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# Treading the path of least resistance: HIV/AIDS and social inequalities—a South African case study<sup>☆</sup>

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## Abstract

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. From the data presented it is evident that the pattern of HIV/AIDS in developing countries in sub-Saharan Africa in particular is unique. The pattern emerging in South Africa follows closely. The features of this pattern are as follows: the epidemic is mainly a heterosexual epidemic, the rates of infection in the general population are very high and the percentage of HIV-positive women is greater than men. An additional unique 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 examine the long standing relationship between social inequalities and health in general and further invoke the concepts of vulnerability and social capital to shed light on the position of women in the epidemic.

Within the constraints of limited and problematic statistical data, the paper argues that a mixture and 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. © 2002 Elsevier Science Ltd. All rights reserved.

**Keywords:** HIV/AIDS; Social inequalities; Gender; Vulnerability; Social capital

## Introduction

For 1/4th of the world's population, absolute poverty remains the principal determinant of their health status, exposure to HIV/AIDS and high fertility levels. Health indicators from Least Developed Countries reveal vast global disparities. Women represent 70% of the world's poor and they have less education, longer working hours and lower life expectancy. Maternal mortality in LDCs is 15 times the rate of that in industrialised countries. There has been a sharp re-emergence of infectious

diseases such as TB, diphtheria, HIV/AIDS and hepatitis B. About 17 million people a year in developing countries die from curable, infectious and parasitic diseases that affect the poorest disproportionately (EU Development, 2000).

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 ante-natal services in the public sector in South Africa were HIV positive. By the end of 1999 this figure had risen to 22.4% (Department of Health, 2000). Furthermore, it is estimated that over 1500 South African's are infected with HIV daily. Recent figures indicate that "one in eight adults (15–49 years of age) is infected with HIV" (between 12% and 14%), in South

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Africa (South African Health Review, 2000). 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. Some of the economic costs were highlighted in a report released by the department of finance: It is predicted that in 2003, the HIV prevalence rate will be "12% among highly skilled workers, 20% among skilled workers and 27.2% among low skilled workers" (Mail and Guardian, 2000, p. 40). Yet the burden of this epidemic does not fall evenly or equally. Rather, as also mentioned in other studies (Susser & Stein, 2000), this paper demonstrates that the overwhelming majority of those currently living with HIV/AIDS are young African women in developing countries. 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 primarily argue that individual behaviour needs to be challenged and altered before transmission rates will decline are naive, misplaced and misleading. Campaigns in South Africa to this effect have failed to curtail the epidemic. While behaviour patterns cannot be ignored this paper argues that social inequality is the greatest transmitter of HIV/AIDS. Strategies for change need to address social inequality and the empowerment of women in particular if rates of transmission are to decline.

This paper presents the multiple dimensions of social inequalities and their complex relation to health. Furthermore, it engages the concepts of vulnerability and social capital and their value in understanding the nature of the epidemic.

### **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; Benzeval, Judge, & Whitehead, 1995; Wilkinson, 1996; Kaplan & Lynch, 1997). However, it was once believed that these differentials in health would diminish with increasing economic development and improvements in the technology, practice and availability of medical care.

These predictions did not materialise as attested by the vast amount of literature pointing to the continuing existence and growth of health inequalities of populations within and between countries (Whitehead, 1988; Townsend, Davidson, & Whitehead, 1988; Nettleton, 1995; Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Lynch & Kaplan, 1997; Ben Shlomo, White, & Marmot, 1996; Marmot, 1996; Robert & House, 2000).

The evidence presented in the literature clearly demonstrates that systematic inequalities in health exist across a range of social dimensions such as social class and/or occupational groups, gender, race and geographical location. These dimensions cannot be examined in isolation since they interact 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 stated in a recent handbook of *Social Studies in Health & Medicine* by Robert and House (2000, p. 115): "Socioeconomic 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."

There is no wonder 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 socioeconomic inequalities in health but have been less successful in explaining why these inequalities persist (Feinstein, 1993; Robert & House, 2000).

The four explanations<sup>1</sup> 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). Furthermore, the ways in which people think, feel and behave are profoundly influenced by their position in society.

Although cultural/behavioural and materialist/structural explanations can be distinguished conceptually,

<sup>1</sup> The artifact explanation, the social selection explanation, the cultural/behavioural explanation and the materialist or structural explanation.

several authors have emphasised that they cannot be isolated (Whitehead, 1988; Macintyre, 1986). It is plausible that behaviour is to some extent embedded in the environment and the social context through aspects such as material deprivation, lack of power, 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 its differential growth patterns in developing and developed countries as well as within countries on racial, gender and class bases necessitate another, more in-depth look at inequality. Since the main purpose of this paper is to focus attention on the vulnerability of African women with regard to the HIV/AIDS epidemic, the social dimensions of gender, race and geographic location as categories of social inequality will be further unpacked.

### **Place/geographical location and health**

There is considerable evidence to suggest that place or geographic location is another social dimension linked to inequalities in health (Whitehead, 1992; Gillespie & Prior, 1995). Curtis and Taket (1996, p. 95) discuss 'spatial expression of health inequalities' and argue that the debates over social inequalities are important to the understanding of regional differences within and between countries. There is no doubt that the geographical distribution of social factors known to be associated with health inequalities such as social class, race and gender will be reflected in marked regional differences in health (Nettleton, 1995). Within the UK there is a clear north-south divide in terms of health status—a divide also found between England and Wales (Blaxter, 1990; Britton, 1990; Nettleton, 1995). In other countries it is the urban-rural divide which attracted more attention due to its visible differential health outcomes (Curtis & Taket, 1996).

It is very difficult to ascertain the extent to which geographical location affects health independently, which is beyond the scope of this paper, since there is always an interplay between the various dimensions highlighted earlier (Britton, 1990). An important finding in this context is that regional variations in mortality rates do not reflect variations in the provision of health care (Eames, Ben Shlomo, & Marmot, 1993). This would support McKeown's (1976) thesis that significant improvements in health status lie beyond the scope of health services. Similarly, evidence from a study taking an international perspective conducted by Kim and Moody (1992) points out that the amount of health resources invested did not make a significant contribu-

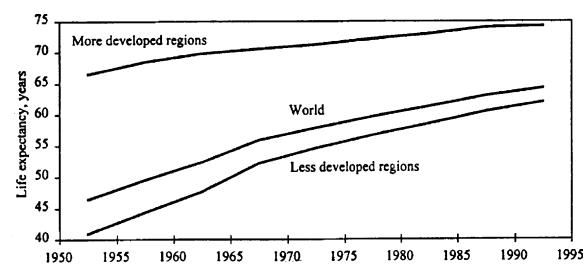
tion to infant mortality rates in contrast to a greater investment in other socio-economic resources which did.

