for 90% and 80% of the total food production respectively (FAO 2010:36). Small and constrained production has resulted in difficulties in creating profit through weak organisations, costly marketing and poor communication infrastructures (FAO 2010:36). These economical weaknesses debilitate the national economies which have to compete in the global market. The poor diversification of African economies and the fall of primary commodity prices may explain why, by the end of 1980s, many African countries had lower GDP per capita than at independence (Mueni W.M. et al 2009:81). HIV may not have such a devastating impact on economies if these economies were not strong. Weak economies can be very vulnerable to the impact of an HIV epidemic. In the case of Africa, the weaknesses of the economies at community and at national level augment the impact of HIV. In this case, the major problem is the weak state of the economies rather than HIV itself. However, HIV may place weak economies in a vicious cycle making it difficult to exit from.

The high numbers of infected patients and the cumulative number of cases for this chronic disease make the cost a significant burden for governmental budgets. The World Bank estimated that "the cost of the care per person for HIV/AIDS was 2.7 times per capita GDP for all the countries in 1997" (Barnett T. et al 2006:138). This high capital demand would make it very complicated for low, and some mid-income countries, to afford the care of the disease. Low- and mid-income countries rely on international support to manage HIV/AIDS care. The global fund for HIV has increased from $ 300 million dollars in 1996 to $ 8.3 millions dollars in 2005 (Jones P. 2009:6). On one hand, sharing the economical burden of the disease is a positive sign from international community. On the other, it may evidence the weaknesses of states to manage the disease and may turn states into a dependent subject of the international community. The deepening of the dependency jeopardises the autonomy of the poorer countries to decide the

direction of their own national economies. Countries can be more exposed to conditionalities from international institutions, international market and other countries. This situates low and mid-income countries in unequal power relations when competing in the global market. This highlights how HIV not only has an impact on the domestic economy, but also in the external dimension of national economies. This represents a serious challenge for Africa.

The injection of international money into a country may help to strength the public structures. However, the national government structures are unable to implement HIV/AIDS services alone and non-state actors are also channelling the international money for the implementation of the HIV/AIDS programs (de Waal A. 2006:115). On the one hand, the irruption of non-state actors may be positive because it may help the state to manage the HIV epidemic. On the other hand non-state actors are taking the responsibility that states should. The constellation of non-state actor is a large hierarchy of organisations ranging from international donors to community base organisations each with their own agendas and ideas (Swidler A.2007: 146). The national government may find it difficult to manage and coordinate all these non-state actors. In this case, many governments may seem to be over-shadowed or have its political legitimacy treated by these organisations and may become reluctant to acknowledge or support them (Poku N. 2005:186). HIV/AIDS epidemic has provoked a reaction from non-state actors that may demonstrate the weakness of some African states and may diminish the role of the state in being responsible for their own citizens. Looking at this confrontation between state and non-state actors, HIV may erode the social contract between state and society. The social contract is “where sovereignty was understood to consist in a law-making power that belonged to the whole body of the people forming the state and that was exercised as through the general will of the people” (Covell C.2009:159). HIV patients are part of a society whose state has the responsibility to care for the general will of its constituency. In the case of HIV/AIDS, NGOs and CBOs as non state actors appear as representing the interest of the HIV/AIDS affected people. The state may have the possibility to use the international HIV funds to enhance the public system and so assume the full responsibility in the management of an HIV epidemic. However, the state is currently not assuming the full responsibility to bear the burden of the disease, but instead transferring this responsibility to non-state actors. This can be interpreted as an attempt by non-state actors to take advantage of the difficult position of African weak states in relation to HIV/AIDS epidemics in order to gain influence and to diminish state power. The issue is that HIV may open the window to transform the social contract in African countries and may diminish state sovereignty.

HIV/AIDS epidemics have influenced political life by either increasing the mortality rate among members of parliament, in Zambia and Zimbabwe, or by diminishing the side of the electoral constituencies due to death of voters or reducing the political base in African National Congress (ANC) and Inkatha Freedom Party (IFP) (Barnett T. 2007: 41-42). HIV has touched the core elements of the liberal democratic system; the electorate, the political parties and the elected members of parliament. HIV can have the capacity to make the smooth running of the political life and political structures difficult. This makes it easier for HIV to come in the political agenda and be politicised. For example, politicians can use the political relevance of AIDS for their own political interest such as to attract votes. For instance Mbeki started to shift his statements towards a more sensitive recognition of HIV in South Africa during elections in 2004 (de Waal A. 2006:45). HIV activists have been able to gain access to international institutions, such as NGOs and multilaterals, gaining power and influence such as Milly Katana, the Ugandan HIV activist and member of the global fund board (de Waal A. 2006:45). This demonstrates the strength of HIV in politics and how it can be manipulated for different interests. HIV as a political issue can be positive because it brings the topic to the table in order for it to be resolved. However, it can be seen as that the topic should remain on the table without being resolved in order to keep power and influence. In the case of the NGOs, they can be criticised because they resolve the symptoms of HIV/AIDS epidemic but not the cause, perpetuating the problem (de Waal A. 2006:55). HIV can be seen as a serious challenge but the major problem is the political manipulation of HIV by different actors that may maintain the problem.

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In conclusion, HIV/AIDS has had a serious impact in Africa. HIV/AIDS impacts on the economy, education and the food security of the household. This can impoverish the household, threaten its sustainability and make it more difficult to escape from poverty. However, poor households are most susceptible to the disease. This creates a paradigm in which poverty is a challenge in stopping the HIV/AIDS epidemic and HIV/AIDS is a challenge in stopping

poverty. Women are the most affected by this disease. They are in a very difficult position within society. If women remain disempowered in society, it will be very difficult to challenge HIV epidemic. Acknowledging HIV status is a very important step to contain the disease. However, lack of education is a major challenge to contain HIV/AIDS in Africa because it will perpetuate the disease and increase the vulnerability of the society. A vulnerable society may overwhelm an already overwhelmed health system. A weak health system may represent a very important challenge to the sustainability of African societies and to overcoming epidemics from either HIV or other diseases.

African societies are already suffering from poverty, inequality and weak social cohesion. All these aspects make societies more vulnerable to the HIV/AIDS epidemic. This can create another paradigm because HIV/AIDS deteriorates societies, making them more susceptible to poverty, inequality and weak social cohesion, at the same time. Similar paradigm can be found in the interaction between HIV and weak economies. This may create a burden for the public budget of poor countries that make poor governments search for international help. This international support has been achieved due to the relevance of HIV/AIDS in African society. However, this support has demonstrated the weaknesses of low and mid-income countries to manage the HIV epidemic and has empowered non-state actors. This has created a dependency of governments of low and mid income countries with non-state actors both domestically and internationally in order to manage the disease. However, the political impact of the disease and its influence in attracting attention makes HIV/AIDS a powerful political argument in achieving the different interests of politicians and non-state actors. Differences among the actors may make it more difficult to achieve goals for the reduction of the disease. HIV/AIDS is an important challenge for Africa. However, there are many challenges that create a susceptible and vulnerable environment for HIV epidemic. The impact of HIV has highlighted these challenges, created new ones and worsened the possibilities to overcome all the challenges.

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