Women pay the price

HIV/AIDS and social inequalities

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argue that strategies around HIV/AIDS need to address social inequality and the empowerment of women.

Since the beginning of the AIDS epidemic, 50 million individuals have been infected with HIV and over 16 million have died worldwide. In 1999, AIDS deaths, internationally, reached a record 2,6 million with a further 5,6 million adults and children becoming infected. In 1990, 1% of pregnant women attending ante-natal services in the public sector in South Africa were HIV positive. By the end of 1999 this figure had risen to 22,4%. Furthermore, it is estimated that over 1 500 South African's are infected with HIV daily. Recent figures indicate that one in eight adults (15 to 49 years of age) is infected with HIV in South Africa.

The HIV/AIDS epidemic is clearly the most serious health and development crisis facing South Africa in the new millennium. Its social and economic costs will be devastating. It is predicted that in 2003, the HIV prevalence rate will be 12% among highly skilled workers, 20% among skilled workers and 27,2% among low skilled workers. Yet the burden of this epidemic does not fall evenly or equally: the overwhelming majority of those currently living with HIV/AIDS are young African women in developing countries. It is these women who are most susceptible to infection, have the highest rate of infection, get the most inadequate and inferior access to treatment, take most responsibility for caring for the sick and dying, and have the shortest survival rate.

An examination of recent South African patterns of infection and death from AIDS-related illness, strikingly reflect broader social cleavages and inequalities. Literature and health education programmes, which argue that individual behaviour needs to be challenged and altered before transmission rates will decline are naive, misplaced and misleading. Campaigns in South Africa to this effect have failed to curtail the epidemic. While behaviour patterns cannot be ignored, we argue that social inequality is the greatest transmitter of HIV/AIDS. Strategies for change need to address social inequality and the empowerment of women in particular.

Health and social inequalities

Research shows that systematic inequalities in health exist across a range of social dimensions such as social class or occupational groups, gender, race and geographical location. These dimensions interact with and produce a complex social pattern of differences in health and illness across populations. We emphasise

the relationship between gender and health to signal the particular position of women in the epidemic.

All societies continue to be divided along the 'fault line' of gender, which affects the health and wellness of both men and women. In South Africa and developing countries generally, it is primarily (and increasingly) young women who get sick and die from HIV/AIDS. A full discussion between gender inequality and HIV/AIDS needs an examination of infection rates for both men and women. However, this paper is mainly concerned with the impact of HIV/AIDS on women because, as Doyle points out 'gender differences are especially significant for women, since they usually mean inequality and discrimination'.

A recent base-line study *Key Indicators of Poverty in South Africa* revealed that South Africa still has one of the worst records in terms of social indicators and income inequality. About half (44%) of South Africans were poor. Nearly 95% of poor people were African. While population estimates (based on the 1996 Census) generally reveal similar numbers of men and women living in urban areas, in non-urban areas, 53% of the population are women. This is in line with the population figures nationally where women comprise 52%. Women predominate in the poorest areas – the rural areas. Moreover, a household headed by a woman is more likely to be poorer than one headed by a man.

Women's position is worsened by the fact that unemployment rates are higher for women than men in all racial categories. In 1995, 47% of African women and 29% of African men were unemployed, compared to only 8% of white women and 4% of white men. On average women earn between 72 and 85% of what men with a similar education earn and continue to predominate in low skilled and low paid occupations. Only 22% of all managers are women, and half of these are white women.

The marginal position of particularly African women in the South African economy is in part due to their limited access to education, historically. For example, in South Africa in 1995, 23% of African women aged 25 years or more had no formal education at all, compared to 16% of African men. Over a quarter of African women had not passed grade 5 (Std 3), compared to one fifth of African men. A household survey conducted in 1995 found that 31% of African women who had not studied as far as they wanted said they had dropped out because of pregnancy.

These figures indicate that young African women are the poorest, most economically marginalised and least educated sector of the South African population. This places them at the bottom of the health pile in this country, and renders them particularly vulnerable to HIV/AIDS, in terms of their race, gender and class position.

Women's 'vulnerability'

What makes people vulnerable to ill-health or certain diseases? At a macro level, countries experiencing political and/or economic instability are more vulnerable to diseases spreading (including HIV/AIDS) and health care systems collapsing. At the level of specific social groups and individuals who are at greater risk or more vulnerable, there are competing social and psychological explanations such as 'learned helplessness', 'social disorientation', and 'individual coping mechanisms'.