According to Marmot (1996), comparison of disease patterns on a global scale leads to the obvious conclusion that social cultural forces are primary in determining health outcomes. Wilkinson (1996) found that the gross national product (GNP) in advanced capitalist societies is related to life expectancy; however, the key variable is the degree of the inequality—the more egalitarian a nation is, the healthier its population will be.

Despite the difficulties in obtaining accurate morbidity and mortality data from developing countries, the differences between them and the so-called industrialised or more developed countries are staggering (Curtis & Taket, 1996; Nettleton, 1995).

Fig. 1 (United Nations, 1998) presents figures of life expectancy in the world, more developed and less developed regions clearly demonstrating the great global divides as well as the fact that the gaps have not decreased in a significant manner.

Although poverty is a major reason for the huge international differences in health status there is no simple link between GDP and life expectancy (Marmot, 1996). Using the Human Development Index which combines real GDP, life expectancy and education, it has been demonstrated that social factors are likely to exert powerful influence on life expectancy (Marmot, 1996). Caldwell (1986) went even further and suggested that countries such as Sri Lanka which achieve long life expectancies in spite of low incomes have certain features in common such as "a substantial degree of female autonomy, a dedication to education, an open political system, a largely civilian society without a rigid class structure, a history of egalitarianism and radicalism, and of national consensus" (cited in Marmot, 1996, p. 57). One of the indices used to prove this point was the high female proportion at school linked to lower IMR where there was a low GNP (Caldwell, 1986). Similarly, mother's education has been shown to be related to survival chances (Hobcraft, 1993). Further using the HDI in an attempt to explain this relationship,



Source : United Nations, 1998

Fig. 1. Life expectancy at birth, both sexes combined: world, more developed regions and less developed regions, 1950–1995.

Marmot (1996) suggests that this might mean “a shift in familial power structures permitting the educated woman to exert greater control over health choices; increased ability to manipulate the modern world; and a shift from fatalistic acceptance of health outcomes towards implementation of health knowledge” (Marmot, 1996, p. 58).

The general message is of a complex interaction between a host of social, cultural and organisational factors linked to the variations in health outcomes between geographic regions within and between countries and not a simple relationship between income and health (Nettleton, 1995; Marmot, 1996).

### **Racial and gender 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’s and women’s health have been extensively researched and well documented (see for example, Doyal, 1994; Graham, 1993; Oakley, 1984; Papnek, 1990; Roberts, 1985; Miles, 1991; 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 social inequality on patterns of HIV/AIDS.

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).<sup>2</sup>

<sup>2</sup>One exception to this is in the over 65 year age group where “more females are victims of homicide” which Pedan and Buchart (2000, p. 335) suggest reflects the greater proportion of elderly women in South Africa.

Similarly, Macintyre’s (1993) research into ‘the common cold’ indicates that “men and women are either equally likely to report related symptoms, or men are likely to report more severe symptoms” (Annandale, 1998, p. 130). The works of Simon (1995), Hart (1989), Verbrugge (1988) 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 the issue of 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 more stark. 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”. For example, recent British literature has focused to a limited extent on the racial division of labour in the health services (Blaxter, 1988; Akinsanya, 1984; Ward, 1993). In brief, these studies demonstrate the existence and extent of racism in the National Health Service and suggest that, “structural inequalities within the [NHS] are as significant in terms of ‘race’ as they are in terms of class and gender” (Nettleton, 1995, p. 206). Scholars concerned with health and race have also sought (in part through epidemiological studies) to uncover relationships between specific health problems and race, for example, sickle cell disease. 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 classifactory gaze (racial and gendered) upon the body” (Annandale, 1998, p. 164) (see also Turner, 1997; Lupton, 1997; Bury, 1998; Fox, 1993). 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. In doing so, the question of whiteness, ‘white’ ethnicity and

health is signaled as one of the biggest omissions in health-related research (Smaje, 1996).

Yet, understanding the relationship between health and race is of 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 "racism should be viewed as integral to whatever analysis is developed, and the question posed not whether it operates but when, where and how". This is certainly the case in the South African (and arguably other) context(s) where race, gender and class are inimical to good health through structural, political, cultural and social inequality. South African health care, health services and health policy have been the subject of an important and growing literature. This literature cuts across the disciplines of health economics, history and sociology. While the political economy of health and disease in the context of apartheid, for example, is well documented, Posel (1998) argues that there has been little research on the social meanings of race under apartheid. The impact and meaning of race in the context of the HIV/AIDS epidemic in South Africa is one such area in which there has been little academic scrutiny.

This paper suggests that the fault lines of gender and race are clearly apparent in the rates of infection of HIV/AIDS and now turns its attention to a brief examination of the social situation of women (particular poor African women) in South Africa.<sup>3</sup>

### 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 are women (South African Health Review, 2000, p. 3). As Baden, Hassim, and Meintjies (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.

<sup>3</sup> According to the Population Registration Act of 1950, all South Africans were classified into a 'population group' at birth, and assigned a status as White, Indian, Coloured and Black (African). 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.

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 particularly of African women in the South African economy is in part due to their limited access to education, historically. For example, in South Africa in 1995, 23% of African women aged 25 years or more had no formal education at all, compared to 16% of African men<sup>4</sup> 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 said they had dropped out because of pregnancy.

These figures indicate that young African women are the poorest, most economically marginalised and least educated sector of the South African population 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 (Susser & Stein, 2000; Williams et al., 2000).

### The concept of 'vulnerability'

So far the paper has demonstrated that women in South Africa are disadvantaged on various levels and as will be shown later have higher rates of HIV/AIDS. In an attempt to further understand this complex scenario, we are posing the question of how do the concepts of vulnerability and social capital assist us in both explaining and changing the current situation?

