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Exploring Feminization of HIV/AIDS and Millennium Development Goals (MDG) with Examples from Botswana and South Africa

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ABSTRACT The paper, through desk a review of literature aims to explore the underpinnings of feminization of HIV/AIDS and their linkages to Millennium Development Goals (MDGS). Findings indicate that: many women than men are infected by HIV/AIDS; feminization of poverty largely informs feminization of HIV/AIDS; societies embrace the myth that HIV/AIDS is a woman's disease; and care giving is predominantly carried out by women. The following are suggested strategies to redress feminization of HIV/AIDS: Forming a men's only sector to mobilize men to expedite response; working to dilute patriarchy; and embracing gender swap, gender readjustment and gender realignment.

INTRODUCTION

While many countries especially in Africa are increasingly investing heavily to fight HIV/AIDS, particularly in the provision of the much needed ARVs (Arghandab River Valley Antiretroviral Drug) and other psychosocial support infrastructure to individuals living with HIV/AIDS (Barnett and Whiteside 2006), it's worrying to note that women more than men are getting infected leading to a state of feminization of HIV/AIDS (Kang'ethe 2013a). This drives down the hope of fulfilling especially the Millennium Development Goal (MDG) number three that envisages achieving gender equality and equity, as well as generally empowering women. It also impedes the fulfillment of MDG number six that envisages combating HIV/AIDS (UNDP 2004; Kang'ethe 2012a). This presents a worrying state of affairs in that some researchers indicate that an inextricable relationship between poverty and HIV/AIDS exists (Kang'ethe 2013). This means that as more women than men get infected, there is a great possibility that women become the victims of poverty more than men. It remains an incontrovertible fact, therefore, that the poverty of women more than men negatively affects the quality of life of the children and the households at large. In many countries of the developing world, household food security is seriously compromised (Musekiwa 2013). This state, no doubt, impedes the realization of MDG number one that aims at eradicating extreme poverty and hunger. The situation also cascades to negatively affect women's maternal and child mortality (Lozano et al. 2011). It is therefore critical that feminization of HIV/AIDS is likely to negatively affect all the facets of women and their capacities to acquire good life for their children and their households generally (Musekiwa 2013; Kang'ethe 2013a). It is then critical and topical that strategies and interventions to derail feminization of poverty are put in place, especially in the developing part of the world where HIV/AIDS has taken a huge toll of its population (Ramphele 2008; Barnett and Whiteside 2006).

Perhaps it's good to note that this state of feminization of HIV/AIDS is a rather newer concept which has not attracted a lot of research examination, and the way forward. In Botswana, at the wee hours of the HIV/AIDS campaign, especially the 1st decade of the 21st century, feminization of HIV/AIDS was apparent, with men shunning to be associated with HIV/AIDS activities. This robbed the country an opportunity for men to contribute to the scourge (Kang'ethe 2009). This is true in many fronts. Incontrovertibly, in many countries of the developing world such as Botswana and even South Africa, men are endowed with financial resources and also leadership prowess than women, which are

necessary factors to contribute to the fight against HIV/AIDS. As a strategy to avert this state, the government of Botswana mobilized the Botswana Defence Forces (armed forces), the Police and the Prison bodies to form HIV/AIDS mobilization organ, the men's sector. In this organ, leadership rotates among these bodies. Their goal is to expedite the mobilization of men's response to HIV/AIDS to the grassroots level. Although a good response mechanism, the impacts of the sector has not been adequately conspicuous especially at the village level (Kang'ethe 2009).

Apparently and in this researcher's contention, feminization of HIV/AIDS has a gender dimension. With care giving in Botswana and South Africa being preponderantly in the hands of women, this reinforces the perception that HIV/AIDS is a disease associated with women more than men (Uys and Cameron 2003; Nurses Association of Botswana 2004; Ministry of Health/JPIEGO 2009). UNAIDS's literature on care giving in South Africa quoted by Kang'ethe (Kang'ethe 2006), however, indicates attempted efforts by men to perform care giving with little success. While those men who have worked in HIV/AIDS organizations are knowledgeable in care giving and could successfully take care of their sick partners and family members well, social and cultural pressures have always dissuaded them from the course. A case study in Soweto, South Africa, gives an account of some men looking after sick partners or relatives magnificently, but some, upon being overwhelmed have abandoned infected partners or thrown them out of the home (UNAIDS 2000). Another case study also suggests that in KwaZulu/Natal, South Africa, it is not unusual for men to volunteer to be primary caregivers, but most of the time they get overwhelmed and abandon their clients to go and do other masculine based tasks. In most cases, they would call for their mothers or sisters from the rural areas to continue with care giving. The above scenarios strengthens the concept, feminization of HIV/AIDS (UNAIDS 2000; Kang'ethe 2013a).

