AIDS AND GENDER: THE AFRICAN REALITY

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ABSTRACT

In sub-Saharan Africa the AIDS epidemic is escalating in its rate of spread through heterosexual intercourse. The narrowly prescribed gender roles of most African women in conjunction with their socio-economic dis-empowerment make them particularly vulnerable to AIDS infection. Women's inability to negotiate their sexual relations with men is ignored by the Western-style AIDS awareness campaigns dominant in the sub-Saharan region. This paper examines some of the counter-strategies formulated by Africans themselves to protect women from the HIV and AIDS epidemic.

1. AIDS IN SUB-SAHARAN AFRICA

AIDS has preoccupied social welfare in Europe and North America throughout the 1990s. That its spread has slowed in recent years and its victims are less stigmatised is due to both effective public information campaigns and the practical, no-nonsense approach of the caring professions. However, the progress of AIDS on the continent of Africa is an epidemic of far more tragic proportions than that in the Northern Hemisphere. Its dimensions sweep out beyond redress by the ameliorative activities of health care workers in developed countries. At the epicentre of this horrific toll in human lives are African women.

Around 1980 the first few cases of AIDS were identified in the sub-Saharan region. By the early 1990s these had exploded to 2 million with a projected rise to 5 million by the year 2000. With only 10% of the world's population the region now contains 50% of all HIV cases, a figure estimated at 9 million (WHO, 1994). Of those infected 80% are women and children, with women testing HIV positive outnumbering men by six to five. A breakdown of these statistics by the World Health Organisation reveals that 5 million women carrying the HIV virus are of reproductive age, resulting in the birth of one million infected children, in turn causing a 30% increase in infant mortality during the 1990s. Parental deaths are also steeply rising and in consequence 10 million children will have been orphaned through AIDS by the end of the decade (WHO, 1994). However, the contention that women are the prime victims of AIDS in Africa rests upon more than statistical inference. As wives, mothers, sex workers and carers the social and health consequences of AIDS fall heaviest upon women.

2. THE ROLE OF AFRICAN WOMEN

Recently I chanced upon the story of a husband and wife living in Koforidua, in the Eastern Region of Ghana. He contracted gonorrhoea and went to the local hospital to have it treated. The infection cleared; however, a short while later he presented himself at the hospital for a second time with the same complaint. Again he was treated for gonorrhoea and returned home to his wife. After another short period he was back at Out-patients suffering from a further episode of the disease. Eventually he left his wife with the explanation, "She kept giving me gonorrhoea". That it was he who most probably brought the disease into their marriage from one of his journeys to the

capital did not occur to him. Nor was he willing to acknowledge that his wife also required treatment if gonorrhoea was to be eliminated from their marital relationship. That recognition would have necessitated expenditure on his wife's health care as well as his own. Confronted with so many uncomfortable facts which demanded a sense of guilt, a change of lifestyle and some expense he choose to foist the blame upon his wife. In sub-Saharan Africa he lives within a fiercely chauvinistic patriarchy which will endorse his actions. A blunter assertion of this viewpoint comes from a taxi driver in Accra who, when asked how someone might contract AIDS, responded: "women" (Joy FM 2/11/98).

These are the modern-day manifestations of a centuries-old attitude, which identifies women as the source of misfortune. In Europe it was a form of misogyny, which passed away with the witch burning of the middle ages, though its vestiges remain in the sexual harassment and discrimination that still pursue her. In Africa, where tradition has a firmer hold, she is bound by much older constructs of gender.

Marriage and motherhood constitute the only viable social identity for women in most of sub-Saharan Africa. Indeed, in many tribal communities the word for an adult single female does not exist and any woman who attempted this mode of living would find herself an outcast (Fortes 1967; Pellow 1977). Self-respect, social acceptance and status are dependent upon a woman's fecundity, which is deemed an expression of her husband's virility. A barren woman is stigmatised and becomes the object of collective scorn. Since here childlessness is seen to reflect upon her spouse's potency, he also is likely to abandon her for another. A man's prestige, like that of his wife's, is a function of the number of children he fathers (Sarpong 1974). Conversely, the Nyongbato ceremony among the Ga of Ghana during which a wife who has ten children is honoured by her husband, exemplifies the high status associated with child bearing and rearing.