There has been much interest in social determinants of health since the public health movement in the 19th century, and the literature on this topic is vast. Although, it is beyond the scope and focus of this paper to examine this literature, it is important to identify the main trends in order to signal where the argument advanced in this paper 'fits in'. In addition, the way the social determinants are understood and explained is further linked to the nature of policies implemented. The range of factors considered as having an influence on health in this context can be positioned on a continuum from the 'macro' material-social environment such as living conditions,<sup>5</sup> cultural-behavioural aspects related

<sup>4</sup> Passing grade 5 is often used as a measure of literacy.

<sup>5</sup> These would fit in with the 'structural/materialistic' explanation of social inequalities and health.

to lifestyle and health behaviour,<sup>6</sup> including knowledge, values and attitudes (Macintyre, 1986) to 'micro' psychosocial/individual factors such as susceptibility, resistance and coping resources (Shuval, 1981). It would seem that so far we have dealt with some of the factors on the 'macro' level, but have not proceeded to more 'micro' social factors and their influence on health.

Following an attempt to explain the demonstrated associations between various social positions and health, Macintyre (1986, p. 393) argues that "...when exploring the social patterning of health, illness and death, it would be profitable for sociologist to consider several of all of these social positions, and to develop models of general vulnerability to ill-health".

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. Unpacking 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) citing Watts and Bohle (1993) 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. 966). This echoes a similar argument 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 somewhat arbitrary 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. Although the data produced cast some light on the general determinants of the epidemic, they do little to help us understand the concept of vulnerability and how it is linked to HIV/AIDS.

What makes people vulnerable to ill-health (or certain diseases)? An attempt to answer this question will have to address a spectrum/range of factors on different levels. 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 Shield (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 Walersteins' (1992) paper in which he "outlines the evidence for powerlessness as a risk factor for disease as well as a health enhancing strategy" (Hawe & Shields, 2000, p. 877).

Using the various explanations from the vulnerability perspective they can all be interpreted as differential access to resources on distinct levels from 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 girls are often subject to further discrimination which adds to their disadvantageous 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 (Papnek, 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 et al. (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 violence and the fear of violence (Watts & Garcia-Moreno, 2000).

<sup>6</sup>These will fit in with the 'cultural/behavioural' explanation of social inequalities and health.

## Social capital

The concept of social capital is strongly contested and consequently, variously defined in the sociological and development literature. Putman (1996), one of leading writers in the field, defines social capital as “features of social life, networks, norms and trust, that enable participants to act together more effectively to pursue shared objectives” (Putnam, 1996, p. 114). Briggs (in Budlender & Dube, 1997) understands social capital as “resources stored in human relationship” and suggests that social capital “makes the other kinds—land, labor and investment—work well” (Briggs, 1997, p. 1). Coleman (1990, p. 302) argues that “social capital inheres in the structure of relations between persons and among persons”. Bourdieu (1986, p. 79) sees social capital as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition—or in other words to membership of a group”. Wilkinson (1999) uses the notion of ‘social cohesion’ to capture his understanding of social capital. Budlender and Dube (1997, p. 19) argue that these different understandings and definitions have resulted in a fuzziness in the use of the concept which renders it theoretically problematic yet allows for its adaptability to specific issues, circumstances and environments. Similarly Wall, Ferrazzi, and Schryer (1998) cited in Hawe and Shield (2000, p. 872) argue that “social capital is on the brink of being used so widely and diversely that its power as a concept may be weakened”. There is clearly no, one version of social capital and it is not one particular thing.

Bebbington (1999, p. 2021) develops an analytical framework for understanding rural poverty which highlights the importance of the relationship between different forms of capital while paying particular attention to the “importance of social capital as an asset through which people are able to widen their access to resources and other actors”. In a similar vein, Hawe and Shield (2000, p. 873) suggest that “[social capital] has relational, material and political aspects and it may have positive or negative effects. It can refer to both dense and loose networks and it takes on a different form depending on whether one is concerned with the individual and his or her immediate group membership or the interaction between social institutions”.

Bebbington (1999, p. 2029) demonstrates that it is interaction between natural capital, human capital, cultural capital, social capital and produced capital which enhances human well being and development. These different forms of capital are understood as both input needed (resources) and output (income for example) generated. According to Bebbington (1999)

and others social capital then can inhere or be absent in individuals, households, communities, societies yet can also be built and generated through intervention. Bebbington (1999) and Hawe and Shield (2000) then take account of, firstly, the distinction between the sources and consequences of social capital, secondly, its positive and negative effects and thirdly, its multi-dimensional nature. These frameworks (although developed in relation to other social problems) are usefully applicable to understanding the incidence and consequences of HIV/AIDS in southern Africa among poor African women. It is arguable that African women living in poor circumstances have limited capital be it natural, produced, human, social or cultural and the deficit of capital at all levels thus surely increases their vulnerability in terms of rates of infection, survival and ultimately prevention. Yet the existence of familial, organisational and community networks may also provide an important source of social and other forms of capital from which to build.<sup>7</sup>

