HIV/AIDS: South African women at risk

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This paper engages some aspects of the HIV/AIDS epidemic and the complexities associated with it. It outlines the socio-epidemiological patterns of the epidemic and in doing so identifies the groups with the greatest and fastest growing rates of infection. The pattern of the epidemic in South Africa is as follows: it is primarily a heterosexual one, the rates of infection in the general population are very high, and the percentage of HIV positive women is greater than men. An additional feature is 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. In order to shed light on the position of women in the epidemic and the particular risks they face, we examine the long-standing relationship between gender and racial inequalities and health.

Within the constraints of limited and flawed statistical data, the paper argues that a complex interaction of material, social, cultural and behavioural factors shape the nature, process and outcome of the epidemic in South Africa. It concludes with recommendations for the way forward.

Keywords: HIV/AIDS, health inequalities, gender inequalities

Introduction

Since the beginning of the AIDS epidemic 50 million individuals have been infected with HIV and over 16 million have died (UNAIDS, 1999). In 1999 AIDS deaths, internationally, reached a record 2.6 million with a further 5.6 million adults and children becoming infected (UNAIDS, 1999). In 1990, 1% of pregnant women attending antenatal services in the public sector in South Africa were HIV positive. By the end of 2000 this figure had risen to 24.5% (Abdool Karim, 2000; Department of Health, 2001). According to the South African Health Review (2000), ‘one in eight adults (15–49 years of age) is infected with HIV’ (between 12 and 14%), in South Africa. The latest MRC report estimates that ‘about 40% of the adult deaths aged 15–49 that occurred in the year 2000 were due to HIV/AIDS’ (Dorrington, Bourne, Bradshaw, Laubscher & Timaeus, 2001, p. 6). 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. Yet the burden of this epidemic does not fall evenly or equally. Rather, as also mentioned in other studies (Ndiaye, 2000; Susser & Stein, 2000), this paper demonstrates the overwhelming majority of those currently living with HIV/AIDS in South Africa are young African women. We argue, 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 reflects broader social cleavages and inequalities. Sociological 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 individual behaviour patterns cannot be ignored this paper argues that social inequality (and gender inequality in particular) is the greatest transmitter of HIV/AIDS. Consequently, strategies for change need to address social inequality and the empowerment of women if rates of transmission are to decline.

To draw attention to the particular position of women in the HIV/AIDS epidemic this article reviews some of the key epidemiological data and situates this in terms of relevant sociological literature on the relationship between health and social inequalities. In doing so it attempts to explain why women in South Africa are currently most at risk.
Health and social inequalities

The existence of health inequalities (measured in a variety of ways by comparing various indices) between populations in more and less developed countries as well as within different groups in industrial countries is a well-established phenomenon (Kaplan, 1996; Wilkinson, 1996). There is no doubt that the size and nature of these inequalities present a major public health issue and as such they have been the focus of numerous health studies as well as health policy undertakings (Black, 1991; Benzenvail, Judge, & Whitehead, 1995; Wilkinson, 1996; Kaplan & Lynch, 1997).

The evidence presented in the literature clearly demonstrates 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 cannot be examined in isolation since they interact with and produce a highly complex social pattern of differences in health and illness across populations (Nettleton, 1995). Socio-economic inequalities and differential income distribution (or class) have been the main focus of inquiry in an attempt to understand the differences in health. As Robert and House (2000, p. 115) state, ‘Socio-economic inequalities in health have been observed persistently over the course of human history. These differences are manifest across individuals, communities, and societies, and recent analyses suggest that for the most part they have increased over the past century, and even in the past few decades’.

It is understandable that in the main, the literature has been concerned with economic indices and their relationship to health outcomes mostly in industrial countries. Many of the studies have managed to successfully document the existence and patterns of socio-economic inequalities in health but have been less successful in explaining why these inequalities persist (Feinstein, 1993; Robert & House, 2000).

The four explanations identified and assessed by the Black Report (Townsend & Davidson, 1982) and The Health Divide (Whitehead, 1988) have formed the basis of the debate concerning the relationship between social and health inequalities. Without entering this debate fully, for the purpose of this paper, reference will be made to the cultural/behavioural and the materialist/structural explanations only, since these two take a sociological standpoint by arguing that inequality in health reflects material or cultural deprivation. According to both, health is recognised as a product of social forces whether these take a material (economic) or a cultural (normative) form (Hart, 1986).

