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# Exploring Pertinent and Fundamental Factors Weighing Down the Battle against HIV/AIDS in a Few African Countries

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**ABSTRACT** This paper, through a review of literature, aims to critically discuss the factors that have made African countries so vulnerable to HIV/AIDS. The following findings were found to contribute to their vulnerability: immense and protracted poverty, migration, state of gender inequalities, the pace of HIV/AIDs response, the nature and type of the virus, the state of health infrastructure, the perceptions surrounding sex and sexuality in many African societies, patriarchy and cultural power dynamics. The following mitigation factors have been recommended: Strengthening poverty alleviation programs; sustained and effective sexual behavioural change; diluting cultures and effectuating a paradigm shift of the patriarchal mindset to be gender neutral. The paper recommends more vigorous research into the dynamics fuelling HIV/AIDS in different countries.

## INTRODUCTION

Perhaps more vigorous research is lacking in regions such as Africa. The fact that close to 80 percent of HIV/AIDS cases finds refuge in Africa is scaring considering the fact than Africa only constitutes about a tenth of the global population (UNAID 2007; UNAIDS/WHO 2005; Kang'ethe 2010a). Another question worth pondering is the fact that the factors that have been validated to cause or fuel HIV/AIDS in African countries such as poverty, patriarchy, stigma and gender inequalities are also much prevalent in other regions of the world such as Asian countries (UNAIDS 2001; Kang'ethe 2010a,b). For example, countries such as India in Asia are known for poverty. This begs the question why is Africa south of Sahara so vulnerable to HIV/AIDS. This makes it imperative, therefore, to look into specific or regional specific factors that could be fueling the epidemic. This also raises the question whether the dynamics or fuelling factors could be carrying different weights for different regions. For example, perhaps the patriarchy practiced in India could be different in terms of securing the rights of women, while the situation in Africa could probably be presenting a different scenario. This paper, therefore, looks into possible fueling factors of HIV/AIDS among the African countries

### Problem Statement

Close to three decades since the first case of HIV/AIDS was discovered in 1981, HIV/AIDS is unrelenting, remains and continues to occupy a very important agenda in the minds, meetings, debates and discourses of development in many countries of the world, but more so in Africa. With literature indicating that close to 80 percent of the people living with HIV/AIDS find refuge in Africa South of Sahara, it is imperative that these countries engage in debates, discourses, evaluation, implementation and planning meetings, all driving to reduce and mitigate the unrelenting state of the epidemic. This researcher considers it pertinent to discuss and debate the possible underpinning factors and their dynamics with the hope of possibly coming with suggestions and recommendations that could possibly change the direction of the epidemic.

## METHODOLOGY

The paper has used a review of literature methodology and has immensely benefitted from United Nations publications, journals, books on HIV/AIDS and gender; as well as from the experience of this researchers who is a HIV/AIDS / gender expert. It has succinctly debated and formed discourses to explain why the fuelling factors are probably still too strong to explain the state of African countries' vulnerability to HIV/AIDS.

## OBSERVATIONS AND DISCUSSION

### Factors Informing Unrelenting Higher HIV/AIDS Prevalence in Some African Countries

#### *Poverty*

Although poverty levels in developing countries are relenting, albeit at a very low rate, as

countries embrace the tenets of development, modernization, Eurocentrism and globalization, it remains a stark naked fact that poverty continues to be one of the fundamental tools driving the epidemic (Barnett and Whiteside 2006). To this end, several empirical research undertaking have validated an inextricable relationship between poverty and the prevalence of HIV/AIDS (Kang'ethe 2012a). However, as globalization and modernization picks momentum, there is improvement in livelihood with poverty changing from absolute to relative terms. While absolute poverty connotes lack of basic necessities of life such as food, shelter, and being in a pathetic state of livelihood in general, one experiencing the state of relative poverty may be getting basic needs, but when compared to the national or global average, he/she may still be in a state of lack (Notten and Neubourg 2011). Apparently and unacceptably, the state of poverty in Africa appears to linger longer than the theories of development expected (Todaro and Smith 2006).

