

## CONTENTS

<b>I. Dimensions of the HIV/AIDS Pandemic.....</b>	<b>2</b>
<b>II. Consequences of the HIV/AIDS Pandemic.....</b>	<b>3</b>
Dimensions of a “Demographic Disaster”	
Macro- and Micro-Economic Impacts: Increased Poverty, Food Insecurity and Vulnerability to Disease	
<b>III. HIV/AIDS-Related Stigma and Discrimination.....</b>	<b>5</b>
<b>IV. Gender Inequality.....</b>	<b>7</b>
Legal Inequality	
Discriminatory Cultural Practices and Social Norms	
Violence Against Women	
Economic Inequality	
Discriminatory Access to Information and Gender-Related Barriers to Testing and Treatment	
<b>V. National and International Responses to the HIV/AIDS Epidemic.....</b>	<b>12</b>
Burdens on Health Workers and Health Infrastructure	
National Responses	
Regional Response	
International Response	
<b>VII. The Future of HIV/AIDS in Southern Africa.....</b>	<b>17</b>

## BACKGROUND: HIV/AIDS IN SOUTHERN AFRICA

Southern Africa is the epicenter of the global HIV/AIDS crisis. This chapter discusses the dimensions of the HIV/AIDS epidemic and its destructive impacts to-date on the populations and economies of the countries in the region. HIV-related stigma and discrimination and gender inequalities are prevalent in southern Africa and drive the epidemic, which results in deepening inequities for these and other already marginalized populations. National, regional, and international responses by governments, donor agencies, and civil society have varied in terms of policy formulation, funding initiatives, and research. But the future of the region is bleak in the absence of sustained commitments of financial and human resources, scaled-up, coordinated and innovative programmatic interventions, and perhaps most significantly, the political will to lead and address the crisis on all fronts with legal, political, socio-cultural and economic reforms.

### I. Dimensions of the HIV/AIDS Pandemic

The HIV/AIDS epidemic is devastating southern Africa.

<sup>1</sup> The region is home to approximately 30 percent of all people living with HIV/AIDS (PLWA), despite having only two percent of the world's population.<sup>2</sup> Among the highest in the world, national HIV prevalence figures in southern Africa are increasing in all southern African countries except Zimbabwe which dropped from 22.1 percent in 2003 to 20.1 percent in 2005.<sup>3</sup> Average national adult prevalence in the region at the end of 2005 was 19.0 percent;<sup>4</sup> Swaziland and Botswana have the highest HIV prevalence globally.<sup>5</sup> (See Table 1). Sub-populations may have even higher HIV prevalence; for example, over 40 percent of Botswana women age 25-34 are HIV-positive.<sup>6</sup>

**Table 1: HIV/AIDS National Adult Prevalence (ages 15-49) in Southern Africa<sup>7</sup>**

COUNTRY	PREVALENCE (%)*
Angola	3.7
Botswana	24.1
Lesotho	23.2
Malawi	14.1 (2005)
Mozambique	16.1
Namibia	19.6
South Africa	18.8 (preliminary data; under revision to assure comprehensiveness)
Swaziland	33.4
Zambia	17.0 (preliminary data; under revision to assure comprehensiveness)
Zimbabwe	20.1 (2006)

\* All data from UNAIDS 2006 Report on the Global AIDS Epidemic. Unless otherwise noted, data is from 2005.

HIV prevalence varies not only between countries, but also within country borders between rural and urban populations. Prevalence also varies by sex and by age. Whereas many southern African countries mirror patterns found in Zambia, where twice as many urban residents are infected with HIV as rural residents, the urban to rural ratio of HIV infection in sub-Saharan Africa ranges from 0.7:1 in the Gambia to 3.6:1 in Burundi.<sup>8</sup>

HIV disproportionately infects women and youth, for reasons discussed later in this chapter. In sub-Saharan Africa, fifty-nine percent of adults (defined as individuals age 15-49) living with HIV are female.<sup>9</sup> The disproportionate disease burden on women is even starker among young people.<sup>10</sup> Seventy-five percent of HIV-positive 15-25 year-olds in sub-Saharan Africa are female.<sup>11</sup> Youth are particularly vulnerable to HIV/AIDS, and nearly two-thirds of all HIV-positive young people reside in sub-Saharan Africa.<sup>12</sup>

## II. Consequences of the HIV/AIDS Pandemic

### *Dimensions of a “Demographic Disaster”*

Prior to the HIV/AIDS epidemic, mortality in southern Africa was principally driven by malaria, post-partum hemorrhage and conflict-related injury.<sup>13</sup> By 1998,<sup>14</sup> AIDS began to surpass all other diseases as the leading cause of death in the region.<sup>15</sup> In South Africa, for example, approximately 48 percent of all deaths in 2000 were attributed to AIDS.<sup>16</sup> In addition, the increased susceptibility of PLWA to other communicable diseases such as tuberculosis (TB) and malaria, and the facilitation of HIV transmission by these co-infections, has increased the death rates from these diseases.<sup>17</sup> There were approximately 986,000 AIDS deaths among southern African adults and children in 2006, accounting for one-third of global AIDS deaths that year.<sup>18</sup>

Only 17 percent of PLWA in need of treatment in sub-Saharan Africa were receiving ARV therapy at the end of 2005.<sup>19</sup> Lack of access to essential medicines directly depresses survival rates.<sup>20</sup> Increased incidence of AIDS and lack of access to treatment have resulted in significantly diminished life expectancy. For example, life expectancy in Namibia decreased from 54 years to 44 years between 1975 and 2005.<sup>21</sup> The current life expectancy at birth in most southern African nations is less than 40 years. Left untreated, HIV/AIDS is expected to decrease life expectancy for individuals born between 2004 and 2014 to less than 35 years in Swaziland, Zimbabwe, and Zambia.<sup>22</sup>