Although cultural/behavioural and materialist/structural explanations can be distinguished conceptually, several authors have emphasised that they cannot be isolated (MacIntyre, 1986; Whitehead, 1988). Behaviour is to a great extent shaped by the environment and the social context, through material deprivation, lack of power, poor living and working conditions — thus freedom of choice with respect to lifestyles may be restricted by the environment (Stronks, Van de Mheen, Looman & Mackenbach, 1996). For these reasons, explanations for health inequalities need to take account of both material and cultural differences (Jewson, 1997).

The HIV/AIDS epidemic and in particular its differential growth patterns in developing and developed countries as well as within countries on racial, gender and class basis necessitates another, more in-depth look at the relationship between social inequality and the epidemic. Zierler and Krieger (1997, p. 401) explain women’s risk of HIV infection ‘in light of four conceptual frameworks linking health and social justice; feminism; social production of disease/political economy of health, ecosocial and human rights’ in the United States. They argue that, ‘fundamental determinants of HIV risk among women are social inequalities involving class, race/ethnicity, gender and sexuality’ (Zierler & Krieger, 1997, p. 425) which are primarily responsible for the higher prevalence of AIDS amongst African American and Latina women living in poverty. Similarly, this paper focuses attention to the vulnerability of African women in the HIV/AIDS epidemic in South Africa, and acknowledges the significance of gender, race and poverty as central in shaping women’s risk. We now turn our attention to these issues.

Gender and racial inequality

This paper rests on a series of assumptions, one of which is that all societies continue to be divided along the ‘fault line’ of gender, which considerably affects the health and wellness of both men and women. The differences (and the factors which influence them) between men and women’s health have been extensively researched and well documented (Oakley, 1984; Roberts, 1985; Papanek, 1990; Miles, 1991; Doyal, 1994; Annandale, 1998). Lane and Cibula (2000) argue that much of this research can be located within two main approaches. The first seeks to understand how culture shapes gender roles and therefore health perceptions, policy and research questions and the second relies on epidemiological measurements of health status, morbidity, and mortality’ (Lane & Cibula, 2000, p. 136). This paper invokes both in an effort to understand the impact of gender and racial inequality on patterns of HIV/AIDS in South Africa.

The refrain ‘women get sick and men die’ rests at the core of a great deal of research (and cuts across different paradigmatic and methodological approaches) on gender and health. Recently, some authors have sought to point to the complexities underpinning gender and health status which are not adequately captured in this notion. For example, Annandale (1998, p. 128) argues that the pattern of female mortality advantage is a contemporary trend which is declining, in part, a result of men’s improved mortality which is itself a feature of the increasingly prominent notion that ‘masculinity is bad for your health’. One unintended (and ironic) consequence of patriarchal power has been to impact negatively on men’s health; for example in South Africa, it is young men between the age of 16 and 24 that are most likely to shoot and be shot at (Taylor, 1998). The work of Verbrugge (1988), Hart (1989), Simon (1995) and others have problematised the concept (and definitions) of gender in measuring the relationship between gender and health in an effort to understand the gendered nature of morbidity and mortality patterns. One issue which inverts the notion ‘men die and women get sick’ is that of HIV/AIDS, for in South
Africa and developing countries generally, it is primarily (and increasingly) young women who get sick and die. A full discussion on the relationship between gender inequality and HIV/AIDS would necessitate looking at infection rates for both men and women. However, this paper is primarily concerned with the impact of HIV/AIDS on women for as Doyal (1995, p. 1) suggests ‘gender differences are especially significant for women, since they usually mean inequality and discrimination’. Nowhere is this more evident than in regard to HIV/AIDS in South Africa.

If the relationship between gender and health (where gender is a category of inequality) has only relatively recently come to forefront of health research then the absence of race and ethnicity is even starker. Annandale (1998, p. 161) remarks ‘...sociologists of health and illness are now beginning, albeit belatedly, to engage with these debates [around the nature of race and ethnicity in the context of post-modernity] and to highlight the crucial importance they have for the relationship between racism and the experience of health and illness’. Some sociologists have also been concerned to expose (drawing on the work of Foucault (1973) in particular) the ‘body’ as a site of racialised discourses: ‘Medicine was, and continues to be a prime vehicle for the imposition of the classificatory gaze (racial and gendered) upon the body’ (Annandale, 1998, p. 164) (see for example: Lupton, 1997; Turner, 1997; Bury, 1998). Much of the current research on race and health has sought to problematise the very categories of race, ethnicity and culture invoked to measure health status and race.