However, African countries feel misused and misguided by the western countries in that the Structural Adjustment Programs (SAP) that developing countries were persuaded to follow by the western world especially under the auspices of the World Bank did not work. In fact the programs left some developing countries poorer than they were. However, although this researcher agrees and regrets the situation, scholarly thinking may demand looking at the issue from various viewpoints. Firstly, although the western world offered the blue print and advisory services, the drivers were the African citizens themselves (Mulinge and Mufune 2003). Perhaps bad political environment, corruption, capacities and the goodwill to effectuate the demands of the SAP; and poor work ethics, are factors that needs to be factored when evaluating the mal performance of the Structural Adjustment Programs. Poverty, therefore, never relented. Massive unemployment, underemployment, despondency and hopelessness have been the best terms to explain the situation of many countries in Africa, with some countries' level of unemployment rising to over 50 percent. According to South African's 2010 third quarter Labour Force Survey, 42 percent of the young people under the age of 30 were unemployed compared with less than 17 percent of the adults (Sunday Times 2012). Kenya presents almost the same state of affairs because statistics from the government of Kenya in 2011 indicated that Kenya's unemployment rate stood at 40 per cent, while youth unemployment was 64 percent (Government of Kenya 2011).

The situation has encouraged other factors such as rural–urban migration, serious housing challenges and governments' inability to plan housing and provide social services and requisite amenities. Other social ills such as prostitution have increased not only in bigger cities and towns, but also in peri-urban settings and rural settings. The environment described has also favoured the proliferation of diseases such as HIV/AIDS and other sexually transmitted diseases (Barnett and Whiteside 2006) . These factors coupled with inadequate information machinery, poor health infrastructure could largely explain why HIV/AIDS has lingered longer than expected.

Poverty has many horrendous and pinching effects. It drives the attitudes to risk taking behaviours. To people struggling to meet their immediate needs such as food and shelter, avoiding a disease which might not materialize for years (long gestation period) can be low on the list of their life agendas. Apparently and in this researcher's perspective, to the very poor and desperate people eking out for the most basic needs of life such as food and shelter, HIV/AIDS is viewed a disease of tomorrow. They therefore concentrate their energies to putting the food on the table, their risk taking behavior notwithstanding. Viewed from another angle, people may feel that putting food on the table is more urgent than thinking of mitigating the effects of HIV/AIDS (Kang'ethe 2012b). This finds evidence in a research undertaken in Botswana in which some people living with HIV/AIDS indicated that prevention of HIV/AIDS took second place, while they had to do prostitution to secure food for their families and themselves (Kang'ethe 2012b).

### *Migration*

Migration phenomenon is a reaction to, or is effectuated by poverty; the need to modernize, the pursuit for newer lifestyles, and an interest to globalize. To say the least, migration is one of the facilitator and a result of globalization. It spurs social and economic development (Kang'ethe 2014a). It is a recipe of factors such as urbanization, industrialization and poverty. Poverty forces more and more people to leave

their families and migrate in search of work. Permanent and seasonal migration to urban and industrial centres or to other countries is increasing with the result of disrupting social and family patterns. This has implications for the spread of HIV. However, it's good to point out that the issue of migration and studies pertaining to the phenomenon have a gender dimension in that most of them investigate male migration. This researcher considers it pertinent that this skewed gender dimension in migration is addressed by having the effects of women also investigated. This is important so that HIV/AIDS phenomenon can be relieved of skewed gender interpretation. It is also significant considering the fact that HIV/AIDS infections in many countries display a characteristic of feminization of HIV/AIDS where many women than men are infected with HIV/AIDS (Kang'ethe 2014b).

