CLUSTER 4 : HEALTH

S.A.H.A.R.A

Social Aspects of HIV/AIDS and Health Research Alliance

SWAA

Society for Women and Aids in Africa

1 - INTRODUCTION

1.1. HIV continues to be the most severe epidemic in West Africa. Of all the people who are infected with HIV worldwide, 70% live in Africa, even if Africa represents only 10% of the global population. Sub Sahara African countries represent the highest rates of new HIV infections per year. 60 % of all women, who live worldwide with the virus, are Africans. Furthermore, Africa has the highest number of orphans who lost their parents through the pandemic.

1.2. The social-economic impacts of HIV have a high influence on the African continent. HIV affects agricultural production, industry and economical and financial development. Moreover, educational systems as well as health systems are affected by the virus. HIV / AIDS provokes a reduction of the production of agricultural products. Moreover, certain branches of the agricultural sector have to be abounded, because of the loss of up to 25% of the work force. Women are highly affected by the pandemic. Different studies show that the income per person has been reduced several times by 0.7% perhaps due to the social-economic impacts of HIV /AIDS. The income per head augmented normally 1.1% per year, but between 1990 and 1997 the income progress was only 0.4%. It must be acknowledged that also before the HIV /AIDS pandemic highly influenced the African economy, there were several inequalities related to these sectors of study. However, HIV can be described as a factor, which can intensify the social economical misery and provoke a vicious cycle between the virus and poverty. Furthermore, the often observed phenomenon of the feminisation of poverty in Africa seems to influence and foster the feminisation of HIV in Africa.

1.3. Moreover, in context with the HIV epidemic, the further development of tuberculosis has been observed. However, the context between tuberculosis and its development has been highly marked by high mortality, infectious diseases and the expansion of non- transmissible diseases.

1.4. HIV /AIDS in combination with the status of women in Africa, their living conditions and the gender situation make African women socially and economically vulnerable. Additionally, women have less access to treatments and they often have to take care of people living with the virus and of

orphans and children, which are affected by the virus. Women are the object of strong stigmatisation and discrimination in relation to HIV and its victims.

1.5. The improvement of living conditions of women, the change of their status and the fight against gender imbalances mark one of the main points of the declarations of actions of the United Nations and of the meetings of the political leaders of different African states. Together they build a central force, mobilizing civil society against the HIV pandemic

1.6. This report represents the situation of HIV in Africa and analyses the political responses, highlighting different plans related to health and legal and socio-economic issues.

2 - METHODOLOGY

2.1. The methodology which is used in this report is based on the analyses of annual reports of UNAIDS, WHO, UNDP, the World Bank and other UN agencies.

2.2. The report is also based on demographic and health related reports and studies, which were undertaken in different African countries. Additionally, this rapport counts some studies done by members of SAHARA (Mali, Guinea, Guinea Bissau, Benin, Côte d'Ivoire, Mali, Mauritania, DRC, Gambia, Cape Verde, Mauritius, Egypt, Burkina Faso, Cameroon, Kenya, South Africa, Ghana, and the Central African Republic).

3 – GENERAL SITUATION OF WOMEN LIVING WITH HIV IN AFRICA

3.1. It is a fact that women living in the Sub Saharan African region constitute majority of persons living with HIV in Sub Saharan Africa. In certain countries, women aged between 15 and 24 years face a six times higher risk of infection of the virus than men of the same age category. The situation of young people in general is even more worrying. More than half of all new infections of the virus occur in the age category under 25 years. In this category, women are the most affected group. The prevalence of women between 15 and 24 infected by HIV in all African countries averages 4.3% (estimation between 3.7% and 5.1%). For men of the same age group, the prevalence amounts to 1.5% (estimation between 1.3% - 1.7%). The highest prevalence of the virus (related to women aged between 15 and 24 years) can be found in Southern Africa where in certain countries the infection rate is higher than 20%. By comparison, only an estimated percentage of 5% of men of the same age category are affected by the virus.

3.2. *Table 1: Prevalence of HIV infections of women and men aged between 15-24 years in Sub Saharan Africa*.