All these explanations, be they social or psychological, highlight different access to resources. From lack of entitlement, political and economic power on the national level, to lack of social and cultural capital (empowerment) of communities to individual's inability to mobilise family and

personal resources. In this context, poverty and gender emerge as the main factors which limit the size and nature of resources available.

Poverty clearly affects both males and females, but women and girls are often subject to further discrimination, which compounds their disadvantaged position and places them in an even more vulnerable position. There is evidence to suggest that women's physical and psychological security might be compromised due to lack of support within the household. Being socialised as a member of a less valuable group shapes and influences women's ability to develop psychological resources, which help them cope with disease. In many societies they are also encouraged to put the well being of others before their own. In addition, a lack of adequate nourishment and unequal access to health care means that sometimes their most basic needs are not met. This is compounded by growing levels of sexual violence, domestic violence and rape in South Africa.

HIV/AIDS in South Africa

Inequalities and health status

Geographical location is a key measure of inequality. Despite efforts to redress past inequalities (particularly at the level of health care services) there are striking inequalities between the nine South African provinces on various levels.

Racial composition (population group) varies greatly between the provinces (Figure 1) – this is of particular significance in the South African context due to the relationship between class and race, in part because of the legacy of apartheid. It also acquires additional significance once examined in combination with socio-economic status by race (Figure 2), unemployment rates (Figure 3) and disposable income (Figure 4).

Socio-economic status is a good indicator of burden of disease. The lower the socio-economic status of a community the more likely it is to be unhealthy. The data in Figure 2 reveal the great differences between racial groups where 94% of the white population, in contrast to only 14% of the African population, has a high socio-economic status. The unemployment rate at the time of the 1996 population census was 34%. An analysis of unemployment rates by provinces (Figure 3) identifies four provinces with higher unemployment rates than the country as a whole – Eastern Cape (49%), Northern Province