Immense literature holds that there is a positive relationship between migration and HIV/AIDS transmission for both the males and females. Majorly, HIV/AIDS spreads between the urban areas, and from urban to rural areas, via corridors of population movement (Glynn et al. 2001; Jochelso et al. 1991). However, it is important to identify the type of migration because its dynamics may also inform the level of infections. For example in South Africa, women tend to migrate shorter distances to informal settlements and regional towns, and retain ties to their rural areas; while men tend to migrate longer distances to urban areas and are less likely to return to the households of origin. The same climate applies to migration patterns in Botswana where women migrate to the farms *(mashimo-in setswana)* and cattle posts *(merakeng-in setswana)* while men besides going to cattle posts *(merakeng-in setswana)* can migrate to other countries. This pattern was especially very common with Batswana men migrating to work in the South African mines *(miepong- in setswana)*. This, to some extent can explain the gender differences informing exposure to sexual risk taking behaviours, with men being more prone to higher sexual risk taking behaviours (Camlin et al. 2007). With literature also confirming men to be more promiscuous than women generally, especially in patriarchal societies such as South Africa and Botswana, then men are more likely than women to be prone to higher sexual risk taking behaviours (Patton 1990). Since with increased urbanization, industrialization, westernization and generally globalization, migration is bound to increase, it is pertinent that issues of prevention are strongly addressed. This calls for a HIV/AIDS structure in which individual prevention agendas takes centre stage.

### *Gender Inequalities*

Gender refers to the tasks that societies have allotted to either men or women, or ones that the society believes should be executed by or belongs to either men or women (Lekoko 2009). Gender inequalities is a result of societal structural arrangements, either by design or by default, which have propelled or positioned men in a vantage position to enjoy resources, opportunities, leadership, more than their female counterparts. This, it is believed has been motivated and prompted by patriarchal societal set up and disposition (Lekoko 2009). To this effect, most patriarchal societies have seen men getting better paid jobs than women, men enjoying leadership positions and recognition as well as preferential treatment in virtually all the structures of the society (UNDP 1995; Kang'ethe 2009). Gender inequalities, therefore, is also a result of skewed gender treatment. For example in many African countries such as South Africa and Botswana, men enjoy more power, leadership roles, take well paid jobs compared to their female counterparts. The effect of patriarchy appears to have an indoctrinating effect in that issues that aggravate the state of gender inequalities appears to be in the minds of both men and women right from childhood. The mindset, therefore, dictates the niches of both genders, that is, it determines where a woman, or a man feels he/she should be, the preferred occupation, and even how to behave. These are gender dynamics that continue to stifle the achievement of women equality with men as well as their empowerment generally (UNDP 2008). It is therefore pertinent that gender neutral education be structured and mainstreamed in schools to children while they are still young. This will give hope to the fact that when children's mind, whether boys or girls, perceive life in a gender neutral and gender understanding ways, then women empowerment process and gender equality mat take roots, albeit slowly.

The effects of gender inequalities and its effect to HIV/AIDS are striking. Due to the fact

that many women are economically disempowered, or even if economically empowered, still socially disempowered, their capacities to negotiate for safe sex have usually faced an arduous and an uphill task. Never the less, it is the phenomenon of gender inequalities that motivates increased acts of gender based violence especially rocking both South Africa and Botswana (UNDP 2008; Gender Link 2012). These aspects that gender inequalities gives effects continue to negatively influence not only the achievement of an HIV/AIDS free generation in both Botswana and South Africa, but also dims these countries' scores in the globally driven millennium Development Goals whose stock taking is year 2015 (UNDP 2004, 2008). The effect of gender and gender inequalities has a huge bearing towards HIV/AIDS infections. In most countries of the developing world, HIV/AIDS infections portray the state of feminization of HIV/AIDS. This is a situation in which more women than men are infected by HIV/AIDS (Kang'ethe 2014b). Infact the male: female ratio of infection is usually 1: 1.2. This is also exacerbated by the fact that some empirical research have validated that men are five times more promiscuous than women; and also that men are perfect transmitters of violence (Bennet 1992; Patton 1990).