Yet, understanding the relationship between health and race is as much an investigation of racism and racial inequality as the study of women’s health is the study of gender inequality. In attempting to tackle this question Andrews and Jewson (1993, p. 149) usefully suggest that ‘race should be viewed as integral to whatever analysis is developed, and the question posed not whether it operates but when, where and how’. This point is reiterated by Zierler & Krieger (1997) in their discussion on race/racism and HIV in women in the United States. This paper suggests that the fault lines of gender and race are clearly apparent in the rates of infection of HIV/AIDS and examines (in brief) the social situation of women (particularly poor African women) in South Africa.

The position of women in South Africa

A recent base-line study ‘Key Indicators of Poverty in South Africa’ revealed that South Africa still had 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 (South African Health Review, 2000, p. 3). While population estimates (based on the 1996 census) reveal similar numbers of men and women living in urban areas (although there are differences across provinces), in non-urban areas 53% of the population is women (South African Health Review, 2000, p. 3). As Baden, Hassim and Meintjes (1999, p. 17) point out ‘Women predominate in rural areas, which are the poorest areas’. Moreover, a household headed by a woman (regardless of geographical locality) 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 economically active African women and 29% of African men were unemployed, compared to only 4% of white men and 8% of white women. On average women earn between 72% and 85% of what men with 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 most African women in the South African economy is largely 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 and over a quarter of African women had not passed grade 5, 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 had dropped out because of pregnancy. This survey is corroborated by recent figures from Statistics South Africa which show that ‘in one year, more than 17 000 babies were born to mothers 16 and younger. Of that number, 4 000 babies were born to mothers under 14’ (The Star, 2000).

These figures indicate that young African women are the poorest, most economically marginalised and least educated sector of the South African population thus placing them at the bottom of the health pile in this country, and rendering them particularly vulnerable to HIV/AIDS, in terms of their race, gender and class position (Ndiaye, 2000; Susser & Stein, 2000; Williams, Gouws, Colvin, Sitas, Ramjee & Abdool Karim, 2000).

The concept of ‘vulnerability’

So far this paper has suggested that women in South Africa are disadvantaged on various levels and, as will be shown later have higher rates of HIV/AIDS. In order to shed light on this complex scenario, we suggest that the concept of vulnerability is particularly useful in both explaining and changing the current situation.

According to Hubert and Delor (2000) the HIV/AIDS epidemic has been linked to the term of ‘vulnerability’. They are of the opinion that ‘although the concept of vulnerability is becoming central, certain difficulties arise when it comes to applying this concept to actual situations at the heart of which individuals and groups are more exposed to HIV’...thus they argue further that ‘work to clarify the concept is necessary’ (Hubert & Delor, 2000, p. 1558) in order to minimise ambiguity in its use. Discussing the concept ‘vulnerability’ in the context of this paper and linking it to the patterns of HIV/AIDS responds, in part, to this challenge.

Kalipeni (2000) refers to a tripartite explanation of vulnerability consisting of entitlement, empowerment and political economy. Applying these concepts to the HIV/AIDS situation in Ghana, Oppong (1998) argues that ‘while all human beings are biologically susceptible to infection by different diseases such as HIV/AIDS, certain social and economic factors place some individuals and groups in situations of increased vulnerability’ (cited in Kalipeni, 2000, p.
This echoes a similar argument previously advanced by Shuval (1981) in order to explain high incidences of various diseases among categories of ‘individuals who are viewed as socially more vulnerable’ (Shuval, 1981, p. 342).

Barnett and Whiteside (1999) provide a conceptual framework in an attempt to explain and predict the HIV/AIDS epidemic. They use the concepts of susceptibility and vulnerability in combination with wealth and income to create a typology of four different ‘types’ of society and argue that these ‘types’ are linked to four different epidemic curves. This is termed the ‘Jaipur Paradigm’ and is used to explain the patterns found in five case studies.

