

CONTRIBUTORY FACTORS TO THE SPREAD OF HIV/AIDS AND IT IMPACTS IN SUB-SAHARAN AFRICAN COUNTRIES

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Abstract

This paper attributes the fast spread of HIV/AIDS in Sub-Saharan African countries to the prevailing dominance-subservience relationships in the region. The unequal relationship exists in gender, economic and international relations. The three forms of inequality work synergistically to make Sub-Sahara Africa the most afflicted and threatened region by HIV/AIDS. Currently, young females group is most afflicted by HIV/AIDS. Differential gender power relations and cultural mores that allow males to have many sex partners precipitate this. Older males often prefer and procure younger female as sex partners. The females yield because of the large material rewards they receive from the men. Due to the economic recession in the region, some young females take to the provision of commercial sex services to meet their material requirements. There is also the international traffic in young female which male facilitate at source in Sub-Saharan Africa and at the point of delivery in the developed countries. It is instructive that females have little power for negotiating safe sex with even their husbands and virtually none to insist on precaution in commercial sex-relations. This fast propagation of the virus in Africa is attributed to its finding a more congenial social, political and economic environment for survival. The congenial environment has been created by, among other vices, economic disorganization, poverty and the sexually permissive youth sub-culture that has emerged from the culture of poverty. The spread of HIV/AIDS has significant impacts on the health sector, education sector, economy, life expectancy, food production and on the children of HIV/AIDS victims. It is therefore concluded that HIV/AIDS, like other infectious diseases (e.g. tuberculosis, cholera, etc), thrive most in poor social economic reforms that make female, in particular,

have adequate material resources and for habitually promiscuous males and females to beware and take necessary precautions against the spread of HIV/AIDS.

Keywords: Dominance, Subservience relationship, Gender relation, Prevalence, Epidemic, Impact, Life expectancy, Mortality, Sexual permissiveness, Safe sex

Introduction

The Acquired Immune-deficiency Syndrome (AIDS) is principally a sexually transmitted disease. Medical scientist agrees that Human Immune-deficiency virus (HIV) cause the syndrome. Currently, 80% of HIV positive people in Africa acquired it through sexual intercourse. Ten percent are infected through blood transfusion donated by HIV positive people, and 10% through contact of blood in circulation system with the HIV contaminated objects like shaving blades, injection needles and other objects used in piercing the body for medical, cosmetic and other purpose (Karewa, 2000).

Although HIV and AIDS were first clinically identified in the USA, in the early 1980s, HIV/AIDS are currently more prevalent in the developing countries. Within the developing countries, the AIDS scourge is most prevalent in the Sub-Saharan Africa countries. Currently there are about 36.1 million people afflicted by HIV/AIDS in the world with about 25.3 million, (70%) in Sub-Saharan Africa (Okeregbe, 2000). The epidemiology of HIV/AIDS across the developed and developing countries is therefore similar to those of the infectious diseases like Cholera, Measles, and Tuberculosis. Their pathogens and respective media of transmission can thrive in virtually all part of the world but whose morbidity and prevalence rates are higher in the developing countries because of poverty, poor knowledge of hygiene and poor availability of disease preventive measures. The combination of low level of knowledge and poverty lead to poor environmental sanitation, malnutrition, and overcrowding, limited availability of portable water and host of other indicators of poverty.

A study conducted by the United Nations Development Program (UNDP) in 1996 on Human Development Index (HDI), whose calculation is based on “healthy life”, “knowledge” and “descent standard of living”, found that 33 (68.8%) of the 48 countries revealed that all over the world, 1.3 years of human development progress had been lost between 1980 and 1992 due to the ravage of AIDS, but that the setbacks were most severe in Sub-Saharan Africa countries. According to the findings, Zambia had a setback of more than 10 years, Tanzania 8 years, Rwanda 7 years and central Africa Republic 6 years. Burundi,

Malawi, Uganda, Kenya and Zimbabwe had setbacks of between 3 and 5 years each (UNDP, 1996). All of these countries are among the 51 countries that have the least HDI in the world. It is therefore justifiable to view AIDS as a disease of poverty.