The epidemic’s widespread impact on life expectancies in the region has changed the demographic composition of southern Africa. As mentioned earlier, HIV disproportionately impacts young adults.<sup>23</sup> By 2025, the hardest-hit countries in the region expect to lose more than half of the projected population between the ages of 35-59 and over one-third of those under the age of 15.<sup>24</sup> This transition, from a pyramidal population graph to an hourglass shape, represents what has been described as a “demographic disaster” – the loss of a community’s most economically productive members.<sup>25</sup> Typically, younger adults have provided for children and older generations of extended families in both their homes and communities.<sup>26</sup> When these primary providers are sick with HIV and die of AIDS, the entire society bears the burden of the disease.<sup>27</sup> This demographic shift has already had a significant impact already over the course of a single decade. Whereas adults ages 20-49 accounted for 20 percent of all deaths in southern Africa between 1985 and 1990, almost 60 percent of all deaths

between 2000 and 2005 were in this age group.<sup>28</sup> The crisis of AIDS orphans is a particularly acute example of the implications of these population changes. For example, data released in July 2004 confirm that close to a million children in Zimbabwe have lost one or both parents to AIDS between the start of the epidemic and mid-2004.<sup>29</sup> Nearly 9 percent of sub-Saharan African children under the age of 15 have lost one or both parents<sup>30</sup> and by 2010, more than one in five children in Zimbabwe, Swaziland, Lesotho and Botswana will be orphaned, with over 80 percent having lost one or both parents to AIDS.<sup>31</sup>

*Macro- and Micro-Economic Impacts: Increased Poverty, Food Insecurity and Vulnerability to Disease*

Given the poverty of the region, the implications of the AIDS-driven demographic shift are profound. Southern Africa is one of the poorest regions in the world.<sup>32</sup> More than 40 percent of the population subsists on less than US\$1 per day<sup>33</sup> and over 72 percent of nonagricultural employment is informal.<sup>34</sup> Nearly one-third of the regional population was unemployed in 2005.<sup>35</sup> Despite overall regional economic growth, the number of people living in poverty is increasing in countries where income inequalities within populations—and particularly urban/rural and male/female dichotomies—are already pronounced.<sup>36</sup> In fact, AIDS has exacerbated the inequalities in wealth and mortality between rich and poor globally, reversing an equalizing trend and accelerating disparities.<sup>37</sup> In 2005, the percentage of people in sub-Saharan Africa living on less than \$1US per day was 17 percent higher than the next poorest region, South Asia.<sup>38</sup> Poverty at the macro level has created a favorable climate for the AIDS epidemic to propagate in countries ill-equipped to address it, which has in turn contributed to a further impoverishment of the region, primarily through a shrinking labor pool (formal and informal, paid and unpaid) and its impacts. It is estimated that there will be a greater than 25 percent decrease in the labor force in the most AIDS-affected African countries by 2025.<sup>39</sup>

Specifically, the HIV/AIDS epidemic has had harmful consequences for southern Africa's largely agricultural economy, particularly given the population's widespread dependence on subsistence farming for food consumption. While there have been significant negative consequences for other workforce-dependent sectors of African economies, particularly education,<sup>40</sup> health services,<sup>41</sup> mining<sup>42</sup> and manufacturing,<sup>43</sup> agricultural impacts have been particularly severe.<sup>44</sup> In most sub-Saharan African countries, agriculture accounts for an average of 30 percent of the national GDP and supports more than 70 percent of the population.<sup>45</sup>

The loss of income and crops resulting from the decrease in farm workers has resulted in increased malnutrition and hunger.<sup>46</sup> It is estimated that between July 2005 and May 2006, over 10 million people in Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe needed direct food aid;<sup>47</sup> the World Food Programme has requested another US\$289 million to provide regional relief efforts through 2007.<sup>48</sup> Over 40 percent of southern Africa's population is currently undernourished as defined by the UN World

Food Programme.<sup>49</sup> Beyond substandard nutrition, poverty is associated with compromised health status, particularly for PLWA.<sup>50</sup>

As noted, changes in agricultural practices and diminished food production have increased poverty and food insecurity on the individual and household level throughout the region, two factors that are both causes and consequences of the HIV/AIDS epidemic, and that particularly impact women, as discussed in more detail later in this chapter. HIV/AIDS impoverishes in many ways at the household level: HIV and co-infections such as TB decrease the ability of ill PLWA to support their families financially and care for dependents.<sup>51</sup> The resources needed to care for a relative with HIV or AIDS, including the cost of medicines, increased food needs and even funeral expenses,<sup>52</sup> often exceed a family's total income within a short period of time.<sup>53</sup> Workers and students, particularly if they are women or girls, often forego income-generating activities and educational opportunities in order to care for sick family members.

Income-seeking also increases vulnerability to HIV for individuals in southern Africa in several ways. Internal and cross-border migration driven by the search for work in the mining, transportation and fishing industries has increased the numbers of people, men in particular, infected with HIV.<sup>54</sup> Though declining, the promise of opportunities in South Africa's mining industry—and the ease of immigration for miners—favors migration of poor men from throughout southern Africa to mining colonies.<sup>55</sup> Similarly, many rural residents migrate internally to company towns and urban areas in search of work.<sup>56</sup> These circumstances of increased anonymity, decreased social support, and isolation from informational resources facilitate the spread of infectious diseases, including HIV.<sup>57</sup>

When separated from families and communities and isolated in single-sex makeshift dwellings, moreover, men are more likely to seek commercial sex or casual sex partners and less likely to use condoms, which may also be unavailable.<sup>58</sup> Other HIV risk behaviors, such as sharing needles for injection drug use, are more common in migrant communities.<sup>59</sup> Consequently, migration-propelled HIV transmission also fuels infection incidence in workers' home communities. For example, when HIV-positive truck drivers return home, they in turn may transmit HIV to their spouses or other sexual partners.<sup>60</sup>

### **III. HIV/AIDS-Related Stigma and Discrimination**

A key dimension of the regional pandemic is HIV/AIDS-related stigma, with acknowledged effects on the trajectory of both individual illness and the epidemic.<sup>61</sup> Both HIV-related stigma and discrimination are widespread in southern Africa.<sup>62</sup> Stigma and discrimination are the result of negative social and cultural associations, with taboo behaviors and marginalized groups identified with transmission of the HIV virus. In turn, they have created an environment of fear, secrecy and shame, facilitating new HIV infection and the unchecked development of AIDS.