Countries	% of women	Interventions	% of men	Interventions
Angola	2.5	[1.2 - 4.2]	0.9	[0.4-1.4]
Benin	1.1	[0.6 - 1.8]	0.4	[0.2-0.6]
Botswana	15.3	[15.2 - 20.3]	5.7	[5.6-7.5]
Burkina Faso	1.4	[0.8 - 2.0]	0.5	[0.3-0.6]
Burundi	2.3	[2.0 - 2.7]	0.8	[0.7-0.9]
Cameroon	4.9	[4.4 - 5.3]	1.4	[1.3 – 1.6]
CAR	7.3	[2.7 - 13.1]	2.5	[0.9 – 4.5]
Chad	2.2	[0.9 - 3.9]	0.9	[0.4 – 1.6]
Comoros	<0.1	[<0.2]	<0.1	[<0.2]
Congo	3.7	[1.9 - 5.7]	1.2	[0.6 – 1.9]
Côte d'Ivoire	5.1	[2.6 - 7.9]	1.7	[0.9 – 2.9]
DRC	2.2	[1.0 - 3.8]	0.8	[0.3 – 1.3]
Djibouti	2.1	[0.5 - 4.6]	0.7	[0.2 – 1.6]

Equatorial Guinea	2.3	[1.8 - 2.7]	0.7	[0.6 – 0.9]
Eritrea	1.6	[0.7 - 2.7]	0.6	[0.3 – 1.0]
Gabon	5.4	[2.7 - 8.7]	1.8	[0.9 – 3.0]
Gambia	1.7	[0.7 - 2.9]	0.6	[0.2 – 1.0]
Ghana	1.3	[1.1 - 1.5]	0.2	[0.2 – 0.3]
Guinea	1.4	[1.1 - 1.6]	0.5	[0.4 – 0.5]
Guinea Bissau	2.5	[1.1 - 4.3]	0.9	[0.4 – 1.5]
Kenya	5.2	[4.5 - 6.0]	1.0	[0.9 – 1.2]
Lesotho	14.1	[13.3 - 15.0]	5.9	[5.5 – 6.2]
Madagascar	0.3	[0.1 - 0.6]	0.6	[0.2 – 1.3]
Malawi	9.6	[3.9 - 16.8]	3.4	[1.4 – 5.9]
Mali	1.2	[0.9 - 1.5]	0.4	[0.3 – 0.5]
Mauritania	0.5	[0.2 - 1.0]	0.2	[0.1 – 0.3]
Mozambique	10.7	[6.0 - 15.8]	3.6	[2.0 – 5.3]
Namibia	13.4	[15.2 - 24.7]	4.4	[1.7 – 8.1]
Niger	0.8	[0.3 - 1.4]	0.2	[0.1 – 0.4]
Nigeria	2.7	[1.3 - 4.4]	0.9	[0.4 – 1.5]
Rwanda	1.9	[1.9 - 2.0]	0.8	[0.7 – 0.8]
Senegal	0.6	[0.2 - 1.1]	0.2	[0.1 – 0.4]
Sierra Leone	1.1	[0.6 - 1.7]	0.4	[0.2 – 0.6]
Somalia	0.6	[0.3 - 1.1]	0.2	[0.1 – 0.4]
South Africa	14.8	[13.2 - 16.3]	4.5	[4.0 – 4.9]
Swaziland	22.7	[11.5 - 35.9]	7.7	[3.9 – 12.1]
Togo	2.2	[1.0-3.6]	0.8	[0.4 – 1.2]
Uganda	5.0	[4.2-5.7]	2.3	[1.9 – 2.6]
Tanzania	3.8	[3.4-4.2]	2.8	[2.5 – 3.1]
Zambia	12.7	[11.9 – 13.6]	3.8	[3.6 – 4.0]
Zimbabwe	14.7	[7.7 – 23.2]	4.4	[2.3 – 6.9]

Source: UNAIDS, 2006

3.3. Based on the information given by demographic and health studies, it is evident that in practically all African countries (except Botswana), men have a better knowledge of HIV than women. Young men aged between 15 and 24 years have shown a better knowledge and comprehension of HIV than women of the same age group.