Two - thirds of all people infected with HIV live in Sub-Saharan Africa, although this region contains little more than 12 percent of the world's population (WHO/UNAIDS/UNICEF, 2011). HIV/AIDS has caused immense human suffering in the continent. The most obvious effect of this crisis has been illness and death, but the epidemic has certainly not been confined to the health sector, households, schools, workplaces and economies have been badly affected.

It has been argued that the spread of AIDS had been escalated to the present dimensions, because it was considered a disease of deviant sub-group in society. The disease was first identified among USA male homosexual and intra-venous drug addicts who shared injection needles. Members of these similar groups are often considered morally deprived and constituting social problem. HIV/AIDS was therefore perceived by some national and international agencies as a self-incurred affliction of members of deviant and other unwanted sub-cultural minorities. The next group of AIDS patients in the USA in the early 1980s was Haitian immigrants, the blacks and set of cultural minorities in the 1980s. Both the USA and the World Health Organization did not accord AIDS the necessary control measures deserved by a new disease that would become a global pandemic (Karewa, 2000).The apparent absence of aggressive enlightenment campaigns on the vulnerability of member of the public resulted in inappropriate attitudes, like disbelief in the phenomenon of HIV/AIDS. These strengthened the continuation of HIV risk laden behavior among underprivileged people.

Some Nigerians, Kenyans and South Africa considered AIDS a foreign disease that could affect only those Africans who travelled abroad and engaged in promiscuous sexual activities (Williams, Nganga and Ngugi). Some Nigerians are reported to have made fun of the acronym "AIDS" as "American Invention to Discourage Sex". The denial of AIDS as a public health problem in Nigeria persisted strongly for several years to the extent that the Nigerian Ministry of Health's 1992 documentary film for public enlightenment on HIV/AIDS was entitled "Dawn of Reality." The film is focused on convincing those disbelief the existence of HIV/AIDS to believe and to protect themselves from the deadly intractable disease.

During 2010 alone, an estimated 1.2 million adults and children died as a result of AIDS – related illnesses in Sub-Saharan Africa (UNAIDS,2011). Since the beginning of the epidemic more than 15 million Africans have died from AIDS – related illnesses (UNAIDS,

2008). Although access to antiretroviral treatment is starting to lessen the toll of HIV and AIDS, fewer than half of African who needs treatment are receiving it (WHO/UNAIDS/UNICEF, 2011).

The purpose of this paper is to highlight and discuss the prevailing social, economic and other power relation in which sexual intercourse takes place between sexual partners that promote the fast spread of HIV/AIDS in Sub-Saharan Africa countries. The paper asserts that people at the lower level of social strata like young female labor migrant and other economically and politically disadvantaged people are more prone to HIV infection. This is because underprivileged people are more prone to having unprotected sexual intercourse. They are also more likely to come in contact with HIV contaminated objects like shaving blades and injection needles. The underprivileged people are also more likely to live with untreated sexually transmitted disease which results in various forms of genital ulcers which drastically increase the risk of HIV transmission.

HIV-prawns in this paper is defined as a propensity to have unprotected forced or promiscuous sexual intercourse. Due consideration is accorded the group of people who by virtue of their subservient status acquiesce in unsafe sex and those who due to limited knowledge are unaware of HIV/AIDS. Thus the role of traditional sex ethos, the current political and economic crises in Sub-Saharan countries and the emergent youth sex sub-culture in a culture of poverty in propagating HIV/AIDS constitute the focus of the study.

Factors Responsible for the Spread of HIV/AIDS

(a)Traditional Sex Ethos to Unsafe Sexual Practices in Sub-Sahara Africa

In several developing countries, sexual prowess is highly valued. There is for instance the machismo complex in the Latin American countries, which requires male to demonstrate virility by having many sex partners (Hughes, 1988). In some Sub-Saharan Africa countries sexual intercourse between non-marriage partners is a requirement for some ritual practices. Cullen and Khalokho (2000) found that in Mbale District of Uganda, boys are circumcised as part of passage de rite at the adolescent stage. A period of one month is fixed during the initiation rites when the boys are required to have sexual intercourse. Eligible female partners must be of comparable ages to the boys, it is necessary for several boys to have sexual intercourse with the same female and vice-versa in order to have the required number of partner for successful completion of the ritual.