Figure 1: Population group by province, 1996

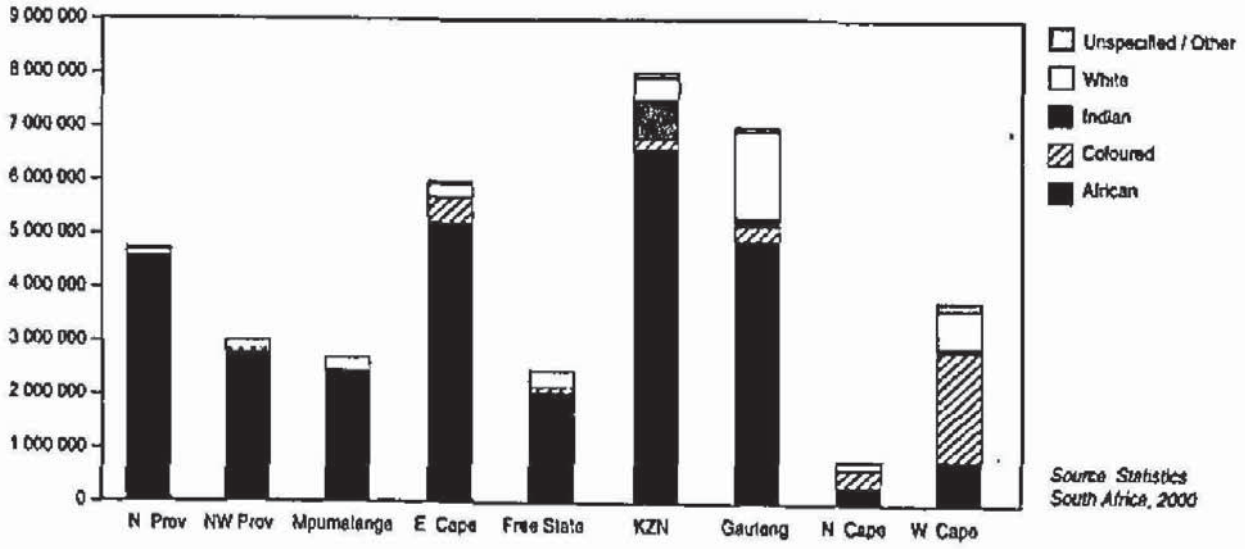
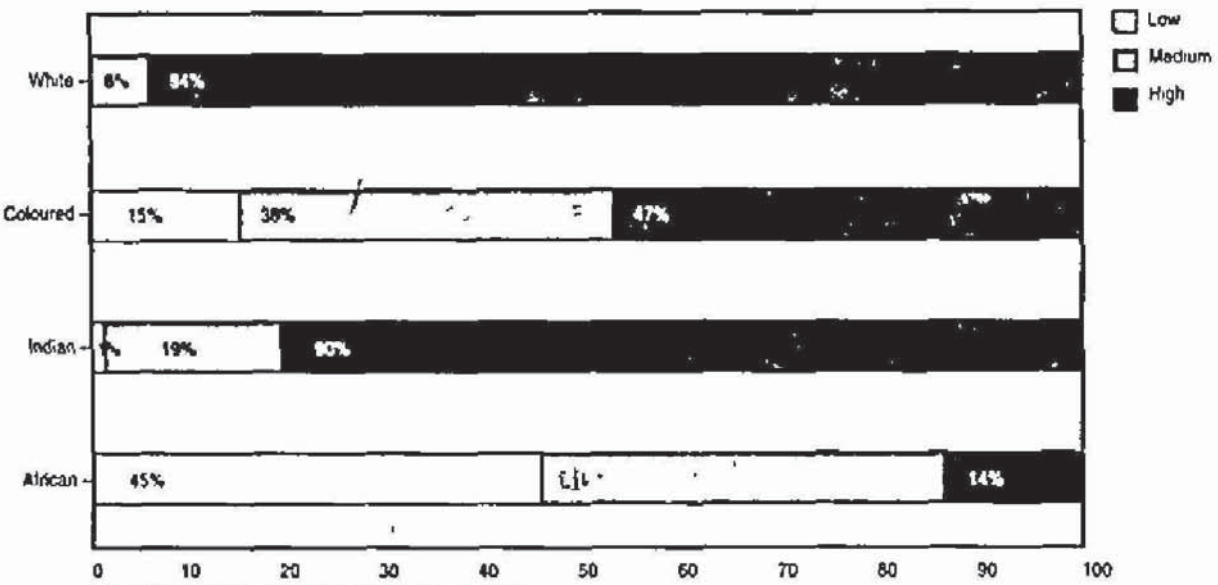
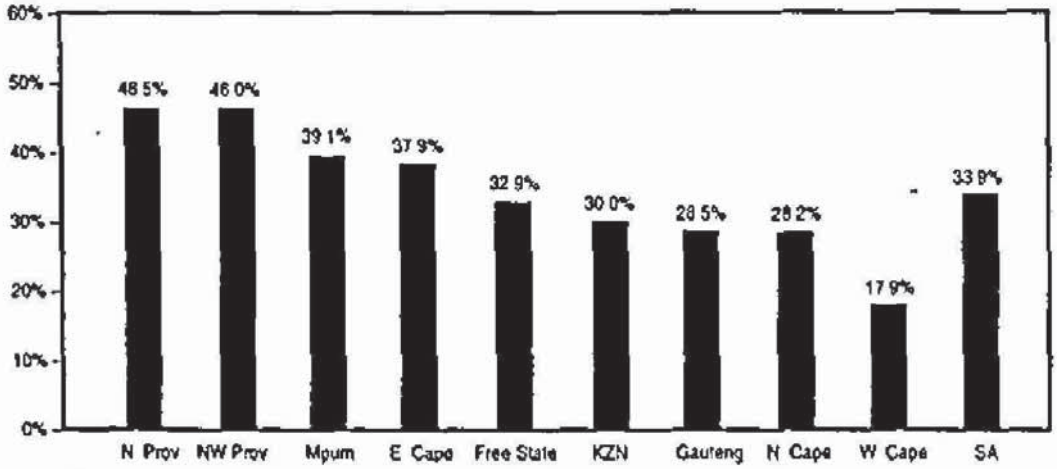