What makes people vulnerable to ill-health (or certain diseases)? An attempt to answer this question will have to address a range of factors and the complex relationship between them. These, it seems, include arguments on the macro-global-national level such as that advanced by Kalipeni (2000, p. 966) that ‘countries experiencing political and/or economic instability have been more vulnerable to the spread of diseases such as HIV/AIDS and the collapse of their health care systems’. Or at the level of local social categories, as implied so far in this paper— the various dimensions of social inequalities put people in vulnerable positions. The answer cannot be complete without narrowing the examination to specific social groups as well as individuals who are at greater risk or more vulnerable, using such explanations as the ones forwarded by Seligman (1975) of ‘learned helplessness’, Totman (1979) of ‘social disorientation,’ Antonovsky (1980) of ‘salutogenesis and the role of coherence’ and Shuval (1981) of incorporating them all into a ‘total way of life’.

Hawe and Shiell (2000, p. 877) argue that learned helplessness theory has been applied to individuals, but more significantly for our purpose here, also as a theoretical construct to explain oppressed communities (Gordon, 1985). They also refer to Waterstein’s (1992) paper in which he ‘outlines the evidence for powerlessness as a risk factor for disease as well as health enhancing strategy’ (Hawe & Shiell, 2000, p. 877).

Although the concept of vulnerability is contested and used differently in a range of contexts, underpinning most versions is the idea that vulnerability ‘means’ differential access to resources on separate levels: from a lack of entitlement, political and economic power on the national level, to lack of social and cultural capital (empowerment) of communities to individual inability to mobilise family and personal resources (Moatti & Souteyrand, 2000). In this context, poverty and gender emerge as the main factors which limit the size and nature of resources available (Kalipeni, 2000).

Poverty can affect both males and females but, women and young girls are often subject to further discrimination which compounds their disadvantaged position, thus placing them in an even more vulnerable position (Doyal, 2000). There is evidence to suggest that women’s physical and psychological security might be compromised due to lack of support within the household (Doyal, 1995). 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 (Papanek, 1990). In many societies they are also encouraged to put the well being of others before their own (Kandiyoti, 1995; Doyal, 2000). In addition, Doyal (2000) citing Tinker, Daly, Green, Saxeman, Lakshminarayan and Gill (1994) argues that 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 domestic violence (Watts & Garcia-Moreno, 2000). Increasingly, HIV/AIDS is both a cause and consequence of domestic and sexual violence. High levels of rape and sexual abuse increase women’s vulnerability (socially and physically) to HIV/AIDS (Zierler & Krieger, 1997). Moreover, some women are subject to abuse by partners and members of their families when they disclose their HIV status. A recent tragic example is the South African woman — Gugu Dlamini — who was murdered by her neighbours soon after she revealed her HIV status as part of the country’s commemoration of World AIDS Day.

**HIV/AIDS**

According to the AIDS epidemic update (UNAIDS, 1999) the overwhelming majority of people with HIV — some 95% of the global total — live in the developing world. It is argued that the ‘proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus’ (UNAIDS, 1999, p.4).

Sub-Saharan Africa continues to have the highest rate of HIV/AIDS, with 23.3 million people infected, close to 70% of the global total of HIV-positive people (33.6 million). New information (UNAIDS, 1999) suggests that 55% of HIV-positive adults in Sub-Saharan Africa are women. This means that between 12 and 13 women are currently infected for every 10 African men. Mortality studies, too, are projecting substantial increases in deaths from AIDS, especially, again, among young women’ (Susser & Stein, 2000, p. 1042), thus confirming that ‘Women bear the brunt of the AIDS epidemic’ (Caelers, 1999, p. 21).

**The South African case**

**Some methodological issues**

One of the major problems in South Africa is the inadequate quality of statistical information. All data should thus be interpreted carefully recognising potential inaccuracies. The main problems are related to inaccuracies in population estimates and registration of information. The general data presented in this paper are derived from three different sources: Statistics South Africa, UNISA’s Market Research Bureau and Community Agency for Social Inquiry.