The traditional sex ethos among some Kenyan and South African cultural groups also requires females of non-prohibited degree of relationship to grant a request for sexual

intercourse by a male. The female themselves express this feeling of obligation to provide sexual service for such male (Bauni and Jarabi 2000; Masland, 2000).

In some cultures, the friends and relation of deceased married male are required to have sexual intercourse with his widows as part of the purification rituals. Similarly, widowers may be required to have sexual intercourse with other females. The widows are sometimes coerced to have the “ritual” sexual intercourse. Some of the male relations of the diseased insist on having the sexual intercourse even when the widow is HIV positive. Other culturally prescribed sexual liaisons for widow is the levirate whereby male sex partners can be arranged for a widow been members of the late husband’s agnatic relatives.

These culturally prescribed acts of sexual promiscuity are potentially HIV-risk laden. Their retention is partially due to cultural lags between the functions that such practices used to perform at an earlier stage in the Cultural Revolution and the present circumstances where unprotected sexual promiscuity is fraught with risk of being infected with HIV. Traditional forms of grooming like traditional/ ritual barbing, tribal marks of identification and ritual circumcision. Procedures for males and females are also fraught with HIV infection. These are often done in ritual ways. There may be resistance to introducing modern hygienic practices that may require sterilizing the object. Fixations to harmful traditional practices are sustained by poverty, low level of educational attainment and superstitious beliefs.

Apart from traditional cultural practices, some modern sub-cultures, occupations and superstructures have emerged that necessitate unsafe sexual practices for particularly underprivileged people. Penetrative homosexual acts are for instance common among male labourers in work camps (Hendricks, 1992). Homosexual acts among males are common in African Prisons. Antonius’ (1994) study of a Zambian prison revealed that 12% of male inmates had anal penetrative sex during their incarceration. Inmates at the lower rung of the pecking order are often forced to have anal sex. Some of the Zambian prisons allow visits by inmates’ wives and other sex partners when sexual intercourse is permitted. Intra-venous drugs reported to be smuggled to prisons and administered to several addicted inmates by a shared needle. On release, inmates who may have been infected by HIV during their incarceration resume normal sexual activities with spouses or other types of sex partners and pass on the virus. Both traditional practices and modern total institutions therefore contribute to the spread of HIV among underprivileged people in Sub-Saharan Africa.

(b)Economic Underdevelopment and Disorganization: Sub-Saharan African Countries are among the poorest countries in the world. They also have the highest HIV/AIDS prevalence

rates (Okeregbe, 2000). Poorly developed extractive industries, distributive trade and services and the traditional peasant subsistence agriculture typify the contemporary pursuits of most of the poorest countries. Factors like civil wars in a large number of countries, low level of technology, poor farm inputs and desert encroachment are weakening subsistence agriculture. Consequently a large number of people of productive age prefer wage employment. Some establish small-scale businesses. These preferred forms of economic pursuits thrive better in the urban than rural settings. There is therefore a substantial emigration of able-bodied rural dwellers to urban areas in search of the few available jobs. A large number of labour migrants end up unemployed and constitute a lumpen urban proletariat.

Most rural-urban migrants are males who meet their sexual needs through commercial or other forms of promiscuous sexual outlets. The female rural counterparts seize the opportunities of the potential male clients of the sex market and migrate to urban areas with the main objective of making a living through full time or clandestine commercial sex work (Chela and Mensah, 1995).

Obbo (1980) and Little (1975) have written substantially on how young African women in their respective communities of study make seasonal or permanent migration to towns with the objective of surviving on male sex partners they would meet there. When in town, it is economically more viable for such females to have more sex partners. Some females who participate in the distributive trade are expected to gratify the male consigners through sexual services.

Rural-urban migration predisposes migrants' spouses left at home to sexual promiscuity. Spouses in the homeland may take up lovers. Moreover, a common feature of rural urban migration in Sub-Saharan Africa is regular home visits to see members of the family or attend festivals. Unprotected sex with infected returning migrant partners takes place, leading to the spread of HIV in the rural homeland. Thus urban areas are endemic foci from which HIV is transmitted to rural areas through various contacts (Good, 1991; Miller 1991; Gelhoed 1991).