Figure 2: Socio-economic status by race



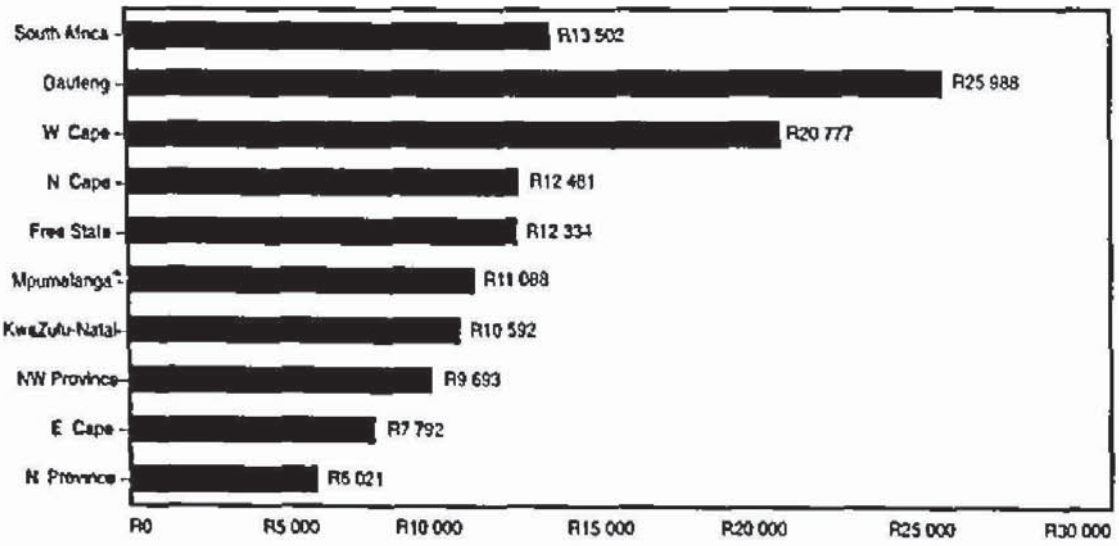
Source Health Systems Trust The Equity Gauge, 2000

Figure 3: Unemployment rates by province (15-65 yrs), 1996*



** The unemployed are those between 15 and 65 years who did not work at the time of the census, but were looking for work*
Source Statistics South Africa 2000

Figure 4: Personal disposable income per capita by province, 2000



(46%), KwaZulu-Natal (39%) and North West (38%). These are also the provinces with the lowest levels of disposable income per capita (Figure 4).

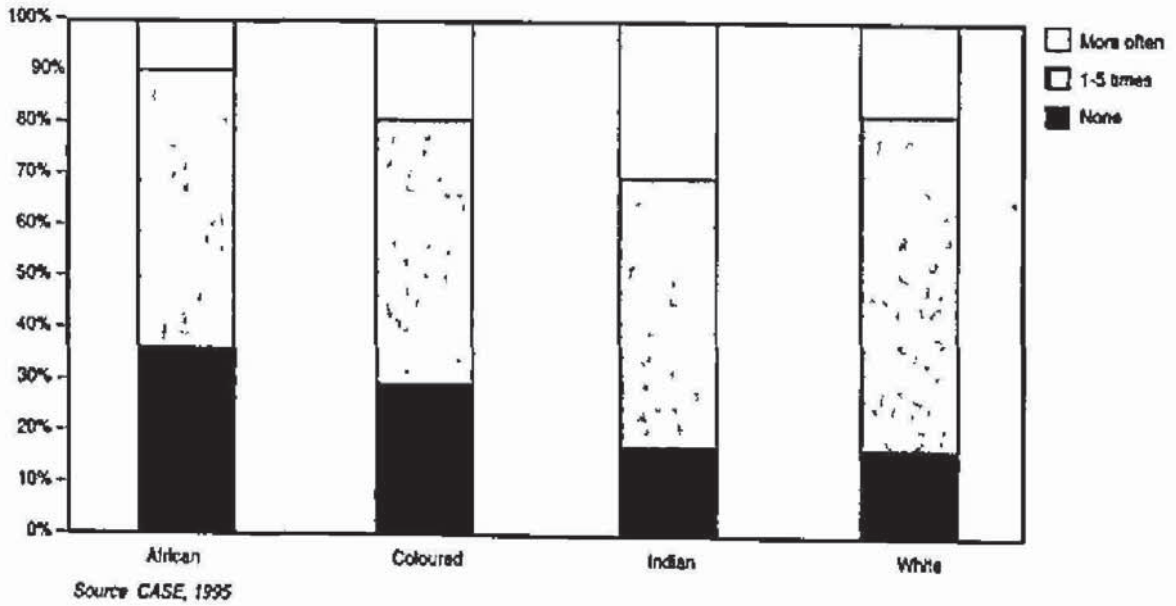
The latest report of the University of South Africa's Bureau of Market Research concludes that South African inequality remains among the highest in the world – this gives South Africa the status as one of world's most unequal societies. The report points to one of the most vivid indications of South African inequality: the sharply differing levels of the human development index for the various provinces. (The human development index is a catch-all indicator of life expectancy, educational attainment and income used by the United Nations Development Programme (UNDP).) Gauteng – South Africa's economic hub – and the Western Cape have the same ranking in terms of the human development index, at 0,73 – similar to a middle-income country like Turkey. By contrast, however, the Northern Province – the poorest province in South Africa – has a human development index of 0,57, close to that of Zimbabwe, which ranks 130th in the index. As can be seen in Figure 4, personal disposable income is more than three times that of the Northern Province. Overall, South Africa has a human development index of 0,67 – this means that it is well short of the 0,8 that the UNDP considered necessary for a high level of human development.