The HIV/AIDS data are obtained from an annual survey of pregnant women attending public health sector antenatal clinics. These data are not perfect, but are the only data available on a national level. There are arguments to suggest both an under and over estimation of the true size of the epidemic from these data. Among adults in the sexually active group, the antenatal survey prevalence figures do not reflect the lower overall risk of men, people who are less sexually active and communities using the private health sector. On the other hand, recent studies indicate that fertility among HIV positive
women is substantially lower than among uninfected women — this suggests that antenatal data may in fact underestimate HIV prevalence in women of reproductive age in many communities. On balance, however, it is felt that these antenatal data are sufficient for purposes of estimating current infection rates in the general population and projections of these rates into the future (Abt Associates Inc. South Africa, 2000). It is worth noting that HIV/AIDS statistics (and their shortcomings) have often been utilised and manipulated to advance ideological positions. The sociological dimensions of the measurement of HIV/AIDS is an area that is largely unexplored and can form part of an agenda for future research.

The continued use of race/population group as a statistical category is a vexed question. Historically, during the apartheid years (Population Registration Act of 1950), all South Africans were classified into a population group at birth, and assigned a racial status as either White, Indian, Coloured and Black (African). This process of racial classification profoundly shaped social and economic position rendering the African population the most disadvantaged. Although this act was repealed in 1991, its social effects will remain present for a long time to come and for this reason, statistics in this paper will be presented according to ‘population groups’ or race where appropriate.

Some indicators of racial and gender inequalities

Racial composition (population group) varies greatly between the provinces (Figure 1) — this is of particular significance in the South African context because to the confluence of class/race due to 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), as well 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 reflect the gross disparities 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 (46%), KwaZulu-Natal (39%) and North West (38%). These are also the provinces with the lowest levels of disposable income per capita (Figure 4). Although the data for the above figures were derived from different sources, they clearly attest to the existing inequalities between the provinces and different population groups in South Africa.

The latest report of the University of South Africa’s Bureau of Market Research (UNISA, 2000) 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 (Katzellenbogen, 2000). The report points to one of the most vivid indications of South Africa’s inequality: the sharply differing levels of the human development index for the various provinces. 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 in Gauteng 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 (Katzellenbogen, 2000).

The National Household Survey of Health Inequalities in South Africa (CASE, 1995) found a range of inequalities along racial lines. Of relevance to this paper 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 existence of the inverse care law, namely, that those who are most in need of health care

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**Figure 1:** Population group by province, 1996 (Source: Statistics South Africa, 2000)

**Figure 2:** Socio-economic status by race (Source: Health Systems Trust, *The Equity Gauge*, 2000)
do not necessarily have access to it. In addition, the data of this survey, indicate that, in general, poverty, overcrowding and unemployment are associated with lack of health care, and that this applies particularly among Africans and Coloureds.

**Epidemiology of HIV/AIDS**

The data in Figure 6 illustrate the rapid growth of the HIV/AIDS epidemic in South Africa as a whole. Examining the latest data of HIV prevalence by provinces (Figure 7) reveals a differential distribution of the burden of HIV/AIDS with KwaZulu-Natal being the province with the highest rates (36.2%) followed by Mpumalanga with 29.7%.

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 15–25 years of age with women generally being infected earlier than men (Figure 8) and the total rate is higher for women (35% as opposed to 29% for men in the 15–30 age group) (Abt Associates Inc. South Africa, 2000).

This is a similar pattern to that presented in most sub-Saharan countries (Turshen, 1991; Whiteside & Sunter, 2000). Data from a recent study in Carletonville support and augment this alarming scenario — an extraordinarily high rate of infection was found among adolescent girls reaching nearly 60% at 25 years of age (Gilgen, Campbell, Williams, Taljaard & MacPhail, 2000).

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 (2000) these include:

- Established epidemics of other sexually transmitted diseases.
- 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 on open discussion of sexual matters, including sex education for children and teenagers.

**Discussion and Conclusion**

This paper outlines aspects of the HIV/AIDS epidemic scenario and the complexities associated with it. It reveals the socio-epidemiological patterns of the epidemic and in doing so identifies the populations with the greatest and fastest growing rates of infection. The epidemic in South Africa is mainly a heterosexual one, the rates of infection in the general population are very high, and the percentage of HIV positive women is greater than men. An additional feature is 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. In order to understand their position we have examined the long standing relationship between gender and racial inequalities and health in general and further invoked the concept of vulnerability to shed light on the position of women in the epidemic.

It appears that there is a strong link between low income, high unemployment, poor education, as indicated by the low Human development Index and rates of HIV infection. In all of these dimensions women emerge as the worst off.
discussed previously, attempts to improve health despite low income have identified the need to reverse these inequalities by increasing the level of women’s social, cultural and productive capital.