The emphasis on marriage and childbirth affects other aspects of a woman's life. She must marry early if she is to have many children, consequently the average age of marriage for females is between 15 and 20 compared to between 25 and 30 years for males (Nukunya, 1969). Apprenticeship for domestic responsibility as a wife and mother begin in childhood. Girls are burdened with the most time-consuming tasks of daily living: collecting firewood and water often located some kilometres from their homes. They are also expected to assist with the care of younger siblings and with the laborious processes involved in the preparation of many African dishes. The combination of these culturally defined commitments together with the devaluing of female formal education relative to her destiny as a wife and mother precipitates high drop-out rates from school (Akuffo 1987). It is for this reason that female illiteracy remains at around 62% in sub-Saharan Africa as against 39% for males (World Bank, 1995).

3. POVERTY AND DISEMPOWERMENT

The perimeters of women's lives are reinforced by a further reality: she cannot inherit. Neither in patrilineal nor matrilineal systems can a woman be the beneficiary of her deceased husband's estate. Without access to assets she has no access to income; their absence deprives her of either security or independence. Dolphyne (1991) argues persuasively that it is the lack of economic power which undermines women's ability to negotiate the terms of her sexual relations within marriage. Perhaps this more than any other aspect impels women towards a deferential relationship with their husbands and sustains the obedience which is culturally demanded of wives. For without her husband she has little means of livelihood.

The ascribed nature of her part does not alter with migration from rural village to urban centre. The rapid expansion of the African city in modern times has not offered women new terms and

conditions. Indeed, the concomitant dispersal of the extended family often leaves her more vulnerable to exploitation. In a survey of women in Accra Pellow (1977) concluded that there is an element of commercialism and a lack of affect in many marital relationships. The husband's obligation consists in providing material support while her reciprocation revolves around domestic duties, sexual fidelity and child rearing. A more recent study of adolescent girls in Ghana by Nabila and Fayorsey (1996) revealed that the major cause of teenage pregnancy was unemployment and poverty, with 34% of respondents citing these as the determining factors for entering into sexual relations. Without alternative means to secure an income, adolescents engaged in sexual activity in order to gain material support. Economic necessity as a coercive imperative in many sexual relationships is evident from Nabila and Fayorsey's finding that 93% of the unmarried teenagers interviewed reported that their pregnancy was unwanted. Poverty conspires with a social norm of teenage marriage to lower the age of first conception to between 15 and 19 years in Accra and between 10 and 14 years in Kumasi, Ghana's second largest city. Of those interviewed 58% were sexually experienced by the age of 15. A further finding of the Nabila and Fayorsey study relating to married teenagers was the high number, at 58%, who regarded their last birth as either mistimed or unwanted. This accords with extensive demographic surveys conducted in West Africa which reveal that husbands' preferences are consistently for three more children than their wives (Roudi & Ashford 1996). When set beside a study from Nigeria in which 90% of husbands reported that they had greater influence on family decisions, with 80% of wives concurring (Isiugo-Abanihe, 1994), it is patent that men's choices in sexual relations prevail over women's.

The high incidence of sexual activity solely for financial gain; the escalating numbers of unwanted pregnancies, and the widespread prevalence and accepted practice of wife beating in sub-Saharan Africa (Nukunya 1992) all attest to the weak negotiating position of women within sexual relationships. Urbanisation and Westernisation have not strengthened her hand. Migration to the cities leaves women in isolated relationships with men from which they cannot appeal to their wider kin for adjudication or support when his behaviour threatens her welfare. The increasingly pervasive Western norm of premarital sex in urban Africa puts women at further risk of abusive treatment as she enters multiple liaisons. For example, in Ghana marriages have decreased over the short period 1988-1993 from 65% to 59% of the total number of unions (GDHS, 1988, 1993). This trend is projected to continue along the trajectory of experience in developed countries. Gender role, political economy and urbanisation all conspire to disempower African women. Summing up their dilemma when directly confronted with AIDS, Miria Matembe (1993), a Ugandan member of parliament, explains,

> The women tell us they see their husbands with the wives of men who have died of AIDS and they ask, "What can we do? If we say no, they'll say: pack up and go. But if we do, where do we go to?"

AIDS has never been a curable condition, but it is an entirely preventable one. The imperative question therefore is why a preventable disease is accelerating in its rate of spread, devastating whole African communities as it invades the remotest of villages. Identifying the beginnings of an answer Daniel (1993) argues that, "Like every other epidemic AIDS develops in the cracks and crevasses of society's inequalities".