Problem Statement

Perturbing questions as to why HIV/AIDS in countries hard hit by the epidemic such as Botswana and South Africa continue to infect more women than men needs to be answered through research, debates and discourses such as this presented in this paper. This is because the impact of HIV/AIDS to women more than men affects families and households, and therefore the quality of life of the children, the elderly and men themselves. It is therefore critical that various underpinnings contributing to this state of affairs are brought to the fore, with the hope of crafting interventions to mitigate the effect.

METHODOLOGY

The paper has used a desk kind of review of literature to elicit debates and discourses unearthing a few underpinning factors informing feminization of poverty in Botswana and South Africa. The researcher has consulted books, journals, United Nations publications and other eclectic sources to enrich his discourse on the phenomenon of feminization of HIV/AIDS.

OBSERVATIONS AND DISCUSSION

Evidences of Feminization of HIV/AIDS in Botswana and South Africa

More Women Infected Than Men

Statistics, either adduced by National AIDS coordinating agency (NACA) in Botswana, or South African National AIDS Council (SANAC) indicate that in virtually all the demographic age groups, more women than men are infected (Central Statistics Office et al. 2005; South African National AIDS Council (SANAC) 2007; Treatment Action Campaign (TAC) 2007). There are many factors behind this scenario, the huge one being the socio-economic situation that women in the region finds themselves in (Mbirimtengerenji 2007). As patriarchy continues to take toll and determine the status of a woman, this together with the physiological make up of women makes them more vulnerable to the infection. This has to be fought strongly if United Nations Millennium Development Goals number six of combating HIV/AIDS; and number three that envisage seeing women economically empowered are to make significant inroads (Lekoko 2009).

Feminization of Poverty Informs Feminization of HIV/AIDS

In both South Africa and Botswana, women largely experience the double challenge of feminization of poverty and feminization of HIV/AIDS. Kang'ethe's work in 2004 and 2013 (Kang'ethe 2004, 2013a) has empirically validated an inextricable relationship between poverty and HIV/AIDS infection. This was made more manifest in another research in Tsabong in Botswana where some women members of various support groups living with HIV/AIDS said they risked further re-infection as they engaged in prostitution due to poverty (Kang'ethe 2012b). This scenario is not a unique phenomenon to Botswana. In a research carried out in Nairobi to investigate the impacts of socioeconomics to HIV/AIDS, 66 percent of the prostitutes of low socio-economic status compared to 31 percent of those of higher socio-economic status were found to be sero-positive. This proves the inextricable relationship between poverty and HIV/AIDS infection, and hence affirming poverty as a driver of feminization of HIV/AIDS. In the same study, a few prostitutes indicated that they never worried about HIV/AIDS, but worried about putting food on the table. They reasoned that AIDS could give them an opportunity to live for the next day, but hunger and poverty could not. They therefore justified their position of continually engaging in prostitution despite the danger it carries of HIV/AIDS infections (Forthal and Friede 1986). According to Mbirimtengerenji (2007), many people in Sub Saharan Africa, especially women, find themselves in abject poverty, but still obliged to put the food for themselves and their household members at the table. This sometimes drive them to indulge in risky behaviors, such as commercial sex, which can bring basic survival resources. This state of poverty, therefore, leads them prone to HIV/AIDS.

Myth that HIV/AIDS is a Woman's Disease in Botswana and South Africa

Perhaps the fact that earlier campaign interventions in Botswana and South Africa displayed a skewed gender dimension in that it used statistics of women attending antenatal clinics (ANC) and men who visited the clinics for STI related challenges could have made HIV/AIDS to be associated with women more than men (National AIDS Coordinating Agency (NACA) 2009; South African National AIDS Council (SANAC) 2007). Although statistics of men were also important, but only a few men volunteered to go to the clinics on an account of STI's at the earlier periods of the HIV/AIDS campaign. Therefore, for many years that HIV/AIDS has been in existence, the HV/AIDS prevalence has largely been computed using the antenatal clinic data for women. This has meant that it has been more women than men who know their HIV/AIDS status. This also determined the kind and direction in which to drive the campaign, with more of it targeting women as easier respondents of it (Kang'ethe 2009). However, many countries in the developing world have followed the same pattern of computing HIV/AIDS from the antenatal clinic attendance of women and a few men who may have visited the clinics due to STI challenges. This pattern has then informed the direction of earlier campaign interventions, concentrating more on women and forgetting their male counterparts (Kang'ethe 2009). However, with the governments now increasingly using population based statistics where the samples come from all the segments of the country's population, this myth of HIV/AIDS being viewed as a disease of women more than men has started to shift and assume a neutral gender dimension. However, cases of men shunning the campaign and women more than men owning the campaign is one of the features of both Botswana and South Africa (Central Statistics office 2008).