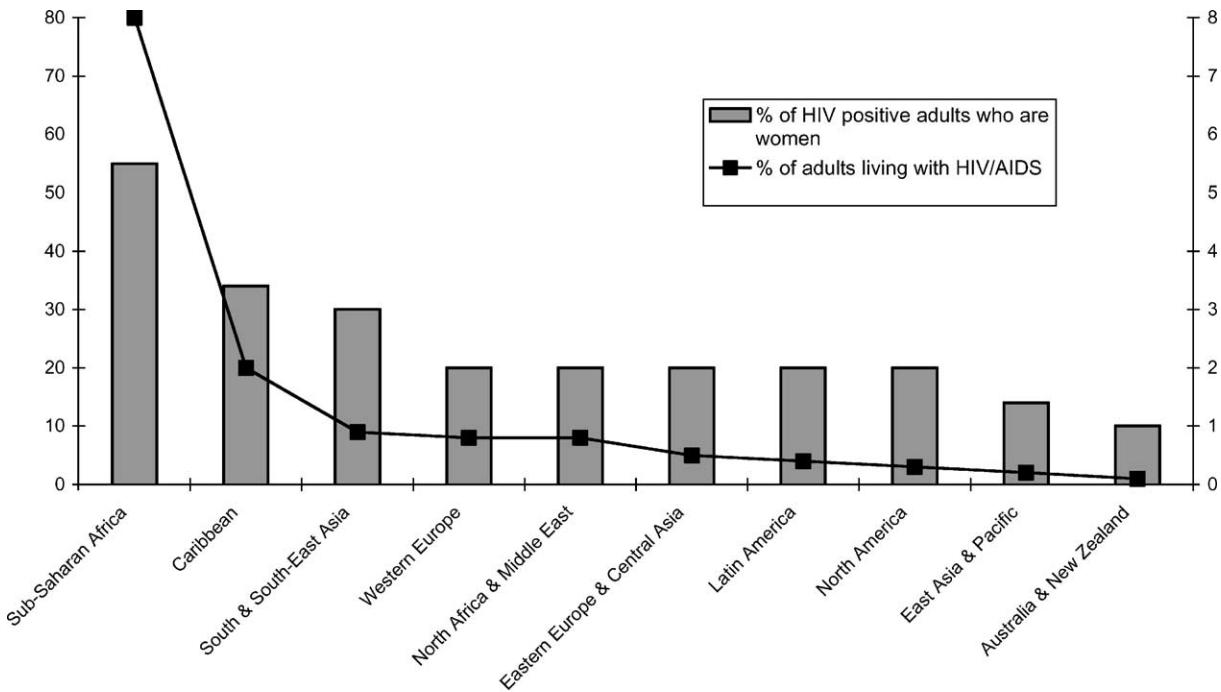
## HIV/AIDS—the global picture

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).

Fig. 2 presents a combination of the percentages of adults living with HIV/AIDS in various parts of the world and the percentage of those who are women. The emerging picture supports what has been mentioned earlier—that the higher the adult HIV-prevalence rate, the higher the percentage of HIV-positive adults who are women.

<sup>7</sup>This idea needs to be tested through research. To the best of our knowledge this literature has not been applied to HIV/AIDS programmes in South Africa.



Source: UNAIDS, 1999.

Fig. 2. Percentage of HIV-positive adults who are women.

### A case study of South Africa

#### *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 (2000), UNISA's Market Research Bureau and Community Agency for Social Inquiry.

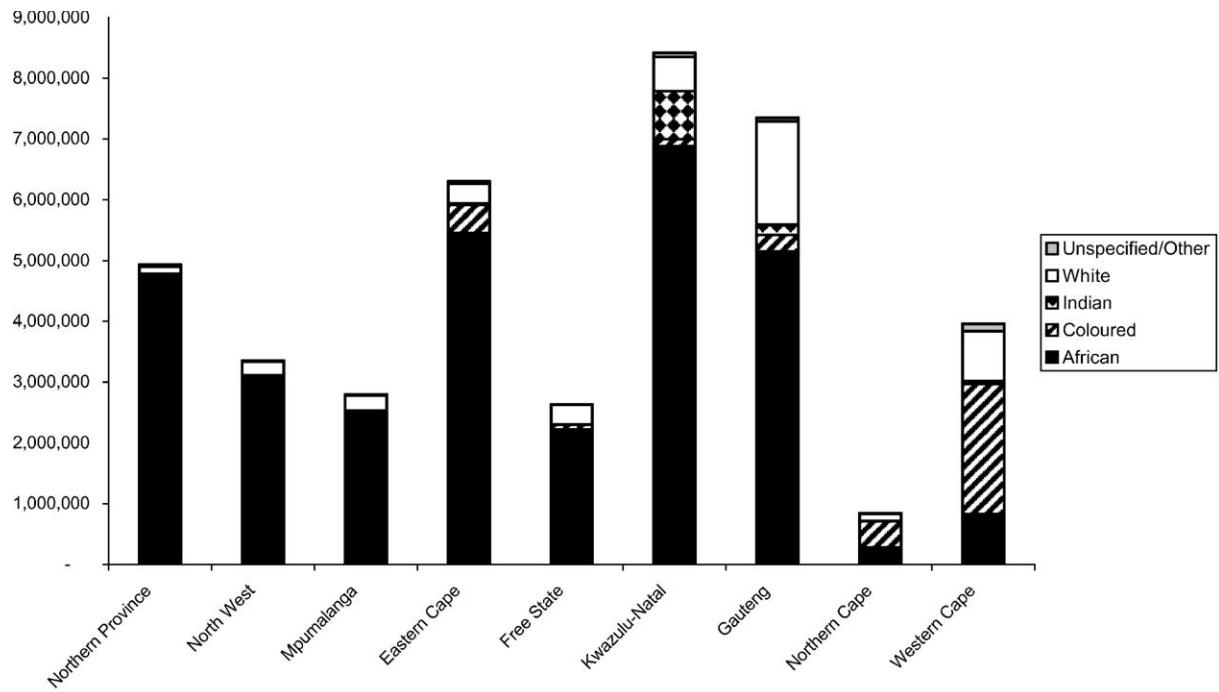
The HIV/AIDS data are obtained from an annual survey of pregnant women attending public health sector ante-natal clinics. These data are not perfect, but are the only statistical material available on a national level. There are arguments to suggest both an under- and overestimation of the true size 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 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.