3.4. The following table shows that in African countries, women and men aged between 15 and 24 years are barely informed about HIV / AIDS. None of the chosen countries has reached a knowledge percentage higher than 50 %.

3.5. *Table 2: Percentage of young people (15-24 years) who have basic knowledge of HIV / AIDS.*

Country	**Men**	**Women**
Benin	14.0	8.0
Botswana	33.0	40.0
Burkina Fasso	23.0	15.0
Burundi		
Cameroon	34.0	27.0
Chad	21.0	8.0
Congo		
Eritrea		37.0
Ghana	44.0	38.0
Kenya	47.0	34.0

Madagascar	16.0	19.0
Mali	15.0	9.0
Mozambique	33.0	20.0
Nigeria	21.0	18.0
Tanzania	49.0	44.0
Zambia	33.0	31.0

Source: ONUSIDA, 2006

3.6. The vulnerability of young women seems even more evident with the supposition that young men between 15 and 24 years often have sexual relations before the age of 15 years. That leads to the assumption that young women are probably infected by older men.

3.7. In countries in which it is more common for women aged between 15 and 24 years to have sexual relations before the age of 15 years, there exists a strong percentage of early marriages of young girls. In these cases, the girls are often infected with HIV by their husbands. Examples are Mali, where 26% and 10% of women and men respectively have early sexual relations, Mauritania (13,.2% and 2.1%) and Nigeria (20.3% and 7.8%).

3.8. The analysis of the situation of HIV in Africa has shown that many pregnant women live with the virus. In this case, very few African countries have registered this female group of HIV victims. Notable progress (2000 –2005) in relation to the treatment and registration of pregnant women, who live with HIV, has been seen in Angola, Burkina Faso, Burundi, Ethiopia, Uganda and Zimbabwe.

3.9. The vulnerability of women who are married or in a stable relationship, seems even more evident when taking into account the percentage of persons between 15 and 24 years, who had sexual relations within the last 12 month with a person other than their husband / spouse or regular partner.

3.10. *Table 3: Percentage of women and men aged between 15-24 years who had sexual relations with a person other than their husband / spouse or regular partner within the last 12 month*

Country	**Women**	**Men**
Burkina Fasso	82.0	19.0
Cameroon	86.0	41.0
Côte d'Ivoire	91.0	51.0
Ethiopia	64.0	7.0
Guinea	92.0	23.0
Kenya	92.0	39.0
Malawi	71.0	17.0
Rwanda		42.0
Tanzania		87.0
Togo		89.0
Uganda		59.0
Zimbabwe		82.0

Source: UNAIDS, 2006

3.11. Finally, prevention programmes, which take place in most African countries, do not seem to have in the majority of the cases any significant impact. The objective of the Declaration of Action against HIV / AIDS is the reduction of 25% of HIV infections of young people (15 to 24 years) during 2000 to 2005. The measures of this plan have to be reviewed and strengthened regarding the rights and protection of young women and married women. At the same time, political declaration and engagements have to be strengthened in terms of socio-economic and material issues.

3.12. In all African countries and especially in those with a low prevalence of HIV, female sex workers face a higher risk of becoming victims of the virus related to their status, the prevalence of HIV and

limited financial aid to fight against the pandemic. These problems are reflected in the case of female sex workers in Ghana, where they constitute the most vulnerable group and receive the least financial benefits.

4 – EVALUATION OF POLICY RESPONSES

4.1. Generally, the comparisons between studies at the start of the epidemic and the actual studies show the tendency of improvement (reduction) in terms of the percentage of young men and women, who have sexual activities before the age of 15 years. This tendency is very clear in 9 of 14 countries. It has to be accompanied by productive responses from different sectors and the sensibilisation in relation to the virus, the acceleration of girls' education and the elimination of socio-cultural and economic limitations and dangers.

4.2. It seems that the majority of the African countries has not accomplished the objectives related to the Declaration of Action against HIV, which consisted of assuring essential prevention to 50% of young people (2005). Only two African countries (Malawi and Swaziland) out of ten with available data have succeeded in offering comprehensive HIV education in 90% of all schools.