Care Giving Largely Carried by Women

Perhaps, no manifestations of skewed gender dimension has been conspicuous than in care giving of individuals with various life debilitating sicknesses such as HIV/AIDS in many countries of the world (WHO 2002). The government, especially of Botswana has taken advantage of immense social capital from the community members especially women to run community home based care programmes (Kang'ethe 2010; NACA 2009). However, care giving appears to have both a socialization and cultural dimension in that literature in both Botswana and South Africa hold that women who care for their loved ones feel culturally bound to do so, as well as fulfilling their blood and kinship obli-

gations (Kang'ethe 2010; Uys and Cameron 2003). While care giving continues to perform a sterling role of complementing government efforts to tackle HIV/AIDS, its skewed gender dimension has made HIV/AIDS appear more of a disease of women than men. Due to the fact that most women who volunteer to take care of their loved ones and their community members are usually women of low socio-economic status, usually with low literacy levels, they have usually displayed some degree of knowledge and skills gap to handle cases of HIV/AIDS with some degree of satisfaction (Uys and Cameron 2003; Nurses Association of Botswana 2004). Some have contracted the disease from their beloved clients. This is especially due to unprofessional handling of clinical waste (Kang'ethe 2008).

Although some scholars from Botswana validated the position of community home based care programmes as a very important programme to respond to HIV/AIDS, others hold contrary views (Motana 2001). Kelesetse (1989) and others from the developed world such as Finch (1984) concur that care giving, despite its invaluable role is an oppressive occupation, whose load has been unfairly placed in the shoulders of the elderly women by the government and the society in general. It is therefore necessary that men are co- opted to participate in the care giving occupation. Perhaps this why advocacy and lobbying for male involvement in the HIV/AIDS campaign has been intensified in Botswana calling upon men to use their physical, social and financial resources to assist in care giving (Kang'ethe 2009). However, despite its gender skewed dimension, and also its oppressiveness to the female gender, care giving has been lauded by the World Health Organization as one of the ways that communities can complement their governments efforts in fighting for the HIV/AIDS. This is because of the dearth of resources that many countries of the developing world face, most of which are in Africa south of Sahara (WHO 2002).

Pertinent Efforts to Redress Feminization of HIV/AIDS in Botswana and South Africa

Forming "Men's Only" Driven Sectors to Mobilize Men to Respond to HIV/AIDS.

On this, Botswana has shown a good example by imploring upon its members of the country's security personnel to lead the men's mobilization campaign. In this set up, the leadership of the men's sector is rotated among the Botswana Defence Forces (BDF), the Prisons and the Police. The role of the sector has been to come up with visionary approaches to lure men to adequately participate and respond to the HIV/AIDS (National Strategic Framework 2003-2009). The men's sector has been conducting meetings at the chiefs kgotla *(traditional chiefs meeting place)* to sensitize the government organs in the district to own the campaign. They have also implored upon the districts to come up with district men's sector that will disseminate the message of men's involvement down to the village level. The men's sector has been a good vehicle. However, this researcher doubts whether its impact has been richly felt especially in the villages where patriarchal forces against male involvement may be immense. However, this researcher calls upon the South African HIV/AIDS campaign machinery and architects to come up with such a male only sector to mobilize men to respond adequately to the HIV/AIDS campaign. Although in this researcher's contention, Botswana apparently appears to be some miles ahead of South Africa in the HIV/AIDS mobilization campaign, South Africa appears more to be endowed with financial resources that can drive the campaign to higher heights. The current government goodwill embraced by the South African is likely to strengthen the campaign and avert the state of the epidemic.

Perhaps the two countries need to be commended for their male circumcision campaign that appears to be doing well. However, the male circumcision campaign needs to be accompanied by the message that the practice does not make the individuals immune from the virus, but only lessens the infections by 60 percent. Male circumcision should therefore strengthen the use of preventive tools such as condoms (Peltzer et al. 2008; Kang'ethe 2013b).