Stigma arises when a community or authority links social differences to negative stereotypes and categorizes these “others,” at best, as different from and inferior to themselves; this results in loss of status<sup>63</sup> and the social sanctioning of prejudice,

domination and inequity.<sup>64</sup> HIV-related stigma developed out of an early association of AIDS with already marginalized populations—the poor, ethnic minorities, women, men who have sex with men, sex workers, and IV drug users<sup>65</sup>—as well as the association of AIDS with certain death.<sup>66</sup> Discrimination, which has been described as “stigma-enacted”<sup>67</sup> is unfair and unjust treatment directed at those who belong to, or are perceived as belonging to, a marginalized group.<sup>68</sup> Such treatment may take the form of denial of health care and other services,<sup>69</sup> exclusion from educational and work opportunities, subjection to exploitative conditions of work or increased vulnerability to sexual and other forms of violence.<sup>70</sup> Discrimination in turn reinforces social stereotypes and inequities and, for populations marginalized on more than one basis—for example, HIV status and gender and/or race—it has a multiplicative effect.<sup>71</sup>

HIV-related stigma, like other forms of stigma, has been described as “a process of devaluation”<sup>72</sup> and operates at several levels for PLWA. First, individuals stigmatize themselves. Self stigma arises from PLWAs’ tendency to conflate their own attributes with their HIV-positive status. Influenced by society’s stigmatization of persons with HIV, PLWA view themselves with blame, scorn and deprecation.<sup>73</sup> This “felt” stigma has the potential for powerful negative psychological consequences<sup>74</sup> and may act as a barrier to admission of HIV-positive status, seeking care and changing behavior.<sup>75</sup>

Second, health workers and other caregivers stigmatize PLWA. Health workers may fear infection (with or without access to universal precautions) or feel that resources are being wasted on individuals who are blameworthy or likely to die prematurely from AIDS.<sup>76</sup> As a result, they engage in discriminatory behavior towards those they suspect or know to have the virus, such as being less aggressive with diagnosis and treatment methods for these patients.<sup>77</sup> This stigma is exacerbated by health systems that offer inconsistent or unclear clinical protocols and insufficient training and support of healthcare workers.<sup>78</sup> Third, PLWA are ostracized by families, communities, employers and society at large (including through the media), and as a result may lose essential social support and become further isolated.<sup>79</sup>

Fear of being stigmatized, moreover, is a significant barrier to ascertaining one’s HIV status in the first instance through voluntary testing<sup>80</sup> and may persist even where actual, measurable stigma is on the decline.<sup>81</sup>

Both social and institutional discrimination exist and persist in many sectors throughout southern Africa. Individuals living with HIV and their families have been excluded from participating in community activities, school, and collective farming.<sup>82</sup> HIV-related discrimination in hiring has decreased the likelihood of employment for PLWA. According to the Southern African Development Community, PLWA are less likely to be hired and more likely to be denied promotions.<sup>83</sup> Female domestic workers, for example, are often dismissed if they disclose that they are HIV-positive.<sup>84</sup>

There is international consensus that HIV-related stigma and discrimination, whether individual or institutional, must be eliminated in order to combat the HIV/AIDS epidemic.<sup>85</sup> The advent of ARV treatment, by removing the specter of an AIDS “death

sentence,” and with the potential to reframe HIV/AIDS as simply another treatable medical condition and chronic disease, has been hypothesized as a significant facilitator for the decreased stigmatization of HIV/AIDS.<sup>86,87</sup> Inclusion of PLWA in governmental leadership and policy making—a principle that UNAIDS calls GIPA, or Greater Involvement of People Living with or Affected by HIV/AIDS<sup>88</sup>—and active PLWA-led community organizations and mobilization are demonstrably effective measures to reduce stigma and discrimination.<sup>89</sup> Innovative programs such as the Tshedisa Institute in Gaborone, Botswana, provide caregiver-specific confidential HIV testing and treatment, as well as counseling and support services to counter health care workers’ fears of stigma, reluctance to come forward for testing and treatment, and provider burnout.<sup>90</sup> Reduction of stigma prevalence—and reliable non-discriminatory provision of health care services—will in turn encourage more individuals to come forward for testing and treatment, as well as to engage in prevention activities such as condom use.<sup>91</sup> Clearly, however, HIV-related stigma is a complex social phenomenon that requires extensive interventions tailored to the particular social inequalities most extant in a given community.<sup>92</sup>

In southern Africa, given that stigma is created by and reinforces social inequality, and that hierarchical power relations underlie discriminatory acts, it stands to reason that women would be differentially affected by HIV-related stigma and discrimination. Indeed, this has been documented to be the case: women are more stigmatized than men with regard to HIV<sup>93</sup> and HIV-related stigma reinforces gender inequities.<sup>94</sup> As with other sexually transmitted diseases, women are blamed for the transmission of HIV, whether explicitly accused of engaging in sex work or witchcraft, or more obliquely being seen as scapegoats.<sup>95</sup> Moreover, social and cultural expectations for fertility, sexual availability and acquiescence to male partners’ demands, reinforce the stigmatization of prevention behaviors such as condom use, abstinence, or requests to partners to remain faithful or take an HIV test,<sup>96</sup> and further entrench fears of being labeled HIV-positive.<sup>97</sup> Thus, gender inequalities in particular must be considered in the context of addressing HIV-related stigma.

#### **IV. Gender Inequality**

Similar to HIV-related stigma and discrimination, gender-discriminatory laws and social and cultural norms, and the resultant gender inequalities, are significant drivers of the AIDS epidemic. Deepening inequities are also the devastating result of HIV/AIDS. Compounded by women’s and girls’ greater biological susceptibility to HIV transmission (see Box 1), the gender-disproportionate prevalence of HIV/AIDS must be understood in this context. Only a multisectoral approach that addresses gender discrimination in all its aspects can be expected to turn the tide in the region.