#### *Social inequalities*

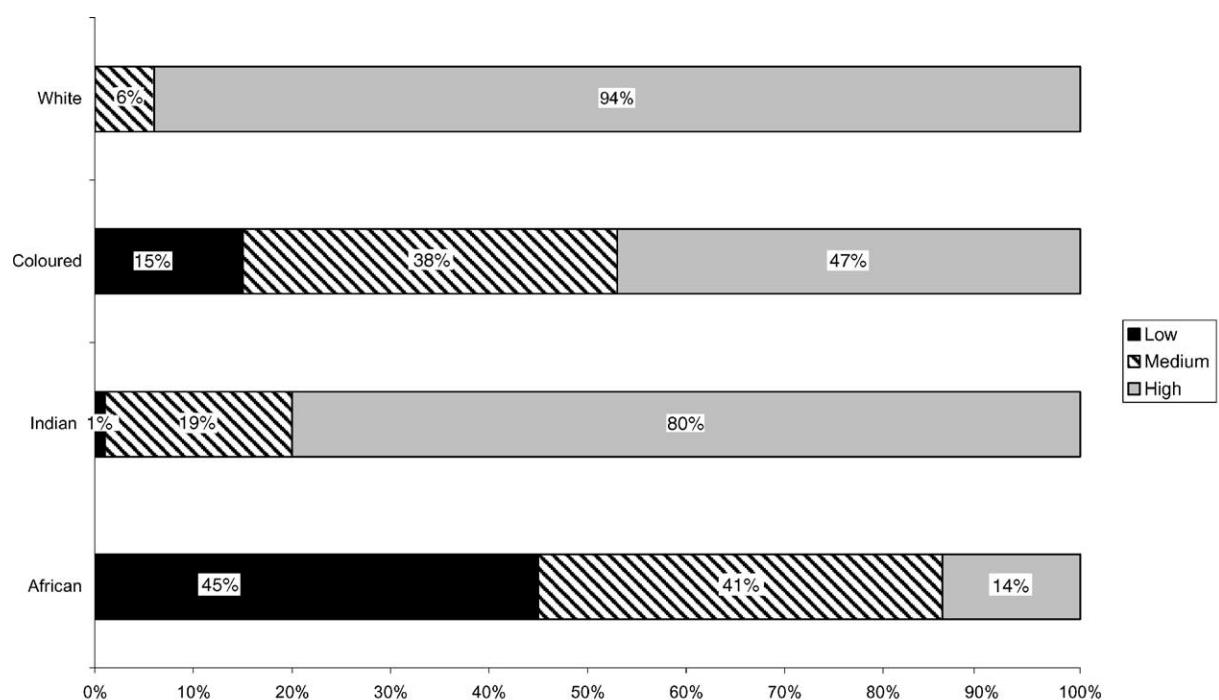
*Geographical locations* have been identified in this paper as one of the categories of inequalities. Following the new political dispensation, South Africa has been divided into nine provinces with the aim of redressing some of the past inequalities and facilitating smoother administration and governance. However, the reality is that there are striking inequalities between the provinces on various levels as will be demonstrated in Figs. 3–6.

*Racial composition* (population group) varies greatly between the provinces (Fig. 3)—this is of particular significance in the South African context due to the confluence of class + race in part because of the legacy of apartheid. It also acquires additional significance once



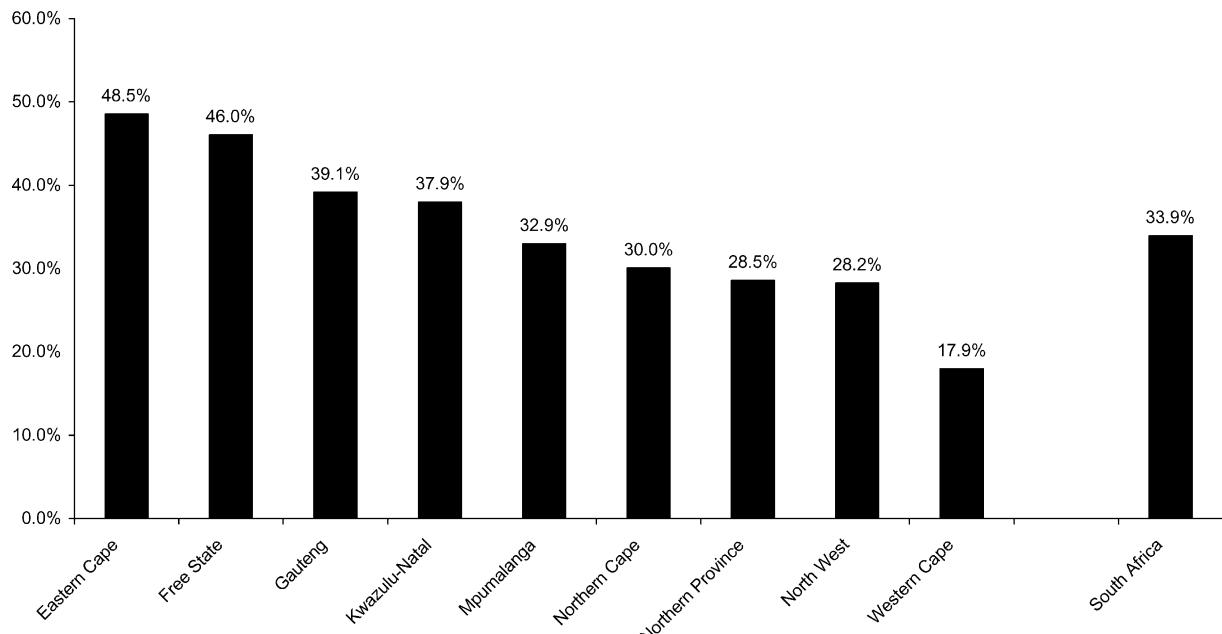
Source: Statistics South Africa, 2000

Fig. 3. Population group by province, 1996.