Another important root of economic disorganization in some Sub-Saharan African Countries is the displacement of indigenous people from their farmlands. The process started in the Eastern, Central and Southern Africa in the early periods of colonization. The countries most affected include Uganda, Kenya, Zambia, Zimbabwe, Angola, Mozambique, and, the most affected, South Africa. In Southern Africa in particular, the effect of this displacement persisted even after independence. The affected Africans continued to work on commercial farms and other extractive industries as labourers. Some of the conditions of employment

require the segregation of spouses and other members of the family, which necessitate involvement in non-marital sex.

The high prevalence of AIDS in Zambia and other countries that had similar colonial histories are related to the subjugation and privations that they had suffered earlier on. The breakdown in traditional economic structures led individuals to resort to strategies of survival in which commercial sex and other promiscuous sexual relations that led to material rewards were practiced. These resulted in high prevalence of STDS. The services of sub-professional medical care providers were patronized for treating the STDS and other diseases with antibiotics and shared needles (van de Gest 1982; 1985).

Heterosexual men who were cut off from female partners also resorted to homosexual acts. Thus labour migration and other forms of economic disorganization are implicated in HIV/AIDS risk laden sexual behaviours. Most of the migrants live in abject poverty and are unable to buy condoms (Chirwa, 1993). These prevailing situations have facilitated the spread of HIV/AIDS. Besides the poverty itself leads to a form of social insulation among the poor group, which hampers the effective dissemination of appropriate information on HIV/AIDS and preventive measures.

Another important component of the modern economy is the transport industry. Long distance drivers and other crew in the transport industry spend several days away from their homes and spouses. They often have sex with partners at various destinations and stopover points along the routes. The risk of HIV infection is increased by the low level of formal educational attainment and disinclination to use condoms among this category of workers. Their spouses are less likely to ask for protected sex and least powerful to insist on safety measures even if they are aware that their husbands have other sex partners on their trips.

Also, there are the armed conflicts that have occurred in several Sub-Saharan African countries since the 1960s to date. War situations are anarchies. Raping is common. It is a common practice for victorious armies to develop consensual sexual relations with females of the conquered group. Robinson (2000) has however found that more than 30% of soldiers in many African armies are HIV positive. Wars therefore help spread HIV in Africa.

It is emphasized that the contemporary economic situations in Sub-Saharan Africa countries have created a category of lumpen proletariats in whose sexual outlets are mostly promiscuous. The use of sex as means to economic goals is commonly resorted to. Some well off members of the society exploits the desperate situations of the underprivileged to sexual access to them. This creates a promiscuous society most of whose members engage in HIV-prone sexual behaviours.

(c) Youth Sexual Behaviour in a Culture of Poverty: The youth bear a disproportionately large proportion of the brunt of economic and political instability that result in adult poverty. When parents experience economic down turns, it is children's interests like school attendance, clothing and feeding that are curtailed as adjustment strategy. Such children may engage in child labour to support their parents. All over the world, 404 million children of school age are not attending school. One hundred million of them make their living on streets either doing odd jobs like begging, stealing or engaging in commercial sex activities. Ten million of the street and working children have cut off tie with their families mostly due to the inability of parents and guardians to provide the means of sustenance for them. On the street, they have n form of adult control over them (UNICEF 2000; PRB 2000; Lugalla and Mbwambo 1999). The affected youth have to develop individual survival strategies, which include commercial sex. Moreover, such children are prone to sexual molestation by stronger members of fellow street children and adults.