Poverty has been singled out as the main culprit responsible for the spread of HIV/AIDS in Africa (Mbeki, 2000). Although the role of poverty as a social cause of health and disease has been widely acknowledged in the literature and elsewhere, there are additional factors which profoundly shape patterns of health and disease. These additional factors emerge strongly in the analysis of the HIV/AIDS epidemic in South Africa. Within the framework of poverty it seems that women are particularly affected resulting in higher rates of infection at an earlier age.

What are these additional components? For the purposes of analytical clarity these can be divided into separate (but not distinct) categories:

The first is the general low status of women in society. This is manifested in low levels of employment, income, and education. Inadequate political representation and lack of access to resources such as health care, transport, housing and government bureaucracy. This is compounded by high levels of racial discrimination and low levels of social capital.

The second derives from their subordinate role in the family, and limited personal resources. Wilkinson (1996) argues that when looking at the nature of the pathways which are most likely to link physical disease to inequalities it seems that the psycho-social pathways are most important. The conclusion therefore is that the ‘quality of social life of a society is one of the most powerful determinants of health’ (Wilkinson, 1996, p. 5). Women’s entangled, uneven, and unstable psycho-social pathways are fraught with a lack of power and breakdown in intimate relationships, exacerbated by high incidence of domestic violence, battery and rape (Leclerc-Madlala, 2000; Watts & Garcia-Moreno, 2000).

The third is related to sexual-cultural norms and values, in particular, men’s and women’s acceptance and encour-
agement of high numbers of sexual partners (especially among men). As claimed by Leclerc-Madlala (2000) ‘there are wide-spread beliefs that males are biologically pro-
gramme to need sexual relations regularly with more than one woman, and often concurrently, such beliefs are logical-
ly consistent with societies that were traditionally polyga-
mous. Research has found that these beliefs are held as strongly by women as by men’. She goes on to say, ‘[that] common to both young men and women is the belief that a man has a right, or even a duty, to force himself onto a women who displays reluctance and shyness’. Being HIV positive does not change these practices.

The outcome of these factors are compounded by misin-
formation and a lack of knowledge of HIV/AIDS, particularly among women. For example, as reported in the latest Health Review, although 97% of women have heard of AIDS their knowledge of ways to avoid it was limited, ‘with up to 10% of women stating that staying with one partner and using a con-
dom during sexual intercourse would not protect them against AIDS. Twenty one per cent still believe that trans-
mission could take place by sharing public toilets while 38% felt HIV could be spread by mosquitoes’ (South African Health Review, 2000 p. 306).

The predicament of women has a profound affect on the impact of the epidemic on society as a whole. On one level, they carry the burden of the disease, yet, they are expected to take responsibility and care for other members of the fam-
ily who are also HIV positive, thus further adding to their dis-
advantage and depleting community resources to cope with the devastating outcomes of the epidemic.

This renders women particularly vulnerable and denies them any real choice. In other words, there are forces beyond the control of individual women which influence their capacity to alter or change individual behaviours (their own or their sexual partners). Freedom of choice of lifestyles is thus restricted by the environment, underscoring the point made earlier, that the explanations for the development and outcomes of the epidemic should be based on an integration of cultural/ behavioural and materialistic approaches. This is not to imply or suggest that African women are helpless vic-
tims, powerless in the struggle against HIV/AIDS and other forms of inequalities (Bozzoli, 1991; Posel, 1991; Walker, 1996). Rather, we are highlighting a series of other forces which shape and limit African women’s ability to act as bro-
kers, as agents in which they assert their power and influ-
ence.

This analysis begs the question: does the combination of a high level of inequality in a variety of dimensions, low lev-
els of social capital, and increased vulnerability, contribute to the fast progress of the disease in South Africa? Within the constraints of limited and problematic statistical data, it is arguably the case that the mixture and complex interaction of these material, social, cultural and behavioural factors shape the nature, process and outcome of the epidemic in South Africa.

The way forward

Attempts to intervene in the spread of HIV/AIDS in South African have not been very successful. There are a range of reasons for this. One of which has been the simplistic focus on changing individual behaviour patterns due to the early framing of HIV/AIDS as an individual health issue (Marais, 2000). Others include the inability to merge the ‘paradigms of the medical and the political, the scientific and the social’ (Marais, 2000, p. 10). In addition, the lack of political will has characterised the epidemic in South Africa from the outset.