Source: Health Systems Trust, The Equity Gauge, 2000

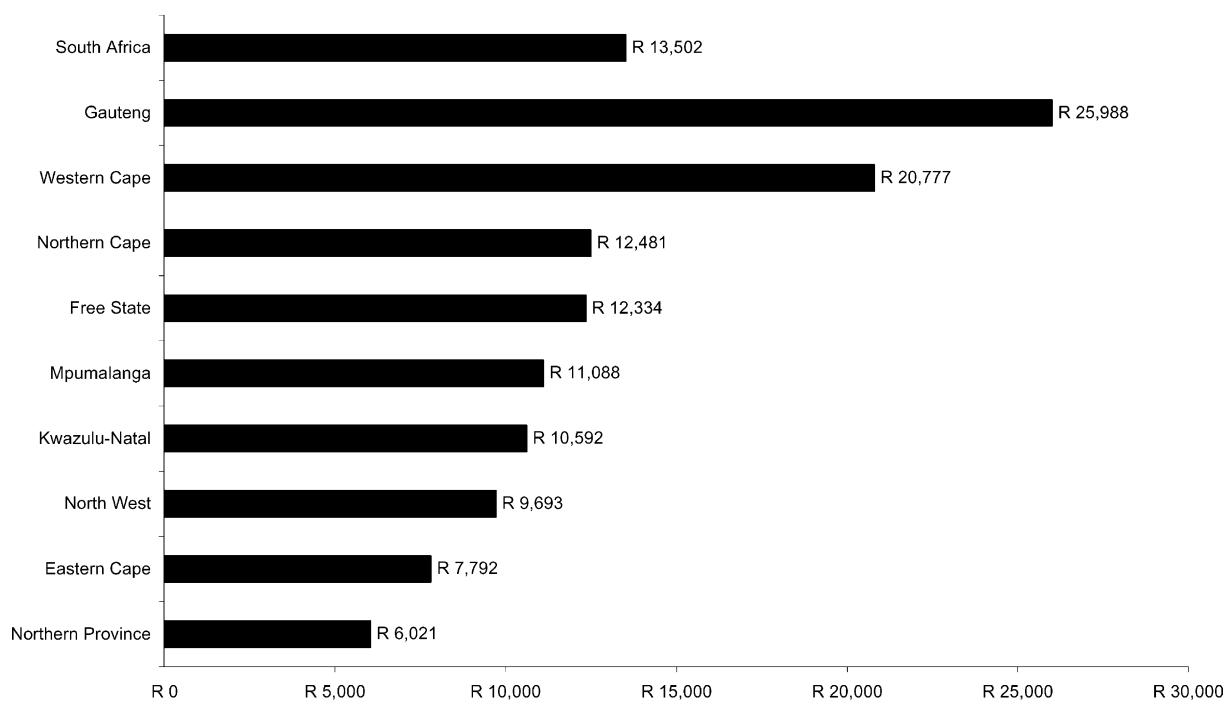
Fig. 4. Socio-economic status by race.



\*The unemployed are those between 15 and 65 years who did not work at the time of the census but were looking for work.

Source: Statistics South Africa, 2000

Fig. 5. Unemployment rates by province amongst those aged 15–65 years, 1996\* (expanded definition).



Source: UNISA, 2000

Fig. 6. Personal disposable income per capita by province, 2000.

examined in combination with socio-economic status by race (Fig. 4), unemployment rates (Fig. 5) as well as disposable income (Fig. 6).

*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 Fig. 4 manifest 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 (Fig. 5) 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 (Fig. 6). Although the data for the above figures were derived from different sources, they clearly attest to the existence of inequalities between the provinces.

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 (Katzenellenbogen, 2000). The report points to one of the most vivid indications of SA inequality: the sharply differing levels of the *human development index*<sup>8</sup> for the various provinces. Gauteng—SA'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 SA—has a human development index of 0.57, close to that of Zimbabwe, which ranks 130th in the index. As can be seen in Fig. 6, personal disposable income is more than three times that of the Northern Province. Overall, SA 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 (Katzenellenbogen, 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 Fig. 7, 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 notion that those who are most in need of health care 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.

#### HIV/AIDS

The data in Fig. 8 illustrate the *rapid growth* of the HIV/AIDS epidemic in SA as a whole.<sup>9</sup> Examining the latest data of *HIV prevalence by provinces* (Fig. 9) reveals a differential distribution of the burden of HIV/AIDS with KwaZulu Natal being the province with the highest rates (32.5%) followed by Free State with 27.9%.

Younger people are most severely affected by the disease—this is not surprising since about 45% of the South African population (16 million) is under 20 years of age. It is estimated that over 60% of all new infections currently occur in those between 15 and 25 years of age with women generally being infected earlier than men (Fig. 10) 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).

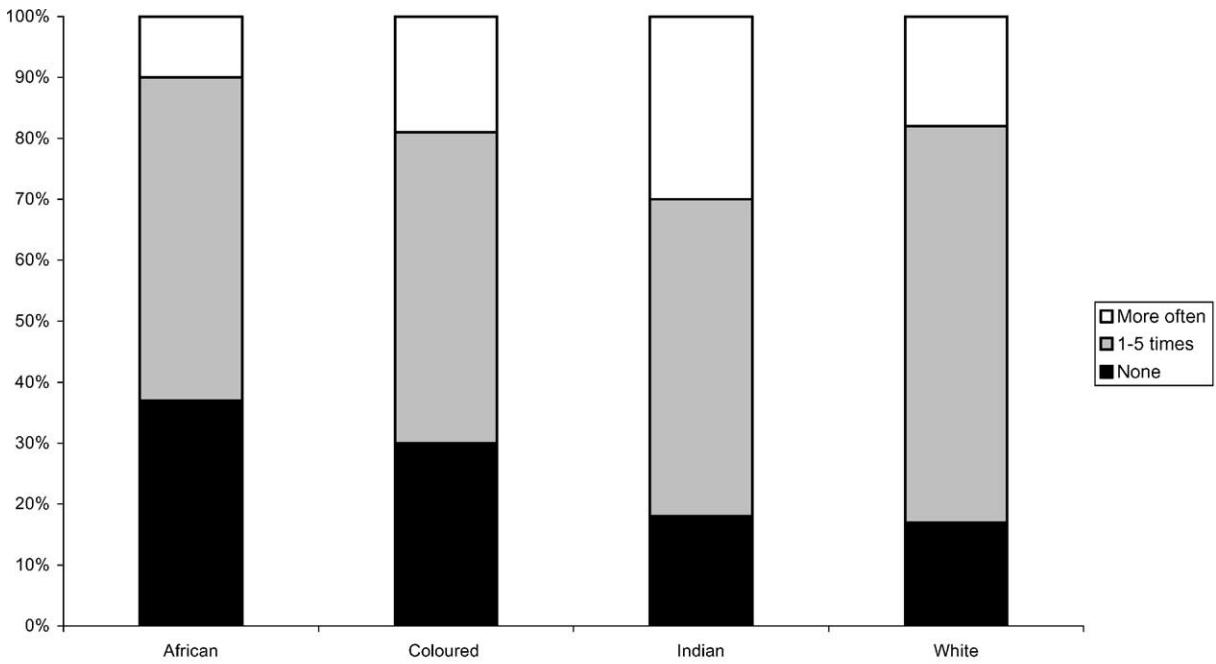
This is a similar pattern to that found in most sub-Saharan countries (Turshen, 1991; Whiteside & Sunter, 2000). Data from a recent study in Carletonville support and augment this alarming scenario—an extraordinary high rate of infection was found among adolescent girls reaching nearly 60% at 25 years 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 upon open discussion of sexual matters, including sex education for children and teenagers.