The National Household Survey of Health Inequalities in South Africa found a range of inequalities along racial lines. Of relevance to this article is the differential access to health care by race as demonstrated in Figure 5, which shows that a larger proportion of Africans (37%) and coloureds (30%) had not received health care in the past year, compared to whites (17%) and Indians (18%). These findings also support the continued existence of the inverse care law – that those who are most in need of health care do not necessarily have access to it. This survey also shows that, in general, poverty, overcrowding and unemployment are associated with lack of health care, and that this applies particularly among Africans and coloureds.

HIV/AIDS

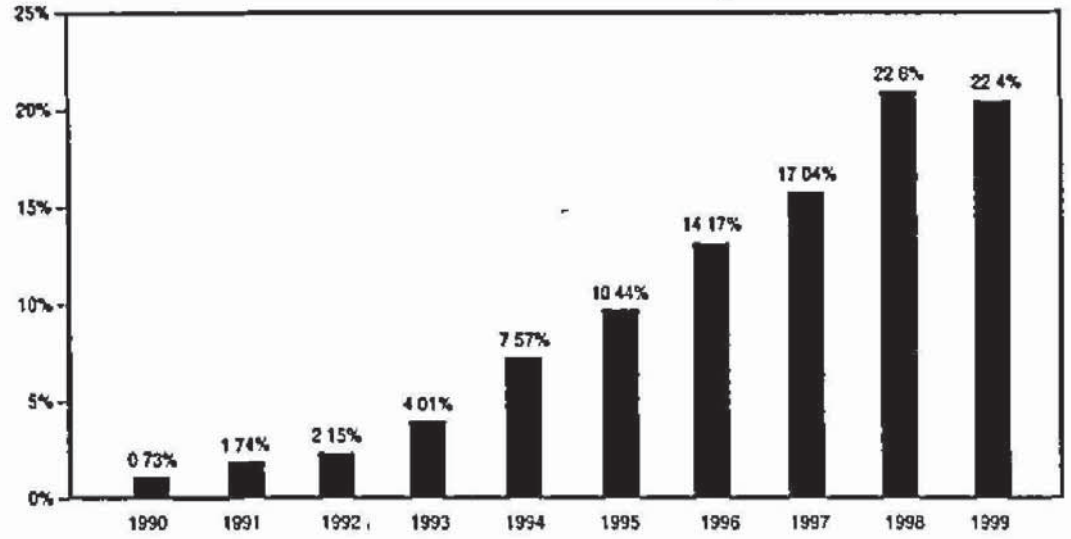
The data in Figure 6 illustrate the rapid growth of the HIV/AIDS epidemic in South Africa as a whole. Figure 7 shows that HIV/AIDS prevalence is different in the

Figure 5: No. of times in the past year South Africans consulted a health profession by race



Source CASE, 1995

Figure 6: HIV antenatal prevalence trends in South Africa 1990-1999



Source: Department of Health, 2000 (Prevalence amongst pregnant women attending public sector clinics in South Africa)

different provinces, with KwaZulu-Natal being the province with the highest rates (32,5%) followed by Free State with 27,9%.