One of the recommendations of the most comprehensive HIV/AIDS studies in South Africa, was that, ‘finding ways to protect young girls must be given the highest possible priori-
ty’ (Gilgen et al., 2000, p. 8). In light of the above discussion it is clear that the following concerns need to be addressed in an attempt to achieve this goal, thereby reducing women’s vulnerability and lowering their risk both social and otherwise.

The long term effects of social inequalities and their impact on the development of the HIV/AIDS epidemic need to be tackled on a national level. As Katzenellenbogen (2000) states, ‘in the southeast Asian countries which made tremendous strides against poverty in the 1980s, education and health care particularly for women as well as rapid growth are attributed by the World Bank as major elements in their success’.

Educational efforts and preventive measures need to take cognisance of the social and cultural factors outlined above. In line with this, Susser and Stein (2000, p. 1042) argue, ‘HIV/AIDS prevention will be successful only to the degree that the changing needs of women as well as men are recognised and responded to by local, national and international policy makers’. The perceptions and responses of men (including those who are HIV positive) to the AIDS epidemic need to be thoroughly understood and researched, for the epidemic has profoundly shaped men’s understand-
ing of their health, masculinity and risk behaviour (see for example, programmes and initiatives which have targeted young men such as Mbizvo and Bassett, 1996 and Gilman, 2001.)

The role of the media is critical in giving voice to and sup-
porting HIV/AIDS intervention and prevention initiatives. Yet, the media has also a crucial role to play in challenging and changing social norms, values and misconceptions sur-
rounding HIV/AIDS. The media’s response (although varied) to the debate surrounding the cause of HIV/AIDS is such an example of this (Searle, 2001).

Women’s double burden of being sick and being primary care givers (in the home and community) is of particular rel-
evance in the HIV/AIDS epidemic. A special report of the EU HIV/AIDS programme in Developing Countries, titled, ‘Women: the Gender Connection’ claims that, ‘increasingly many women are forced to cope with an overwhelming bur-
den in their roles as both principle carers and breadwinners. Dead or sick spouses or other family members and possibly their own illness all play a part in increasing the demands under which women increasingly find themselves (EU HIV/AIDS Programme in Developing Countries, 2000, p. 4). This has direct implications for planning and implementation of home-based and community-based HIV/AIDS pro-
grames.

A useful strategy deriving from this paper is to direct intervention specifically towards young, African women, which should not exclude the possibilities of incorporating
young men (Mbizvo & Bassett, 1996; Gilman, 2001). This strategy is also recommended by Barnett, Whiteside & Decosas, 2000, p. 5) who claim, that ‘such interventions are complex and related to wider issues of social and economic policy. They should target populations subgroups driving the epidemic and subgroups most likely to be adversely affected by excess mortality and morbidity.’

The legal tools to address women’s inequality in South Africa are in place. Yet, the challenge is to translate these into reality by creating the social context which facilitates and encourages men and women’s ability to invoke their legal rights when appropriate (Albertyn, 2000). Better partnerships between gender and AIDS activists will enhance this process. This is evidenced in the current struggles around the provision of anti-retroviral drugs particularly as regards mother to child transmission. This also necessitates the need to address patriarchal and prejudicial attitudes within the legal profession.

The Minister of Health, Dr Tshabalala-Msimang, on presentation of the 1999 HIV survey results (Health Systems Trust, 2000) stated that, ”the problem could be successfully handled through intersectoral collaboration and social mobilisation” (HST, 2000, p. 2). This approach is undoubtedly appropriate and implicit in our analysis, yet characterised by complexity, adversity and practical barriers. Achieving the objectives detailed here is beyond the realm of health interventions only, however well intended and executed. It requires a concerted effort and political will on behalf of the government to confront the epidemic in the manner outlined in this paper. As yet it has not taken full advantage of existing bio-medical and social science research, although it is clear that relevant research must inform HIV/AIDS policy and practice.

Notes
1 The artefact explanation, the social selection explanation, the cultural/behavioural explanation and the materialist or structural explanation.
2 The human development index is a catch-all indicator of life expectancy, educational attainment and income used by the United Nations Development Programme.
3 Although this paper comments at a general level on HIV/AIDS intervention priorities, it does not aim to evaluate specific programmes.

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