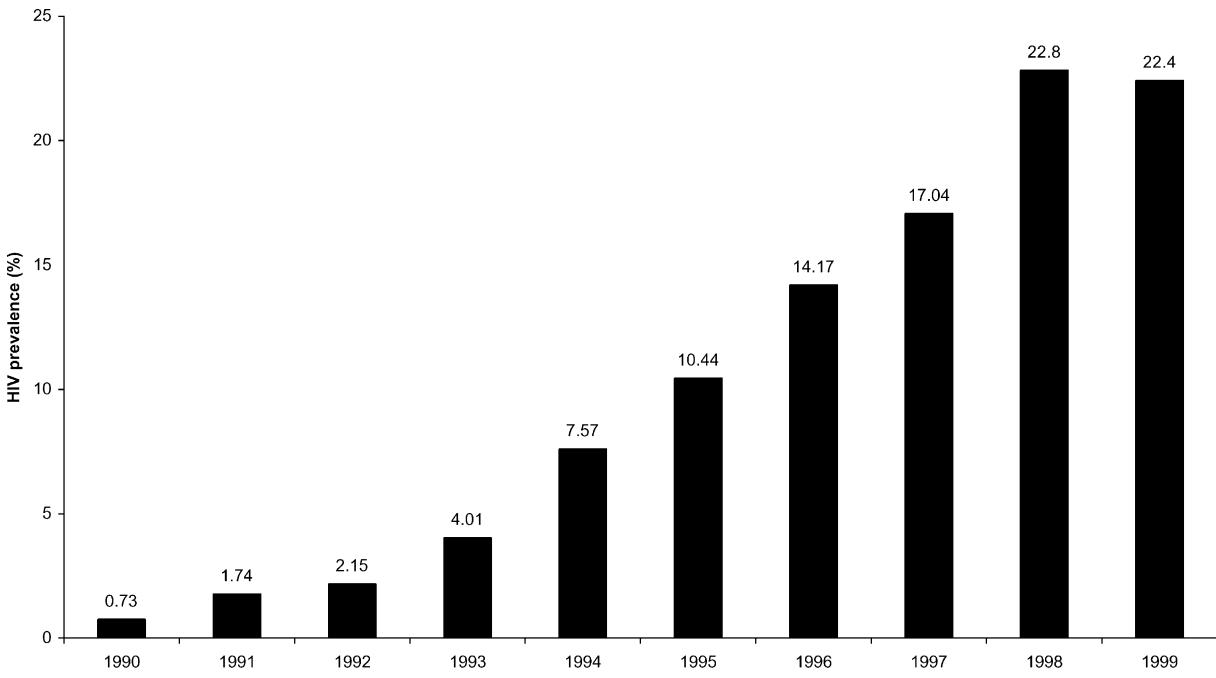
<sup>8</sup>The human development index is a catch-all indicator of life expectancy, educational attainment and income used by the United Nations Development Programme.

<sup>9</sup>The data in Figs. 8 and 9 were drawn from the results of the 10th national antenatal survey.



Source: CASE, 1995

Fig. 7. Number of times in the past year South Africans consulted a health professional by race.



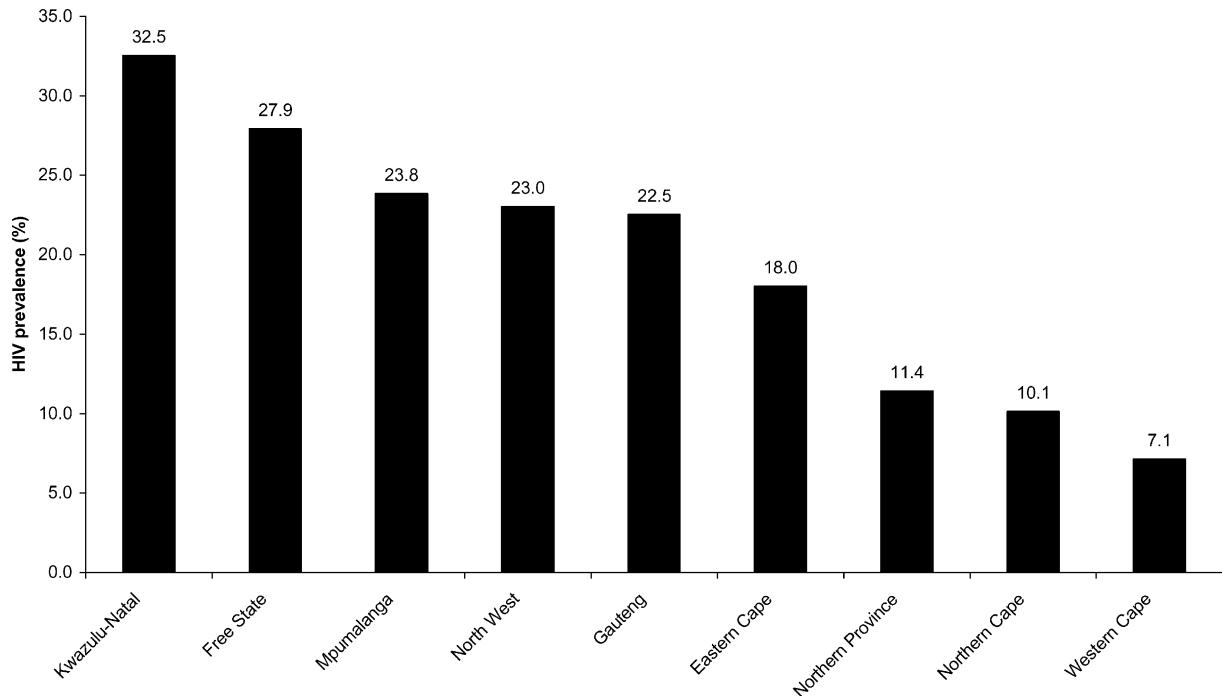
Source: Department of Health, 2000

Fig. 8. HIV prevalence trends in South Africa, 1990–2000.