The street children are however mostly perceived as a deviant group rather than victims of economic and political circumstances (Lugalla et al 1999). This is mainly on account of innovative strategies like the consumption of addictive drug, instrumental sexual liaisons, theft and other behaviours considered as vices that they resort to for coping. The fact that street children start taking to the streets at young ages (in some cases as young as eight years), the period of sexual maturity sets in when they are on their own in the street with no adults in authority to control,. The turbulent sexual behaviours of adolescents, the street children develop their own sex ethos, which include HIV-risk laden behaviours and penetrative anal sex is for instance common among males. Older members resort to it as an initiation for new arrivals in the street when the novice is virtually gang-raped. Others also mete out gang raping as punishments to "deviant" male and female members of street children. Some street girls attach themselves to particularly night watchmen for protection in exchange for sexual favours. Some proprietors of sex industry establishments are reported to engage the services of street children whom they pick, clean up, dress them in clean clothes and give them out to clients for sexual services (Gaviria ,1990).

In some of the down trodden communities however, both parents and female children view commercial work by girls as the only means of earning income for the family. A trend is emerging in the sex industry in the developing countries that is the international trafficking in young females for the sex industry. The females are moved either from the developing countries to another or from developing to developed countries. Although this traffic does not preclude street children, the emphasis at this point is on the fact that some parents

facilitate their children's entry into the business. Some parents are to pawn their children to the dealers on terms that are very difficult for themselves and their children to redeem. It is a form of sex slavery. Poverty is therefore instrumental to the thriving of the international sex market.

For children who continue to live with parents, a culture of pre-marital sexual activity is fast developing in both developed and developing countries. This trend is in fact quite a common sexual behavioural trait in Sub-Saharan Africa. Some female students in tertiary institutions of learning for instance maintain several other rich male sex partners known to a male student sex partner. The male student acquiesces in the relationship because his girl friend maintains the other sex partners for the material rewards they provide for her and often shared by him.

From the foregoing, it is evident that the poor material conditions of some parents could subject their children to cater for their own material needs. In the process of acquiring such needs the children subject themselves to exploring various avenues, which include the provision of various forms of sexual services. These sexual services are either presented on a competitive basis or commandeered by some powerful partners or exploiters. The children are not in a position to opt for safe sex in most of such instrumental sexual liaisons. Besides, it is evident that some of the children do not know the dangers of their sexual behaviours. A large number of them have none or low levels of formal educational and have lived most of their lives in streets without adults who could educate them on safe sex. The consequences of these traits for the youth are manifesting in the fact that HIV positivity is higher among the youth. Within the youth category, HIV positivity is higher among the females than males.

Impacts of HIV/AIDS

1 .**Impact on Health Sector:** As the HIV prevalence of a country rises, the strain place on its hospitals is likely to increase in Sub-Saharan, people with HIV-related occupy more than half of all hospital beds (UNAIDS,2006).Hospitals are struggling to cope, especially in poorer African countries where there are often too few beds available. This shortage results in people being admitted only in the later stages of illness, thus reducing the chances of recovery. While HIV and AIDS are causing an increased demand for health services, large numbers of health care professionals are being directly affected by the epidemic. For example, 17% of its health care workforce due to AIDS between 1997 and 2005. A study in one region of Zambia found that 40% of midwives were HIV- positive (UNAIDS, 2006).

The recent increase in the provision of antiretroviral drugs (which significantly delay the progression from HIV to AIDS) has brought hope to many in Africa. It has also put increased strain on health care workers. Providing antiretroviral treatment to everyone who needs it requires more time and training than is currently available in most countries.

2. The Economic Impact: AIDS has played a significant role in the reversal of human development in Africa. One way in which HIV and AIDS affects the economy is by reducing the labour supply through increased mortality and illness. Among those who are to work productivity is likely to decline as a result of HIV-related illness. In the same vein, Government income also decline as tax revenues fall and governments are pressured to increase their spending to deal with the expanding HIV epidemic. The impact the HIV and AIDS has had on the economies of Africa countries is difficult to measure (UNDP, 2005).

3. The Impact on Life Expectancy: In many countries of Sub-Saharan African AIDS is erasing decades of progress in extending life expectancy in the worst affected countries. Average life expectancy has fallen by twenty years because of the epidemic (UNAIDS, 2008). The impact that AIDS has had on average life expectancy is partly attributed to child mortality, as increasing numbers of babies are born with HIV infections acquired from their mothers.