Diluting Patriarchy

Patriarchy is a phenomenon of male dominance, usually associated with attitudes and mindset that men should control women and children. Women are usually taken as sexual objects and only considered important as vehicles of child birth and issues of nurturance gen-

erally (Lekoko 2009). In this researcher's contention, it is a retrogressive phenomenon in a fast modernizing and globalizing world as women's capacities and potent is stifled. Men as well as women supported by social and governmental structures should give women an equal playing field to allow their complete emancipation from men's patriarchal set up (Lekoko 2009). It is still an incontrovertible fact that in both South Africa and Botswana, the HIV/AIDS campaign appears to be derailed by cultural and patriarchal mindset that does not allow men to view women as equal partners in development. The same phenomenon affects women making them view themselves as subservient to men instead of being complementary in developmental scope (UNDP 2008; Gender Link 2012). The two countries' statistics of gender based violence is a clear testimony that men are not fast giving away their culturally grounded and patriarchal mentality of gender inequality between men and women (Gender Link 2012).

Gender Swap, Gender Readjustment and Gender Realignment

Holistically, the place of a woman occupation wise, the attitudes of both men and women, and the whole society need to undergo a paradigm shift to put a woman in a place deserving equality and equity in terms of resources, leadership, respect and decision making process (UNDP 2008). Occupational paradigm shift is necessary to obliterate the fact that there are occupations for men and those for women. This is because these demarcations have defined a man's niche as well as a woman's niche. For example, there has been a traditional patriarchal belief in many African countries that a woman can better be a nurse, a teacher, a cateress, while it is a man's job to be a pilot, an architect, a mechanic etc. These role demarcations have strengthened gender differentiation and therefore curved a niche for both men and women. This has posed challenge in breaking the gender wall between men and women. For example in Botswana, there are gender based beliefs that women cannot make good leaders. This is evidenced by a popular proverb that says that *"Ga di ke etelelwe ke di managadi pele"* that means that a herd of cattle is never led by a female one, but a bull. This translates to the fact that men should always lead and women have to follow (Garegae and Gobagoba 2009). This mindset is true on the ground because Batswana have resisted calls by the ruling establishments to consider electing women into both parliamentary and civic positions. Rarely are more than three women nationally elected to parliament. The civic seats are also rarely won by women. This is despite the fact that Batswana women have proved to be competitive professionally making them occupy over fifty percent of middle level managerial positions in the country. This could explain the fact that the country enjoys one of the highest gender development index (GDI) in Africa (Kang'the 2009).

Although the South African country is immensely democratic, having reserved 30 percent seats for women, and setting a good example of fulfilling the 2008 South African Development Cooperation (SADC Protocol 2008), women generally decry lack of power when compared with their male counterparts. This is because of the patriarchal power hangovers in the minds of the South Africans. A lot of advocacy and lobbying to change the patriarchal mindset needs to be done especially to children while still in their lower primary school level. In both the countries of Botswana and South Africa, gender needs to be mainstreamed in all the social institutions, schools, religious bodies, initiation schools, and any other institutional groupings.

Perhaps the fact that Batswana traditional custodians of culture have yielded to the government call to have the initiates attending either bogwera *(initiation school for male adolescents in Botswana*) and Bojale (*initiation school for adolescent girls)* be counseled, tested for HIV/AIDS before going to the secluded venue of learning and training, gives hope that patriarchal mindset could be diluted, albeit at a slow pace (Kang'ethe and Rhakudu 2009).

CONCLUSION

Feminization of HIV/AIDS in many African countries, Botswana and South Africa included, is a catastrophe that needs timely attention if countries heavily hit by the epidemic are to liberate its women and make the countries achieve gender equality and equity in line with Millennium Development Goal number three. In equal measure, strategies to ensure women's control of their sexual reproductive health and rights needs to be strengthened if these countries are also going to address the MDG number six to

combat HIV/AIDS. Since feminization of HIV/AIDS appear to be inextricably related to feminization of poverty, these countries, then, need to come up with newer approaches to curb the poverty of women. Sustainable ways of diluting patriarchal and cultural mindset for men as well as women to respect and ensure women's equal status with men is topical, timely and long overdue.

RECOMMENDATIONS

Campaign to dilute cultures such as patriarchy should be strengthened so that men can coparticipate with women in many chores traditionally believed to be women's tasks. It is important also that different stakeholders whether government, NGOs and private bodies collaborate to make prevention gender friendly. Ensuring that all the genders understand all aspects of HIV/AIDS prevention and everyone's responsibility to respond to diseases generally could possibly reduce aspects of feminization of HIV/AIDS. Importantly, HIV/AIDS bodies as well as government bodies should work to discourage myths that point to the disease as belonging to women more than men

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