#### **Box 1: Biological Factors for Women’s Vulnerability to HIV**

Women’s greater vulnerability to HIV as compared with men has biological as well as social dimensions. In southern Africa, HIV is primarily transmitted through heterosexual sexual intercourse.<sup>98</sup> The vaginal mucosal barrier is particularly vulnerable to viral invasion and the resultant systemic infection,<sup>99</sup> and the vaginal vault provides a large

surface area for HIV transmission through semen, which contains a high concentration of the HIV virus.<sup>100</sup> The cells lining the vagina and cervix in the still-maturing genital tracts of young women provide even fewer barriers to the virus.<sup>101</sup> For similar reasons, women are at higher risk than men for other sexually transmitted infections (STIs) such as herpes simplex infection. STIs decrease mucosal integrity, increasing susceptibility to infection with HIV.<sup>102</sup> Moreover, forced sex, which is of serious concern in the region,<sup>103</sup> increases the likelihood of vaginal tears, facilitating the transmission of HIV.<sup>104</sup> Nutritional deficiencies also lower immunity and compromise genital mucosal integrity,<sup>105</sup> contributing to the greater biological vulnerability of women, who are more likely than men to be under- and malnourished, and contributing to increased risks of vertical transmission.<sup>106</sup>

These factors contribute to a significant increase in HIV transmission for a single unprotected incident of sexual intercourse for women as compared with men.<sup>107</sup> A study following 2200 sero-discordant and concordant HIV-negative married adults in Uganda over 7 years found that female partners were twice as likely as male partners to become infected and attributed this greater susceptibility to biological factors.<sup>108</sup>

### *Legal Inequality*

Women in southern Africa do not enjoy the same rights and full legal status as do men. All countries in the region have dual civil and customary legal systems (with the exception of Namibia, South Africa and Zimbabwe, which have incorporated customary rules into state law),<sup>109</sup> creating ambiguity, particularly in areas related to women's rights.<sup>110</sup> In the majority of cases, women in the region cannot own or register property in their own names, contract without a husband's permission, or inherit from a deceased spouse.<sup>111</sup> In Lesotho and Swaziland, for example, unmarried women remain under the guardianship of their fathers until they are married, the majority "in community of property," thereby becoming wards of their husbands.<sup>112</sup> Even where civil law or national constitutions grant some rights to women, conflicting customary law frequently prevails. For example, while the Namibian Constitution Married Persons Equality Act of 1996 and the Communal Land Reform Act of 2002 protect widows' rights to property in Namibia, women are routinely evicted from marital property upon their husbands' deaths in accordance with customary rule.<sup>113</sup> Failure by national governments to enact or enforce laws criminalizing intimate partner violence and marital rape,<sup>114</sup> and to enact or implement laws concerning custody and maintenance rights, have disenfranchised women and placed them in positions of subordination to male partners and other male relatives.<sup>115</sup>

There are some signs of progress on the legal front for southern African women, however, thanks in large part to efforts from women's movement activists and female parliamentarians.<sup>116</sup> For example, in December 2005 a female magistrate presiding over a local court in Lusaka, Zambia, held that women married under traditional law were entitled to a portion of marital property upon the husband's death or divorce.<sup>117</sup> Under the Zambian system, women married under customary law had been denied any share of marital property, even if they assisted in its acquisition.<sup>118</sup> While reforms to the legal



infrastructure are necessary, they are often piecemeal or merely symbolic and leave unchanged deeply embedded, gender-discriminatory cultural and social norms.

### *Discriminatory Cultural Practices and Social Norms*

Linked with and enforced by customary law, certain traditional norms and practices also contribute to women's low status and resultant vulnerability to HIV and AIDS by subordinating women and girls to male heads of household and financial providers. In Mozambique, for example, wives are traditionally subordinate to husbands who are the heads of family and sole decision makers.<sup>119</sup> The tradition of "widow inheritance," whereby a widow is forced to marry her deceased husband's brother in order to maintain clan relations and her status in the family, remains prevalent in some areas.<sup>120</sup> In Botswana, customary courts reflect social norms by viewing adultery as a crime only if it is committed by women, thereby legitimizing discriminatory stigmatization and punishment of women for having multiple sexual partnerships, while tolerating such practices among men.<sup>121</sup>

Traditional divisions of labor disproportionately burden southern African women with caring for family members with HIV/AIDS. Not only are women in southern Africa often responsible for running the household (without concomitant authority), they also have primary responsibility for caring for the sick.<sup>122</sup> The lack of resources, including money for health care fees, transport, medication, gloves and other materials for safe home care, particularly affect women charged with providing care for family and community members whose needs are not met by public health systems overwhelmed by the epidemic.<sup>123</sup> In this environment, girls are often removed from school in order to maintain the household, decreasing their future opportunities for self-sufficiency and thus increasing their vulnerability to HIV infection.<sup>124</sup>

Derived from traditional norms of gender roles and entrenched beliefs, social norms in most southern African countries, as in many others, dictate that men may, or even should, have multiple sexual partners,<sup>125</sup> thus putting women at risk for HIV infection even if they themselves are monogamous.<sup>126</sup> In addition, commonly held definitions of masculinity and the social recognition of manhood hinge to some degree on sexual activity, such that boys and young men are expected to show sexual prowess and fertility.<sup>127</sup> Men, moreover, are commonly said to lack control over their sexual desires, thereby legitimizing male authority, including forced sex with female partners, and denying women the right or expectation to refuse sexual relations or relationships.<sup>128</sup> Cultural norms dictate that women prove fertility prior to or shortly after marriage.<sup>129</sup> They are expected to remain faithful to one partner or suffer punitive results, in private at the hands of their husbands or families<sup>130</sup> or publicly, through community ostracization, violence or legal sanctions.<sup>131</sup>

### *Violence Against Women*

Violence against women in traditionally male-dominated cultures is frequently viewed as judicious discipline or normalized to the point of invisibility,<sup>132</sup> rather than acknowledged as an abuse that creates and maintains gender inequality. Given that most countries in the southern African region do not collect data on gender-based violence, it is difficult to

accurately measure the extent of the problem. Several studies present suggestive information, however. A study of three South African provinces revealed that nearly one-fifth to more than one quarter of women were physically abused by an intimate partner in their lifetime; of those reports, almost 7 percent included rape.<sup>133</sup> Another study in Soweto found that just over 50 percent of women had experienced violence from a partner at least once in their lifetime and 5 percent had been raped prior to the age of 15.<sup>134</sup> A WHO study conducted in Namibia reported that one in five women had experienced physical or sexual abuse over the course of a year.<sup>135</sup> Another study from Zimbabwe found that domestic violence accounts for over 60 percent of murder cases in the Harare courts.<sup>136</sup> The failure to condemn violence against women, coupled with legal impunity for perpetrators, has direct consequences for women's wellbeing, including vulnerability to HIV.