### *The Pace of Response to HIV/AIDS*

Though the pace of response is not a clinical factor, but a social factor, it is a strong factor that determines, and could still be determining the efficiency and effectiveness of HIV/AIDS response in many countries ravaged by AIDS (Barnett and Whiteside 2002; Treatment Action Campaign 2007; Ramphele 2008). As HIV/AIDS epidemic continues to spread its tentacles to virtually all the age segments in societies, the time factor between the onset of the disease and time of administration of the life prolonging drugs is critical. This is because if not addressed, the time of development to AIDS and eventual death is short, usually between 3-10 years (Barret-Grant et al. 2001). However, without access to life elongating ARVS, people die within the first five years after infection (Barret-Grant et al. 2001). Perhaps this is why many people in South Africa were believed to have succumbed to HIV/AIDS during the time of Mbeki Presidency. Many critics indicate that the government response was slow, directionless and riddled with controversies that HIV virus does not cause AIDS. This was later proved to be a pseudoscience. A pseudoscience is a faulty ideology that has no adequate scientific validity (Kang'ethe 2014c). The world was immensely shocked by Mbeki's assertion and faulty scientific contention that HIV does not cause AIDS. As one of the most learned sons of Africa, and a President of one of the strongest economy in African continent, perhaps many people including his Health Minister, Tshabalala Msimang agreed with the ideology (Kang'ethe 2014c). She is on record advising people to rely on vegetables such as carrots, beetroots to mitigate the effects of HIV/AIDS (Barret-Grant et al. 2001).

Despite policy and ideological disposition surrounding HIV/AIDS response, the pace of response is also multifaceted in that it is determined by countries' socio-economic statuses, people's cultural belief systems, and other spiritual based factors. For example, with countries whose some people embrace deep cultures especially associated with medication, such population tend to take long to dislocate themselves from the culturally grounded beliefs in medication, and accepting that most of their cultural practitioners, who may have from time immemorial played a significant role in their medical and diagnostic health seeking behaviours, are not adequately placed to handle HIV/AIDS and its related complications (Kang'ethe 2014d).

### *The Nature of the Virus*

Perhaps the biggest difference between HIV/AIDS and other diseases such as tuberculosis, malaria, diarrhoea, is that the latter are either airborne or waterborne, meaning that their epidemiological route has to take place either in the air or in the water; while HIV/AIDS is a sexually transmitted disease. This makes the disease at the centre of life. This is because sex is a basic physiological human need according to Maslow's hierarchy of needs (Maguire 2002). This is perhaps why some religious bodies such as Judeo-Christianity equate sex with life giving process, or a procreation process (Kang'ethe and Rhakudu 2010). This means that the virus usually affects people who are sexually active (15-49) years. While airborne or waterborne diseases can be mitigated by positively changing the environments, such as hygiene and possibly annihilating some of the disease causing

microorganisms, unfortunately HIV/AIDS is a sexually driven disease. This implies that everyone who undertakes to get involved in the process of procreation has to embrace the risk irrespective of the prevention effectiveness in one's disposition. Sex, therefore, becomes an inevitable phenomenon in people's lives (Bennet 1992). Additionally, the longer incubation period of HIV/AIDS, whether one uses life elongating ARVS or not is a critical factor that determines the potency and capacity to infect others. Worse more, during the disease incubation, one may not show symptoms or even realize them if one does not have a culture of health seeking behavior (Bennet 1992). The long incubation, therefore, makes the issue of response an un urgent one. Although this quality of HIV/AIDS affects people of all races and regions, the type of virus, subtype 2 that affects people in Africa South of Sahara is believed to be more virulent than other subtypes or categories. Also, the issue of prevention among the African populations, perhaps due to cultures and poor information dissemination could be stifling the process of conceiving effective and prevention campaign. This state is also exacerbated by a poor health infrastructure to manage the campaign and also treatment mechanisms (Barret-Grant et al. 2001; WHO 2002).