## Discussion and conclusion

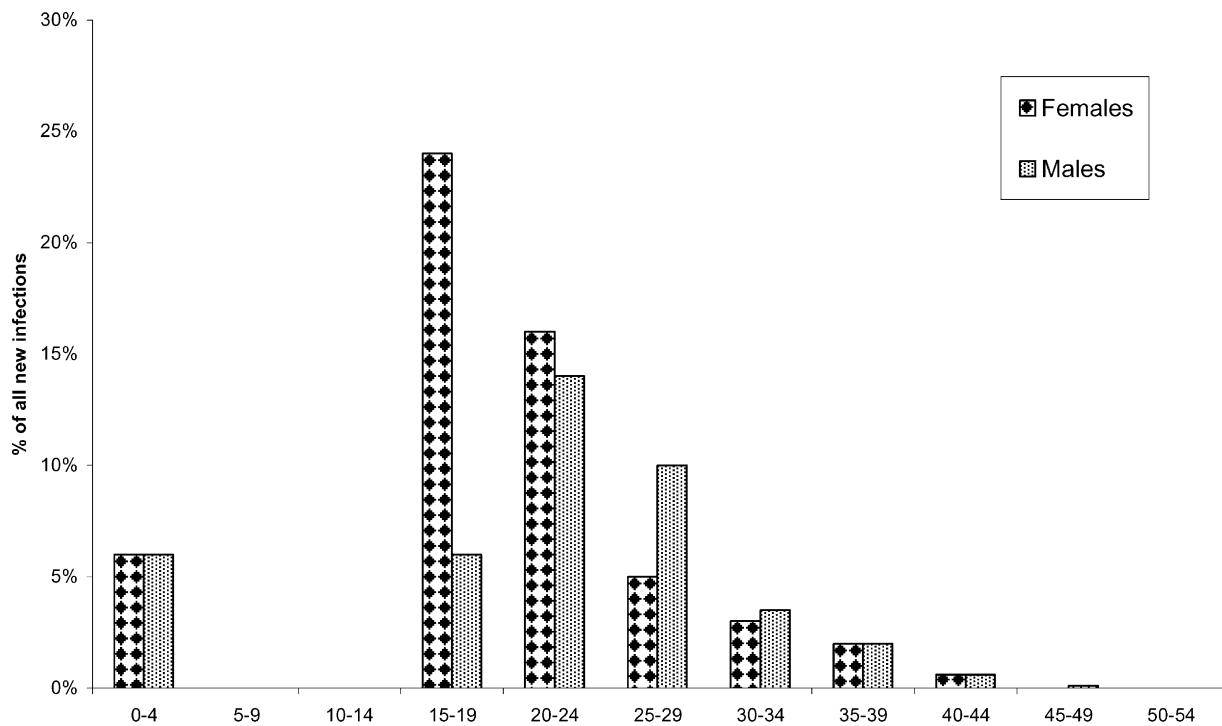
This paper outlines aspects of the HIV/AIDS epidemic scenario and the complexities associated with

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. From the data presented it is evident that the pattern of HIV/



Source: Department of Health, 2000

Fig. 9. HIV prevalence by province in South Africa, 1999.



Source: Abt Associates Inc. South Africa, 2000

Fig. 10. Proportion of all new infections between 1995 and 2010 by gender and age categories.

AIDS in developing countries in sub-Saharan Africa in particular is unique. The pattern emerging in South Africa follows closely. The features of this pattern are as follows: the epidemic is mainly a heterosexual epidemic, the rates of infection in the general population are very high and the percentage of HIV-positive women is greater than men. An additional unique 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 examine the long standing relationship between social inequalities and health in general and further invoke the concepts of vulnerability and social capital to shed light on the position of women in the epidemic.

It appears that there is a strong link between low income, high unemployment and 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. As 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 in 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 (Watts & Garcia-Moreno, 2000; Leclerc-Madlala, 2000).

- The third is related to sexual-cultural norms and values, in particular, men and women's acceptance and encouragement of high numbers of sexual partners (especially among men). As claimed by Leclerc-Madlala (2000) "there are wide-spread beliefs that males are biologically programmed to need sexual relations regularly with more than one woman, and often concurrently, such beliefs are logically consistent with societies that were traditionally polygamous. 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 is compounded by misinformation 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 suing a condom during sexual intercourse would not protect them against AIDS. Twenty one per cent still believe that transmission could take place by sharing public toilets while 38% felt HIV could be spread by mosquitoes" (South African Health Review, 2000, p. 306).

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, reiterating 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 victims, powerless in the struggle against HIV/AIDS and other forms of inequalities (Bozzoli, 1991; Posel, 1991; Walker, 1997). Rather, we are highlighting a series of other forces which shape and limit African women's ability to act as brokers, as agents in which they assert their power and influence.

This analysis begs the question: does the combination of high level of inequality in a variety of dimensions, low levels 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 arguable 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 Africa 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, a lack of political will has characterised the epidemic in South Africa from the outset.

One of the recommendations of the most comprehensive HIV/AIDS study in South Africa was that, “finding ways to protect young girls must be given the highest possible priority” (Gilgen et al., 2000, p. 8). In the light of the above discussion it is clear that the following concerns need to be addressed in an attempt to achieve this goal.

- 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 1908s, education and health care particularly for women as well as rapid growth are attributed by the World Bank as major elements in their success” (Katzenellenbogen, 2000).
- 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”.
- Women’s double burden of being sick and being primary care givers (in the home and community) is of particular relevance 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 burden 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 programmes. It is imperative that all community/family networks be engaged in the process of building the social and cultural capital required to realise this.

- A useful strategy deriving from this paper is to direct intervention specifically towards young, African women. This strategy is also recommended by Barnett, Whiteside, and 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’s 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 also necessitates the need to address patriarchal attitudes within the legal profession.

The Minister of Health Dr. Tshabalala-Msimang on presentation of the 1999 HIV survey results (Health Systems Trust, 2000a, b) stated that, “the problem could be successfully handled through intersectoral collaboration and social mobilisation” (Health Systems Trust, 2000a, b, 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 alone, 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.

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