Violence against women both directly and indirectly increases their risk of HIV. The lack of control over decision-making experienced by women living in patriarchal societies is magnified for women living in situations of violence, such relationships being characterized by the exertion of power and coercive control by the violent partner. Forced sex facilitates the transmission of the virus [reference Box 1] and intimate partner violence as an independent factor has been linked to HIV-positive status among women in a study from South Africa.<sup>137</sup> Furthermore, women in violent sexual relationships are less likely to use condoms to prevent HIV transmission due to fear of provoking additional violence.<sup>138</sup> In one study among South African women age 15-24, women experiencing forced sex were nearly 6 times as likely as other women to use condoms inconsistently.<sup>139</sup>

Consequently, women currently in or having survived such circumstances may engage in sexual risk-taking, such as unprotected or transactional sex, out of limited opportunities for independence or the inability to negotiate safe relationships. For example, one study from Cape Town found associations between having a history of sexual assault and risk-taking behaviors, including increased numbers of sexual partners and incidents of unprotected sex. Women who had been abused were more than 5 times as likely to have exchanged sex for money or accommodation.<sup>140</sup> Violent male partners may present a greater risk for HIV transmission to women than other men: results of a recent study from South Africa found that perpetration of intimate partner violence by men is associated with men's sexual risk-taking, and more severe violence is associated with higher levels of risky behavior.<sup>141</sup>

### *Economic Inequality*

As mentioned previously, poverty is not only a result of the HIV/AIDS pandemic, but also fuels it; women are most adversely affected by this dynamic. As a result of recurrent food crises and extreme poverty in southern Africa, both women and men often take sexual and other risks in order to survive. For example, people discontinue their education, migrate to urban or mining centers, engage in unsafe work in the informal sector or in hazardous occupations, and exchange sex for resources such as money, food or accommodation.<sup>142</sup>

Given the widespread gender discrimination that results in limited economic and other opportunities for women and girls, they are more likely than men to remain in unsafe relationships and engage in transactional or commercial sex in order to survive and provide for their families.<sup>143</sup> In one study from Soweto, South Africa, for example, one-fifth of women interviewed at antenatal clinics reported ever having sex with a non-primary partner for money or other resources.<sup>144</sup> In the context of desperate financial circumstances, difficulty accessing resources and economic dependence on male sexual partners or other family members, and lacking the power to negotiate safer sexual practices, women are likely to agree to unprotected sex due to risk of losing economic support from their male partners<sup>145 146</sup>

In addition, as a result of the HIV/AIDS crisis, southern African women and girls increasingly find themselves as heads of households responsible for caring for HIV-positive loved ones, earning money and feeding their families.<sup>147</sup> In Botswana, for example, nearly half of all households are headed by women; these make up the majority of households living in poverty.<sup>148</sup>

Young women in southern Africa may seek older male partners (“sugar daddies”) for economic security and resources, such as school fees.<sup>149</sup> Such intergenerational sexual relationships carry high risks of HIV transmission. Early sexual debut, for both young women and men, is associated with having more sexual partners and a lower likelihood of condom use at first intercourse.<sup>150</sup> Moreover, older men are more likely to have had multiple previous sexual partners, increasing the likelihood that they are HIV-positive and therefore a transmission risk to their current partners.<sup>151</sup> This is especially salient because intergenerational sex reinforces the powerlessness of girls and young women, increasing the likelihood of forced sex, unprotected transactional sex and unsafe sex in general more likely and thereby increasing the risk of exposure to HIV.<sup>152</sup> In part as a result of the gender disproportionality in intergenerational relationships, sub-Saharan African women age 15–24 are three times more likely to contract HIV than their male counterparts.<sup>153</sup> Due to the youth of regional populations, this phenomenon has significant national impacts. For example, a 2005 South African national survey revealed that girls ages 15-19 who had sexual partners who were five or more years older had a 30 percent prevalence of HIV, compared with seven percent for girls in the same age group who had partners within five years of their own age.<sup>154</sup>

#### *Discriminatory Access to Information and Gender-Related Barriers to Testing and Treatment*

Another point of vulnerability for young women in particular is lack of knowledge concerning the transmission and prevention of HIV. Studies show that women and girls receive less HIV-related information than men and boys.<sup>155</sup> One major barrier to women and girls’ access to HIV/AIDS-related information is their inequitable access overall to education and employment. Girls are kept from school by lack of fees, lack of value placed on education for girls, duties in the home, discrimination on the basis of pregnancy, and lack of appropriate facilities, thus denying them not only a general education with its associated positive impacts on health and well-being,<sup>156</sup> but also valuable information regarding HIV prevention<sup>157</sup> and sexuality.<sup>158</sup> A UNAIDS study in

Uganda found that a child who drops out of school is three times more likely to have HIV in his or her twenties than a child who stays in school.<sup>159</sup>

The same denial of information takes place in workplaces, where discriminatory practices may prevent women from having access to the information and services, such as HIV testing, provided by some employers.<sup>160</sup> Throughout the region, moreover, there is a lack of HIV information specific to women's needs, for example, on the topics of breastfeeding and HIV, accessing assistance in situations of violence and caring for those living with HIV/AIDS.<sup>161</sup>

With regard to services, data indicate that women are more likely than men to be tested and treated for HIV. Testing and treatment sites in Botswana, for example, have reported that over half to nearly two-thirds of their ARV patients are women.<sup>162</sup> Médecins Sans Frontières reports that 70 percent of the patients in its treatment program in Khayelitsha, South Africa are women as a result of its connection to a PMTCT site.<sup>163</sup> However, women face distinct barriers to testing and treatment as compared with men, given their diminished control over decision making, financial matters and even their own bodies. In Zambia, for example, women cited discrimination and poverty as reasons that they could not receive ARVs; when financial resources are limited, often only the male partner receives treatment.<sup>164</sup> The Government of Botswana has recently recognized that special attention needs to be paid to the influence of male partners who have in some cases prevented women from enrolling in ARV treatment.<sup>165</sup> It is also worth noting that although it is an important means of connecting women to testing, services and treatment, less than 6 percent of pregnant women in sub-Saharan Africa were offered PMTCT services in 2005.<sup>166</sup>

## **V. National and International Responses to the HIV/AIDS Epidemic**

HIV/AIDS has presented a significant challenge to the largely under-resourced countries in the southern African region,<sup>167</sup> particularly to frontline health workers and the public health infrastructure. In addition, many national and international governments and donors have been slow to coordinate and scale up their evolving responses in testing, care and treatment, and in particular to address the gender dimensions of the disease and its impacts in concert with civil society and national populations.