*Perceptions of Sex in Most African Societies*

To say the least, sex in most societies of Africa is surrounded by controversies, myths, taboos and mores (Kang'ethe 2014d). This is a very important phenomenon in determining people's vulnerability. In most societies which are still modernizing at a snail's pace, or are moving at a lagged out process, sex remains a sacred and sacrilege area (Kang'ethe and Rhakudu 2010). This means that the control and intervention of the disease epidemiology may be stifled. This has made the campaign against HIV/AIDS an arduous and an uphill task. Perhaps this is why making formidable HIV/AIDS campaign endeavours is determined by how well the campaign architects, policy makers and other HIV/AIDS friendly groups are able to handle the issue of cultures. The realization that culture is the mirror of the society, informing the do's and don'ts of a particular society could help strengthen the strategies, or the interventional approaches (Kang'ethe 2009). These practitioners described above need to understand the requisite efforts to dismantle the cultural bonding if people are to leave some of the retrogressive faith systems that continue to provide a fertile ground for the proliferation of HIV/AIDS.

However, perhaps also considering repositioning, reconsidering and rejuvenating some aspects of culture associated with sex and sexuality could also be a panacea towards HIV/AIDS response (Kang'ethe 2014e). For example reclaiming the Zulu virginity testing could hopefully encourage young women to avoid sex during their teenage years. Since this is one of the riskiest age in terms of vulnerability, first due to the fact that their sexual organs may not be adequately developed, and therefore prone to increased wear and tear; and their knowledge about HIV/AIDS epidemiological path is still not adequately developed, then avoiding sex at this age will strongly strengthen the HIV/AIDS response (Kang'ethe 2014 d,e). In recent times, the western countries have been advocating for males from countries hardest hit by the epidemic to consider undergoing the rite of circumcision as a strategy to mitigate the effects of HIV/AIDS. This has been informed by empirical validation that males who get circumcised are 60 percent resilient to HIV/AIDS (Peltzer et al. 2007; Kang'ethe and Gutsa 2015). This has seen many circumcision campaigns being funded by western countries targeting HIV/AIDS ravaged countries such as Zimbabwe, Botswana, Swaziland and South Africa, etc. The campaign has also targeted countries like Kenya where a bulk of its population does not culturally practice male circumcision. On a positive score, some countries such as Botswana and Kenya are doing well as far as the campaign on male circumcision is concerned (Kang'ethe 2013).

***The State of Health Infrastructure***

To say the least, timely treatment of diseases such as the sexually treated diseases (STDs)/sexually treated Infections (STIs) contribute hugely to the prevalence of HIV/AIDS. The reasons are both clinical and physiological. Clinically, untreated cases of HIV/AIDS weaken the body and also lowers the immunity against other related diseases. The body parts are also exposed to other disease micro-organisms. This, therefore, means that healing may take longer. Physiologically, untreated cases of STDs/STIs

make the sexual body parts weaker and prone to the wear and tear during the sexual process. Ulceration, therefore, becomes very possible allowing the virus to easily find its way into the blood stream. Untreated cases of STDs, therefore, facilitate the transmission of HIV and may hasten the development of AIDS. Because of the fact that most countries of the developing part of the world are still struggling to increase the number of health facilities especially dealing with STIs, or to bolster their health infrastructural facilities (WHO 2002), there are so many cases of untreated cases of STI's. Inadequate knowledge of the relationship between untreated cases of STIs and HIV/AIDS also poses a challenge to prevention. The situation is serious with women who may stay with sexually treated diseases for a longer period without suspicion that they are infected. A woman may just be experiencing some itches around the genitalia and may think it's a just a normal phenomenon. The fact that a woman's sexual organs are inside the body unlike the male sexual organs that are almost outside the body compounds the challenge (Maundeni and Mookodi 2009).