4.3. Several African countries have been engaged in facilitating access to HIV treatment. However, the coverage of countries with anti-virus treatment is still highly unequal. (Examples: in Central Africa only 3% of treatments in demand are available compared to 47% in Senegal and 85% in Botswana). The mother-child transmission prevention programmes show highly different results, due to the different situations in terms of coverage and the import of anti-virus medicine (2003 to 2005).

4.5. *Table 4: Prevention transmission mother-child / anti-virus prophylaxis*

Country	% of pregnant women infected with HIV, receiving anti-virus treatment to reduce the transmission between mother and child	% of pregnant women infected with HIV, receiving an anti-virus prophylaxis	% of pregnant women infected with HIV, receiving anti-virus treatment to reduce the transmission between mother and child	% of pregnant women infected with HIV, receiving an anti-virus prophylaxis
Angola		0.0	23	
Benin	0.0[1]	94.0	18.0	38.0
Botswana	34.0	18.8		
Burkina Faso	<1.0	0.1		1.1
Burundi		1.2	13.2	2.4
Cameroon		6.9		4.2
Central African Republic			16.4	
Chad	0.0[1]			0.2
Comoros				
Congo		13.3	98.6	
Democratic Republic of the Congo		0.6		
Côte d'Ivoire		1.5	4.4	4.3
Djibouti				
Equatorial Guinea				
Eritrea		0.9		

Ethiopia	<1.0	0.2	3.0	0.3
Gabon			10.7	0.7
Gambia		2.8		16.6
Ghana		1.3	0.5	1.3
Guinea		0.0		0.4
Guinea-Bissau			19.5	
Kenya	1.0	3.4	9.3	27.0
Lesotho			5.3	5.1
Liberia				
Madagascar			0.0	0.0
Malawi	<1.0	1.7	2.3	
Mali		0.5	0.7	0.8
Mauritania		40.4		
Mauritius	100.0			
Mozambique		1.3	4.9	3.4
Namibia	7.0	1.3	25.0	17.4
Niger	0.0[1]			
Nigeria	<1.0	0.1		0.2
Rwanda		13.8	9.4	
Senegal		0.4		1.4
Seychelles	100.0		97.7	
Sierra Leone	0.0			
Somalia			3.3	
South Africa	<1.0[1]	8.9	78.7	14.6
Swaziland		1.4	16.2	11.9
Togo	4.6	0.3	32.8	1.8
Uganda		6.6	12.0	25.9
Tanzania	0.0	0.3		
Zambia		6.3	25.0	4.0
Zimbabwe		4.1	6.6	4.4

Source: ONUSIDA, 2006

4.6. The lack of access to anti-virus treatment for women and in particular pregnant women leads to the urgent discussion of the stigmatisation and discrimination of women living with the virus. SAHARA has collected information in twenty countries, in which the organization runs programmes, related to women, AIDS and their discrimination and stigmatisation. SAHARA has documented cases in which women have been abandoned, rejected by society or excluded of their heritage rights. Legal measures protecting infected women are hardly existent in the majority of African countries - and in countries, in which a corresponding legal framework exists, it is hardly ever used.

4.7. The information, provided by UNAIDS does not permit to name the clear number of African countries which have accepted or introduced new laws and rights to protect persons, who are living with HIV. However, different consultations exist between African countries, the ECOWAS and different parliaments. In fact, they are discussing projects to ensure the legal protection of persons living with HIV. To date, the section on women's rights and their protections in these projects seems quite limited.

4.8. The majority of legislation in Africa related to human health and reproduction is exclusively focused on the traditional framework of family and marriage. However, women in sexual relationships, who do not fit into this traditional framework, are hardly protected.

4.9. The traditions and codes of conduct of the society / family can perpetuate sexual inequalities. Furthermore, a patriarchical system can intensify the vulnerability of women with HIV. For example, in Senegal the «family code» promotes early marriages – girls get married at the age of 16 years and boys at the age of 18 years. The man is considered as the chief of the family (a position which gives him sexual and social control over his wife and children). In the context of AIDS, the majority of

women have been contaminated by their husbands. Furthermore, polygamy is an accepted option by family traditions, while polyandry is not. In this context of social inequality and lack of economic autonomy, women have hardly any chance to oppose the traditional system (polygamy).