### *Burdens on Health Workers and Health Infrastructure*

Health workers face a three-pronged challenge from HIV/AIDS: increased patient caseloads, risk of HIV as a result of the lack of guidelines and equipment for universal precautions, and stigmatization for caring for PLWA.<sup>168</sup> The AIDS epidemic has increased the work burden on health workers while simultaneously demanding new skills and expertise.<sup>169</sup> Meanwhile, the region was already poorly resourced in terms of health workers; for example, physician-patient ratios in southern Africa countries range from 77 physicians for every 100,000 people in South Africa to two physicians per 100,000 people in Malawi.<sup>170</sup>

The increasing demands of HIV/AIDS upon the African health workforce are worsened by the emigration of local health personnel to developed countries.<sup>171</sup> African physicians and nurses are leaving the continent for better living and work conditions overseas (“pull factors”) as well as out of a sense of frustration at being unable to practice up to professional standards given the inadequate health infrastructure in their home countries, including lack of drugs and equipment<sup>172</sup> (“push factors”). Developed countries have aggressively recruited (or “brain looted”)<sup>173</sup> countries throughout Africa for both newly trained and experienced health professionals.<sup>174</sup> The so-called “brain drain” has become so severe that in 2004 the United Kingdom’s National Health Service (NHS) tightened a ban on recruiting from poor countries.<sup>175</sup> Nevertheless, in the period 2004–2005, over 900 South African nurses and midwives joined the NHS register, as did 311 Zimbabweans.<sup>176</sup> Shortages in staff directly result in the denial of health care to already underserved populations, as health facilities are forced to provide substandard services or to close altogether.<sup>177</sup>

### *National Responses*

AIDS impacts every facet of life and society including health, development, culture and security; effective responses must be driven by national governments and tailored to address local needs.<sup>178</sup> In a March 2006 follow-up to the 2001 Declaration of Commitment on HIV/AIDS, UNAIDS recommended that national responses 1) be prioritized and evidence-based in line with national development plans; 2) have secure and sustainable funding; 3) address human resources shortages with increases in wages, benefits and training, among other measures; 4) institute legal reform and remove obstacles to establish access to essential HIV medicines and technologies; 5) ensure human rights are promoted and protected, HIV-related stigma and discrimination eliminated, and PLWA included and integrated at all levels of response; 6) address gender inequalities through legal reform and enforcement and the funding of gender equity programs and girls’ education; and 7) set ambitious targets, monitor progress and hold themselves and each other accountable for meeting goals.<sup>179</sup>

National governments in southern Africa have responded to the HIV/AIDS epidemic by drafting national policies, passing legislation, seeking donor funding, mounting prevention campaigns and implementing treatment programs, with varying degrees of comprehensiveness, universality and oversight. According to the WHO, the success of ARV treatment programs depends on areas where governments have fallen short: ensuring provision of appropriate HIV counseling and testing services; training and retaining adequate healthcare worker staffing; and management and supply of medications for opportunistic infections.<sup>180</sup>

Given the social, cultural and economic dimensions of the AIDS epidemic, the lack of human resources in many countries in the region, and the encouragement by international donors and policymakers for governments to work closely with civil society, non-governmental organizations (NGOs) have played a key role in the epidemic globally and in southern Africa. Especially significant have been their contributions to prevention and education campaigns, PLWA support provision, treatment access advocacy and anti-violence and women’s rights reform.

For example, the Treatment Action Campaign (TAC), a pioneering NGO in the region, was launched in South Africa in 1998 with the purpose of expanding ARV treatment.<sup>181</sup> To date, it has achieved several notable victories for PLWA in South Africa, including bringing a case before the Constitutional Court securing pregnant women the right to voluntary counseling and testing, health care and Nevirapine access to reduce vertical HIV transmission.<sup>182</sup> The Court ruled that the program be “realized progressively within available resources;” government funding was increased from R350 million in 2001-2002 to R1.8 billion in 2004-2005.<sup>183</sup>

### *Regional Response*

United by many common challenges, many NGOs in the region have worked collaboratively. The Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) in Zimbabwe provides regional capacity building for NGOs through policy analysis and research, dissemination of biweekly informational newsletters and through an accessible internet library of resources.<sup>184</sup> The Southern Africa Regional Poverty Network promotes similar informational sharing on critical issues impacting the region’s HIV/AIDS epidemic including poverty, food insecurity, governance, democracy, gender equality and land reform.<sup>185</sup> A global network of HIV-positive women, the International Community of Women Living with HIV/AIDS (ICW), has upwards of 4,000 members in over 90 countries.<sup>186</sup> ICW is working with WHO to promote equal access to prevention and treatment for girls and women through the Global Coalition on Women and AIDS.<sup>187</sup> In 2005, ICW joined with the International Center for Research on Women, the European Parliamentarians for Africa, the Centre for the Study of AIDS at the University of Pretoria, and Realizing Rights: The Ethical Globalization Initiative (EGI) to initiate a three-year project, *Parliamentarians for Women’s Health*. The coalition lobbies and educates legislators in Kenya, Tanzania, Namibia and Botswana and links them directly to networks of PLWA.<sup>188</sup>