4. THE SCAPEGOATING OF WOMEN

In sub-Saharan Africa 80% of HIV cases are caused through vaginal intercourse (Hamblin & Reid, 1993), with less than 10% of infections attributable to contaminated blood products or unsterilised implements used for health treatments or ritual scarification (WHO, 1994). It is at the moment of intercourse that a woman is exposed to or protected from AIDS. Yet her vulnerability is

disregarded by a society of men and sometimes women who displace the problem away from themselves in a faltering effort of denial. Just as the gay community and drug users were scapegoated for creating the AIDS epidemic in developed countries, so in the sub-Saharan region women are identified as the source of AIDS infection. "Is AIDS and prostitution separable" (Daily Graphic, 6-11-97) an African newspaper headline demands to know for the umpteenth time. No one conversant with the research would seek to deny the contribution of the sex trade to the spread of HIV in black Africa. What is to be faulted is the exclusivity of emphasis upon this fact. The ease with which the media and the population alike malign a group of women for causing disease is indicative of a wider attitude, which associates the feminine with vice and malevolence.

In many African communities painful widowhood rights on the death of a spouse subject the surviving wife to physical ordeals, which seek to purge her of presumed culpability for her husband's death. These frequently involve depriving her of food, forcing her into physical discomfort and putting pepper in her eyes. This form of assault may last for many weeks and is usually imposed at the hands of the deceased husband's family.

Regarding her supposed malevolence, in Ghana there are approximately 750 women in "witches camps" (Dept. of Social Welfare, 1997). These are usually older females who have been accused of witchcraft and ostracised from their communities. Gambaga camp in northern Ghana witnessed an increase in the number of women sent there during an 1997 outbreak of cerebro-spinal meningitis in the region (Public Agenda, 10-11-97). Reflecting the vulnerability of women in the face of grossly negative attributions are the widespread instances of lynchings. For example, in November 1998 four village elders were brought to court in Uganda on charges of inciting the murder of 50 women suspected of witchcraft in that country's eastern region (BBC World Service, 8-11-98). The targeting of sex workers as the source of the HIV infection has to be understood in a broader context of belief systems which associate women with misfortune and against which women are unable to defend themselves.

5. THE FAILURE OF AIDS AWARENESS

AIDS awareness has been the major weapon of developed countries in tackling the spread of HIV. These campaigns have concentrated on safe sex and limiting the number of sexual partners. Within these wider programmes social workers and health care professionals have operated at the level of family and small group intervention to reduce the stigmatisation of AIDS sufferers and improve their care. However, such approaches in Africa do nothing to ameliorate the problem.

During a recent field visit with an NGO outreach worker assisting street children in Accra I asked about her approach to AIDS education. She told me,

> I teach the children about STDs and AIDS and how to protect themselves. A lot of the girls are into prostitution to get some money. I explain to the children that they should use condoms and not have so many sexual partners.

When I asked if street girls could afford condoms or could realistically reduce the number of sex partners when they were completely dependent on these for income, the worker offered no answer.

This exchange typifies a response to the AIDS epidemic which, like its American and European counterparts, focuses on providing information. However, unlike developed countries where relative economic prosperity and financial independence enable most women to both purchase condoms and negotiate their use in sexual relationships, African women can accomplish neither.

6. SEXUAL RELATIONSHIPS

Up to 80% of women in the region who contracted the HIV virus had sexual intercourse only with their husbands (Hamblin & Reid, 1993). Married women are confronted with a series of obstacles to safer sex. Firstly, their lower literacy rates make them less likely than their husbands to have access to information on AIDS. Even in situations where they are informed, the high prevalence of other STDs such as gonorrhoea – present at rates 10-15 times higher than among women in developed countries and syphilis up to 100 times higher – leave women even more susceptible to HIV infection (WHO, 1994). Given that most women have no access to assets through inheritance and therefore cannot raise credit against securities, they are unable to afford treatment for STDs. In this sphere they are more often than not dependent on their husbands' willingness to pay for health care.