4. The Impact on the Educational Sector: The relationship between HIV/AIDS and the education sector is circular - as the epidemic worsens, the education sector is damaged, which in turn is likely to increase the incidence of HIV transmission. A decline in school enrolment is one of the most visible effects of the epidemic. This is itself will have an effect on HIV prevention. This is because a good, basic education ranks the most effective and cost effective means of preventing HIV (The World Bank, 2002).

HIV and AIDS are having a devastating effect on the already inadequate supply of teachers in African countries. For example, a study conducted in South Africa found that 21% of teachers aged 25 – 34 were living with HIV (UNAIDS, 2006).

5. The Impact on Children: As parents and family members become ill, children take on more responsibility to earn an income, produce food, and care for family members. It is harder for these children to access adequate nutrition, basic health, housing and clothing. This is because AIDS claims the lives of people at an age when most already have young children. More children have been orphaned by AIDS in Africa than anywhere else. Many children are

now raised by their extended families and some are even left on their own in child-headed households (UNAIDS, 2008).

6. Impact on Food Production: The HIV and AIDS epidemic adds to food insecurity in many areas, as agricultural work is neglected or abandoned due to household illness. In Malawi, where food shortages have had a devastating effect, it has been recognized that HIV and AIDS have diminished the country's agricultural output (bbc.co.uk.October,2005). It was calculated in 2006 that by 2020, Malawi's agricultural workforce will be 14% smaller than it would have been without HIV and AIDS. In other countries, such as Mozambique, Botswana, Namibia and Zimbabwe, the reduction is likely to be over 20% (UNAIDS, 2006).

Conclusion and Recommendations

In conclusion, it is emphasized that differential power relations at the international, national and micro-social levels of interaction propagate HIV/AIDS in Sub-Saharan Africa. Although the issue of cure for AIDS has not been the focus of this study, it is necessary to mention the significance of failure to find a universally available remedy for the disease. There are presently drugs that inhibit and therefore delay the development of HIV into full-blown AIDS in the developing countries. Similarly, there are palliative drugs for managing full-blown AIDS patients, however, the drugs are still very expensive and cannot be afforded by most HIV positive and full-blown AIDS patients developing countries and Sub-Saharan African in particular (Adekeye, 2000). Why do the drugs continue to be so expensive? What prevents the formulation of less costly versions of such valuable drugs that can prolong the working lives of dying people? It is also necessary to consider the claims of discovery of prophylactics and cures for HIV/AIDS by several spiritual and traditional healers, even scientists in Sub-Saharan African countries (Lucas, 1994). How have the respective national governments of such claimants reacted to the claims? In Nigeria the government banned the application of vaccination and treatment of AIDS by all categories of healers in the country when two claimants were becoming famous for their perceived successes in preventing and treating HIV/AIDS in Abuja in 2000 (Adekeye, 2000).

Sub-Saharan African Countries have 70% of the world's HIV/AIDS patients. Have the governments in the countries in the region adopted viable measures of prevention? What are the specific aspects of interpersonal relations that helped propagate AIDS in Sub-Saharan Africa that are absent or controlled in the developed countries? The answer to the last question is very pertinent to the control of HIV/AIDS in Sub-Saharan Africa. This is because

HIV/AIDS, unlike other virile infections that can either be air-borne, through casual or droplets, is contracted through intimate contacts sharing procedures that are often planned by either both or at least one of the parties. Eighty percent of such contacts that result HIV/AIDS infection is sexual intercourse. It is therefore recommended that governments of Sub-Sahara African countries should mount aggressive campaigns on safe sexual behaviour. Both religious morals and scientific medical principles should be applied to attain the required level of sexual hygiene that could reduce the incidence of the HIV infections. Uganda and Senegal are for instance reported to have reduced HIV transmission through radio campaigns for safe sex and blood transfusion. Senegal started its own campaigns in the 1980s. It still has an infection rate of less than 2% in the year 2000. This shows that the knowledge and application of common health risks to the dominant and subservient partners in sexual relations can result in the practice of safe sex that would reduce HIV/AIDS prevalence. In pursuing such enlightenment campaigns, the social, economic and political inequalities that predisposed low status citizens to unsafe sex must be attacked and eliminated.

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