Regional governments have also made joint efforts in the area of HIV/AIDS policy with inconsistent success. The Southern African Development Community (SADC) was formalized through declaration and treaty in August 1992 and committed its 14 signatories to a number of regional objectives. These objectives integrate poverty eradication and HIV/AIDS prevention and treatment<sup>189</sup> and recognize the importance of food security, reproductive health and other essential public services in the attainment of goals.<sup>190</sup> The SADC endorsed the Abuja Declaration in 2001 and reaffirmed its commitment to addressing the AIDS epidemic through strategic and comprehensive national and regional interventions in the July 2003 Maseru Declaration and the SADC HIV and AIDS Strategic Framework and Programme of Action 2003-2007.<sup>191</sup> Regional leaders convened in Maputo for the WHO Regional Committee Meeting in August 2005 declared 2006 “the year for accelerating access to HIV prevention” and launched a new prevention initiative spearheaded by African Ministers of Health. The initiative began in April 2006<sup>192</sup> and has proceeded in fits and starts. In two May 2006 conference documents, measurable health care, treatment and VCT access targets by 2010 were agreed upon.<sup>193</sup> The prevention initiative had a setback in June 2006, however, when the UN General Assembly’s Special Session on HIV/AIDS (UNGASS) Declaration did not

affirm the commitments laid out in May and civil society groups refused to endorse it, arguing that it is regressive and excludes important target groups: women and young girls, men who have sex with men and commercial sex workers.<sup>194</sup>

SADC members have also recognized the importance of setting gender equity goals in the region. In the SADC Gender and Development Declaration of September 8, 1997, member countries pledged to increase women's participation in government decision-making positions to at least 30 percent by 2005.<sup>195</sup> By the end of 2005, 9 of the 13 countries had less than 20 percent female representation in Parliament, Namibia (24.4 percent) and Tanzania (28 percent) were close to the goal, and only South Africa (32.75 percent) and Mozambique (33.3 percent) had achieved it.<sup>196</sup>

### *International Response*

#### Food Aid

Southern Africa's severe food insecurity compounds and exacerbates the HIV/AIDS crisis in the region. Periods of drought, sky-rocketing debt, ineffective governance and agricultural policies, failing or non-existent public services, and high HIV prevalence have directly threatened Angola, Malawi, Zambia and Zimbabwe with serious food shortages that have affected neighboring countries and created a humanitarian crisis.<sup>197</sup> In 2002-2003, the World Food Programme (WFP) provided emergency food assistance to an estimated 1.8 million Angolans, 3.1 million Malawians, 2.8 million Zambians, and 4.7 million Zimbabweans.<sup>198</sup> While food production improved in ensuing years, the Food and Agriculture Organization (FAO) warned in 2003 that because food stocks were not where they were prior to the depletion of limited reserves, and because of threats to communities' livelihoods due to AIDS deaths, the region would require food assistance for years to come.<sup>199</sup> Studies have shown that Namibia could lose up to 26 percent of its agricultural workforce by 2020 due to AIDS-related deaths, Zimbabwe up to 23 percent, Mozambique and South Africa 20 percent each, and Malawi 14 percent<sup>200</sup>. WFP requested US\$404.5 million to provide 656,573 metric tons of food assistance in southern Africa from January 2005 to December 2007.<sup>201</sup> USAID provided over half this emergency food assistance and made an additional US\$4.8 million commitment in February 2006.<sup>202</sup>

#### HIV/AIDS Policy

Given the overwhelming nature of the epidemic, the initial lack of technical expertise, and the widespread poverty and wealth inequity in the region, international agencies, NGOs, foreign governments and academic institutes have played a significant role advising the formation of policy, funding programs and infrastructure, and conducting research on HIV/AIDS in southern Africa. The region has been a focus of both biological and social science research into the high prevalence of HIV/AIDS and of potential interventions to address the epidemic and its effects.<sup>203</sup>

As mentioned previously, the United Nations, through the Joint United Nations Programme on AIDS (UNAIDS) and WHO, have assisted governments in developing a comprehensive, multi-sectoral approach to their HIV/AIDS epidemics and have provided guidelines for the formulation of coordinated, evidence-based national policies.<sup>204</sup>

In 2003, in a reversal of prior policy thinking around an exclusive emphasis on HIV prevention,<sup>205</sup> WHO initiated the “3 by 5” campaign. The program’s name comes from the intentionally<sup>206</sup> ambitious goal of increasing the number of individuals receiving ARV treatment globally from an estimated 480,000<sup>207</sup> to three million worldwide by the end of 2005 (50 percent of those estimated to be in need treatment).<sup>208</sup> By June 2006, over 1 million PLWA in sub-Saharan Africa were receiving ARVs, a ten-fold increase since December of 2003.<sup>209</sup> This accounts, however, for only 23 percent of the approximately 4.6 million people in the region in need of treatment.<sup>210</sup>

### HIV/AIDS Funding

The Global Fund to Fight AIDS, TB and Malaria was created by a UN General Assembly Special Session on AIDS in 1992, in response to UN Secretary General Kofi Annan’s call for its creation at the Abuja meeting in 2001 and after the endorsement and financial commitment of the G8 nations.<sup>211</sup> The Fund was established to raise, manage and disburse resources for combating the three preventable infectious diseases accounting for more than six million annual deaths worldwide.<sup>212</sup> The Global Fund distributes monies to national programs through grants, contingent on annual review.<sup>213</sup> In addition to specific disease prevalence targets, a stated goal of the Fund is to build health care infrastructure as an integral part of national HIV/AIDS responses.<sup>214</sup> While the Global Fund is an ambitious display of donor commitment to the fight against HIV/AIDS, donors have failed to meet their resource commitments<sup>215</sup> and there have been problems with implementation resulting in delays in the receipt and distribution of funds.<sup>216</sup> These problems include corruption in recipient governments<sup>217</sup> and lack of bureaucratic infrastructure to absorb large donations.<sup>218</sup>

The European Union and individual countries in Europe also donate significant funds to countries in southern Africa. In 2003, the European Parliament adopted a regulation on aid to fight “poverty diseases” in developing countries, in which member nations pledged financial and technical assistance to developing nations for HIV/AIDS, malaria and TB programs.<sup>219</sup> The European Union contributes approximately 50 percent of donor country funds to the Global Fund.<sup>220</sup> The European Council advocates for tiered pricing and reduction in ARV treatment costs.<sup>221</sup> Southern African countries have also received hundreds of millions of dollars in bilateral HIV/AIDS aid from the British Department of International Development (DFID), the Canadian International Development Agency (CIDA), the Norwegian government’s international aid agency NORAD, and from the governments of France, Italy and Ireland. The Japan International Cooperation Agency (JICA) is also a significant donor.<sup>222</sup>