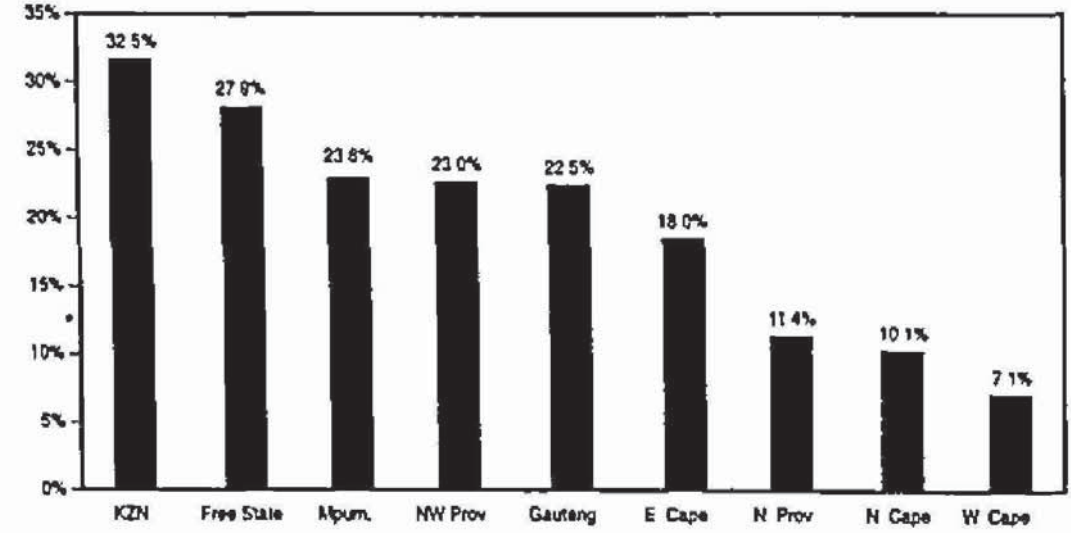
Younger people are most severely affected by the disease – this is not surprising since about 45% of the South African population (16 million) is under 20 years of age. It is estimated that over 60% of all new infections currently occur in those between 15 and 25 years of age with women generally being infected earlier than men and the total rate is higher for women (35% as opposed to 29% for men in the 15 to 30 age group).

This is a similar pattern to that presenting in most sub-Saharan countries. Data from a recent study in Carletonville, Gauteng support this alarming scenario – an extraordinary high rate of infection was found among adolescent girls reaching nearly 60% at 25 years of age.

In addition, there are a number of factors that have influenced the pattern and severity of the HIV/AIDS epidemic in South Africa. According to the report by Abt Associates Inc South Africa these include:

- established epidemics of other sexually transmitted diseases;

Figure 7: HIV antenatal prevalence by province in South Africa, 1999



Source: Department of Health, 2000. (Prevalence amongst pregnant women attending public sector clinics in South Africa)

- disrupted family and communal life, due in part to apartheid, migrant labour patterns and high levels of poverty in the region;
- good transport infrastructure and high mobility, allowing for rapid movement of the virus into new communities;
- resistance to the use of condoms, based on social and cultural norms;
- the low status of women in society and within relationships;
- social norms that accept or encourage high numbers of sexual partners, especially among men;
- parallel norms that frown upon open discussion of sexual matters, including sex education for children and teenagers.

Conclusion

The pattern of HIV/AIDS in South Africa is unique (similar to Southern Africa).The features of this pattern are as follows:

- the epidemic is mainly a heterosexual one;
- the rates of infection in the general population are very high;
- the percentage of HIV positive women is greater than men;
- the young age of onset of infection for women.

These data demonstrate the need to focus our attention on young African women and the factors underpinning their predicament. 'Finding ways to protect young girls must be given the highest possible priority.' (Gilgen et al) Achieving this goal and thereby reducing women's vulnerability and lowering their risk of infection requires a multifaceted approach including among other things:

- The need to tackle the long-term effects of social inequalities. Success in stemming the tide of the HIV/AIDS epidemic in south-east Asian countries is attributed mainly to enormous strides against poverty in the 1980s, education and health care particularly for women.
- The need to incorporate social and cultural factors into all educational efforts. In particular, the perceptions and responses of men to the HIV/AIDS epidemic and their role in the spread of the disease need to be thoroughly understood and researched.
- The need to address women's double burden of being sick and being primary care givers (in the home and community).
- The need to create better partnerships between gender and AIDS activists.

Achieving the objectives outlined here is beyond the realm of health interventions only, however well intended and executed. It requires a concentrated effort and political will on behalf of the government to confront the epidemic in ways that are mindful of the arguments stated here. ★

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