### *Patriarchy and Cultural Power Dynamics*

Several researchers have linked HIV/AIDS prevalence with the concept of patriarchy and cultural power dynamics in several countries of the developing part of the world. Perhaps the hugest impact of patriarchy to women prevention methodologies is the fact that it disempowers them economically, socially, psychologically and intellectually (Kang'ethe 2009; Lekoko 2009). Patriarchy has an indoctrinating effect in that women embrace and believe in it. This to a huge extent means that women are not adequately placed to negotiate for safer sex methodologies and therefore become prone to HIV/AIDS infections. It is this state of patriarchy that in many countries of the developing part of the world could largely explain the state of feminization of poverty and also feminization of HIV/AIDS (Kang'ethe 2014b). Since patriarchy does not seem to respect the rights of the younger girls in terms of their sexual rights, in many societies, it is condoning marriages of the minors to men who are old enough to be the grandfathers of the girl to be married. This is very common among the pastoral communities of Kenya such as the Maasai, the Pokot and the Rendili (Kang'ethe 2013). This explains a situation in which a young woman is exposed to sex before her genitalia are strong or ready for the task. This also could easily allow viral transmission with ease. This is because of the increased probability of bruises in the vagina during intercourse. Some of the patriarchal societies have also culturally maintained the practice of female genital mutilation (Wodenmicael 2009). Since the process is usually carried out without the observation of scientific ethos such as ensuring anesthesia and using only one cutting instrument for each initiate, this gives birth to opportunities for viral epidemiology with ease.

## FACTORS MITIGATING THE EFFECTS OF HIGHER HIV/AIDS PREVALENCES

### Strengthening Poverty Alleviation Programs

Since poverty has been pinned as the single most factors driving the epidemic, it is incumbent upon resource constrained countries to plan, replan, reformulate and strategize newer approaches of tackling poverty. Since the Structural Adjustment Programs (SAP) of the 1980's did not succeed in tackling poverty, this researcher advises resource constrained countries to look for economic solutions in their backgrounds. This would mean identifying indigenous ways and methodologies to approach economization of their resources. Exploring indigenous resources and coming up with people driven and people friendly approaches could be in this researcher's contention, a panacea (Kang'ethe 2011; Osei-T Hwedie and Rankopo 2008; Alexander 2009; Mulinge and Mufune 2003).

### Sustained and Effective Sexual Behavioural Change

All the HIV/AIDS campaign should invest heavily in behavior change. The pathetic state of the affairs of the campaign is that a lot of money is used to address the symptoms and effects of the HIV/AIDS. This indicates that the campaign has not been well formulated and conceptualized. Perhaps the countries that are not doing well need to borrow a leaf from countries such as Uganda that invested heavily in prevention (Kang'ethe 2014c). However, because ARUS are giving people a new slate of life even

when one is infected, it is important to also invest heavily in anti-stigma campaigns. This is to ensure people living with the HIV/AIDS enjoy positive living. This researcher takes this forum to urge South African government to continue investing heavily in the campaign to address stigma. This is because stigma, according to the wise words of former Botswana President, Festus Mogae is the hugest stumbling block towards prevention, care and support (UNDP 2004).

### Diluting Cultures and Weakening the Patriarchal Mindset

Countries that are patriarchal needs to mobilize and urge its citizens to undergo a paradigm shift and become culture neutral, gender neutral and human rights sensitive. This is to allow women empowerment and emancipate them from oppression and suppression emanating from cultural and patriarchal mindset of especially men and also the serving social institutions (Kang'ethe 2010a). This may require ample goodwill from the government and other human rights and gender friendly bodies such as the NGOs. The government and these bodies need to consider a thorough cost benefit analysis of the impacts of cultures and the developmental gaps that they are responsible for by stifling women's emanicipatory prowess.

## CONCLUSION

The fact that 70-80 percent of the HIV/AIDS cases find refuge in Africa South of Sahara is not only heartbreaking to governments of these countries, but also to HIV/AIDS practitioners such as this researcher. However, countries should seriously continue to engage in interventions to change the environment that makes the HIV/AIDS epidemiology a fast one. Researchers have a responsibility of investigating and reinvestigating the different dynamics responsible for this epidemiological terrain, even after governments through the assistance of international bodies and countries continued to financially fund most of the HIV/AIDS campaigns. Since poverty, gender inequalities, state of health infrastructure have been pinned as major driving factors fuelling the HIV/AIDS epidemiology, it's is high time that more money is directed to addressing these challenges. Collaboration between the government and other stakeholders such as the NGOs is critical.

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