In addition to the Global Fund and donor governments, a significant funding source for HIV/AIDS in sub-Saharan Africa is the US President’s Emergency Plan for AIDS Relief



(PEPFAR). Though the program focuses on fifteen countries, five of which are in southern Africa (Botswana, Mozambique, Namibia, South Africa and Zambia),<sup>223</sup> it is highly influential in terms of programming and US funding throughout the region. A certain distribution of funds that emphasizes treatment and care of PLWA is congressionally mandated. Over half the funds are designated for treatment, fifteen percent for palliative care, ten percent for orphan programs and 20 percent for spending on prevention initiatives.<sup>224</sup> The 2003 Leadership Act required that one-third of prevention funds be allocated for programming on abstinence before marriage. Office of the Global AIDS Coordinator (OGAC) policies for fiscal year 2006 directed 20 country teams to spend half of their prevention funds on prevention of sexual transmission, with two-thirds of these funds mandated for programs exclusively promoting abstinence and fidelity.<sup>225</sup>

The central philosophy of prevention under PEPFAR is known as ABC: abstinence before marriage; being faithful to one sexual partner; and failing A and B, consistent condom use.<sup>226</sup> PEPFAR has garnered criticisms from leading AIDS activists, including Stephen Lewis, the UN Special Envoy for AIDS in Africa, who see the ABC approach as ineffective<sup>227</sup> and as a “one size fits all,” epidemiologically-inappropriate intervention.<sup>228</sup> Critics charge that ABC is imposed in contexts in which the practices of premarital abstinence and monogamous relationships are not available to many women (particularly young women and married women whose husbands have multiple sexual partners), and they are opposed to its sidelining of condom use.<sup>229</sup> In an April 2006 report, the US Government Accountability Office (GAO) found that 17 out of 20 country teams were finding it difficult to address local prevention needs, particularly due to PEPFAR’s requirement that they spend over 33 percent of prevention monies on abstinence-based interventions.<sup>230</sup> While the initial monetary commitment of US\$15 billion appears to be on track,<sup>231</sup> questions have been raised concerning PEPFAR’s lack of financial transparency and the restricted ideological cast of its grantee pool.<sup>232</sup> Other critiques of PEPFAR have focused on its reliance on expensive brand-name drugs over generics<sup>233</sup> and the creation of a PEPFAR global supply chain duplicative of local systems and undermining local sustainability.<sup>234</sup>

Private foundations, such as the Bill and Melinda Gates Foundation and the Kaiser Family Foundation, which have invested millions of dollars in local, national and regional HIV prevention, care and treatment programs are another source of funds. Central to the Kaiser Foundation’s strategy is long-term investment and capacity-building in the development of effective institutions in the South African health sector.<sup>235</sup>

## **VI. The Future of HIV/AIDS in Southern Africa**

Despite the galvanization of enormous resources and attention to HIV/AIDS in the region, the future of the pandemic in southern Africa—and therefore, the future of the southern African countries themselves—is uncertain. Addressing the various epidemics will depend not only on medical and scientific advances in preventing and treating HIV/AIDS, but also on successfully implementing policy and programmatic reforms that make fundamental changes to the socioeconomic, cultural and political factors that are

driving the epidemic. Ending gender inequality, HIV-related stigma and discrimination and food insecurity, and mitigating poverty are central to the response in southern Africa, as these are root causes and consequences of the pandemic.

AIDS, accompanied by loss of human capacity and food insecurity, has been called a “triple threat” to the well-being, and, for the least populous ones, even the continued existence of countries in the region.<sup>236</sup> Regional scholars hypothesize that the current food shortage in the region will be distinctly more devastating than prior ones as a result of the HIV/AIDS crisis.<sup>237</sup> This “new variant famine” features labor shortages, decreased household-level assets and coping skills, increased burdens of care and associations between malnutrition and HIV which increase the hazards of going hungry in the face of an inadequate food supply.<sup>238</sup> Although the region has recovered from previous food shortages during times of droughts and conflict, population changes due to the AIDS epidemic, in particular the loss of rural women who are in large part responsible for the care of children and other dependents, suggest that this coping capacity has been greatly diminished. Widespread impoverishment, the shift in resources to food consumption away from educational or other social investments, and the continued breakdown of social cohesion are likely results. Destructive on their own, these are also factors which lead to sexual risk-taking, such as exchanging sex for basic resources, and therefore have the potential to greatly increase HIV transmission.<sup>239</sup>

The collapse of entire economies due to the loss of young people in the productive period of their lives can be prevented only by decreasing the incidence of infection and increasing access to treatment for PLWA. For example, one study revealed that South Africa’s overall growth rate over the coming decade will be 0.3 - 0.4 percent lower than it would have been in the absence of HIV/AIDS, resulting in a loss of US\$22 billion to its overall economy.<sup>240</sup> South African households will also be financially weakened by the epidemic; the same study revealed household disposable income would decrease by 13 percent per household member as a result of the costs of AIDS- and orphan-related care.<sup>241</sup>

Without widespread prevention, testing and treatment, the HIV/AIDS epidemic in southern Africa will continue to grow. UNAIDS has predicted that by 2025, if the response to the epidemic is not strengthened, 38 African countries will see populations 14 percent smaller than they would have been without HIV/AIDS.<sup>242</sup> Current projections predict an adult HIV prevalence of 14 percent in southern Africa in 2025.<sup>243</sup> While new infections are expected to taper off during that time period,<sup>244</sup> the cumulative total death toll since the beginning of the epidemic will have surpassed 83 million on the continent.<sup>245</sup>

Clearly, national and donor governments, international agencies and NGOs, national civil societies, and the general populations of the affected countries, must be mobilized in a comprehensive and coordinated effort to address all the dimensions of HIV/AIDS. Without leadership and a sustained commitment of resources, the devastation of the epidemic will continue to decimate the region.

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