The nature of the male physique means that he must wear the condom. So she is reliant on his compliance to protect herself; she cannot take sole control, no matter how much she alters her own behaviour. In this endeavour she is confronted by a plethora of cultural norms which construct masculinity and femininity in ways directly at variance with her strategies for protection. In African societies polygamy is widely practised and masculinity is predicated on virility and fecundity. Women become central to men's social standing and that position rests upon their sexual relations both in terms of the number of partners and the number of children fathered. Child bearing therefore becomes a central determinant of women's social identity. Indeed, she cannot possess a viable identity without children. Such pro-natalist norms militate against contraceptive use by either partner. However, even in circumstances where a wife seeks safer sexual practices within marriage, she is confronted with the tenuousness of her material preservation. Without her own source of income she is unable to survive without him. In black Africa there are no social safety nets outside of kin. Women are locked into a political economy which determines their negotiating strength vis-à-vis their husbands. It is a negotiating position eroded to nothing by her financial dependency and a cultural milieu which will turn a woman's very conscience against herself as she bargains for safer sexual practices with her husband.

Even outside of marriage economic necessity continues to dictate sexual terms between men and women. It does so most particularly for the growing number of migrants who make up the majority of young people living on the streets of urban Africa in the absence of family support. Lower literacy rates and lack of access to other sources of income continue to force single women, often the mother of several children, into sexual liaisons to obtain material security. Whether married or unmarried the African woman is subject to a political economy which disempowers her within the most intimate of relations.

Poverty and socio-economic inequality within a framework of ascribed gender identities conspire to disable women from exercising choice within sexual relationships or compelling the fidelity of their partners outside of them. AIDS awareness disseminated through mass education campaigns have focused attention on barrier methods during intercourse and a reduction in the number of sexual partners. As Hamblin and Reid (1993) point out, these are interventions best directed at men. They are ineffectual in respect of the majority of women who have one permanent partner and are unable to negotiate the terms of their sexual relationship with them.

Mass education which brings information to remote rural constituencies has long been an effective channel of communication for community development and health workers. Other innovations such as peer education among street children, during which selected individuals are trained in AIDS awareness and then spread their knowledge through word of mouth to other children living on the streets, seek to reach the most disadvantaged groups (Apt & Blavo 1995; Mupedziswa, Matimba & Kanyowa, 1996). However, information delivery without empowering recipients to act

upon it is a meaningless excursion into AIDS prevention. It leaves workers with "the feel good factor", while creating anxiety among those at risk who cannot protect themselves.

7. NEW STRATEGIES FOR COMBATING AIDS

Managing the AIDS pandemic in sub-Saharan Africa demands an entirely different approach by social welfare agencies and non-governmental organisations to that of their counterparts in Europe and America. In the first instance, AIDS awareness premised on the Western model should be directed at men alone. New strategies should be developed to address the particular circumstances in which women find themselves. These initiatives must start from the actual socio-economic and cultural contexts of women's lives. They must also be anchored in the African social milieu and not the marketing techniques of the Western mass media. Paramount must be a strategic focus on the dynamic of inequality. A number of African women have already begun identifying viable routes to empowerment.

By demonstrating that sexual relations are a function of the marital political economy, Dolphyne (1991) deduces that negotiating leverage can only be derived from women's acquisition of an independent source of earnings. It is on the basis of this premise that she makes income generation the sine qua non of women's social emancipation. These initiatives are best supported by increased attention to micro-finance, which alleviates the anxiety of falling into bludgeoning debt by advancing small sums of money for income generation. This encourages borrowing by women who otherwise would be reluctant, as debt default usually becomes the husband's liability with its attendant threat to her marriage and security (Osei-Mensah, 1998). However, political economy is only one aspect of culturally patterned gender relations.

Ilumoka (1993), admonishing the tendency of Western feminists to concentrate upon rights, argues that, "The challenge before women in Africa ... is how to tap existing forms of resistance and learn from positive aspects of old modes of social organisations". In this context Obermeyer (1994) suggests that traditional kinship structures and systems of family decision making could act as positive forces in securing more reproductive choice for women. Censure by extended family members can operate to support wives in curbing their husband's promiscuity. Drawing on social arrangements normally condemned by women's movements, Diagne (1993) argues that polygamy can be a source of advantage for women. She contends that the presence of co-wives divides responsibility for domestic tasks and child rearing, permitting greater freedom to each woman in the pursuit of business activities. Here too is the possibility of a solidarity among women within the same marital relationship.

What is patent is that development and community workers in Africa must innovate beyond the formulations of Western industrialised societies. Social welfare agencies and non-governmental organisations must be more than well-wishers in the midst of AIDS awareness programmes. Educators and practitioners alike must seek out those societal structures and traditional strategies which African women use to resist the choices of others and assert their own. In discovering them professionals must broaden these avenues to women's efficacy for they are her only means of protection against AIDS.

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