4.10. In the majority of African countries, the legal framework suppresses sexual relations between men. These legal measures make access for homosexual men to HIV prevention much more difficult. HIV prevalence of 20% was noted in Senegal among homosexual men. The general HIV prevalence in Senegal is 0.7%. In some cases, men frequently have sexual relations with men as well as with women. In this context, women re-enter a vicious cycle of victimisation and HIV.

4.11. Between 2001 and 2005, public expenses of African states fighting against HIV /AIDS has considerably augmented (130%). In 2005, approximately 641 million dollars were invested for the fight against the virus and its consequences. The most important augmentations have been noted in South Africa and Botswana.

4.12. *Table 5: Domestic and public expenses (in millions $)*

Country	2001	2002	2003	2004	2005
Angola				$8.90	
Benin				$10.60	
Botswana	$69.80				$165.00
Burkina Faso	$2.20	$5.40	$9.30	$11.00	$8.00
Burundi		$5.70	$5.70	$18.60	$14.00
Cameroon					$4.40
Central African Republic			$0.60		$0.70
Chad			$0.20	$0.50	$0.90
Congo			$0.10	$0.10	$4.70
DRC					$3.60
Côte d'Ivoire			$1.80	$5.20	$5.80
Djibouti					
Equatorial Guinea					
Eritrea					
Ethiopia					
Gabon					$6.70
Gambia				$5.50	
Ghana		$2.50	$9.30		
Guinea			$0.20	$0.20	$0.30
Guinea-Bissau	$0.50	$0.50	$0.50	$0.50	
Kenya		$22.10	$33.10	$33.20	
Lesotho				$1.30	$1.40
Liberia				$0.10	
Madagascar			$0.10	$0.20	$0.20
Malawi	$3.10	$4.50	$5.40	$10.70	$8.70
Mali				$3.50	
Mauritania					
Maurice				$0.10	
Mozambique				$2.60	
Namibia			$35.00		$38.60
Niger					
Nigeria			$6.40	$6.50	
Rwanda			$1.30	$2.70	$1.70
Senegal			$5.90	$11.90	

Sierra Leone					
Somalia					
South Africa	$79.50	$121.20	$219.20	$340.50	$446.50
Swaziland			$2.60		$4.00
Togo			$0.70	$0.90	$0.60
Uganda				$18.80	
Tanzania	$2.80		$5.60	$22.10	$45.00
Zambia					$32.00
Zimbabwe			$6.30	$9.90	$12.10

Source: UNAIDS, 2006

4.13. It remains difficult to estimate the amount of money from the budget that went directly into projects and programmes, which are conceptualised to promote women's protection and women's rights.

4.14. There are only very view studies on the situation of women and gender and socio-cultural aspects which could influence the introduction and development of new technologies in terms of prevention, studies and courses (circumcision, oral prophylaxis, vaccine, etc.).

CONCLUSION

Sustainable progress has been realized regarding the Declaration of Action against AIDS and the conferences in Abuja and Maputo.

Even if the global situation of HIV /AIDS continues to look worrying and indicates alarming tendencies, signs of hope remain in several countries, which show a lowering prevalence or growing stability in terms of HIV.

The mobilization of women has grown in all African countries, leading to recognition of the issue as well as to the development of laws and specific programmes. However, in the majority of all cases, these programmes are still very limited and financial funding is cumbersome and often insufficient. Additionally, the structural changes initiated to transform the social system are slow and time-consuming. However, the mobilization of states and civil society could help constructing necessary and useful frameworks and impacts.

RECOMMENDATIONS

- It is urgent, that African States, civil society and the engaged entities pool their forces to support social science research as well as measures to analyse gender and socio-cultural aspects, which victimise and discriminate women. These studies will help to elaborate continental and local strategies to transform this situation of vulnerability.

- It is necessary to implement different strategies to evaluate projects and programmes conceptualized to fight against HIV and to take (according to experiences gained) new decisions.

- It is important to foster and support women's associations and the dynamics of research at the continental and local level to secure and support female leadership in the fight against HIV.