



Chapter Two

Living Positively in Changing Demographics

A changing demography

The epidemic is taking its toll . . . According to the latest population report prepared by the population division of the UN Department of Economic and Social Affairs, children born in 29 sub-Saharan African nations face a life expectancy of just 47 years because of the toll the epidemic is taking in the region. This life expectancy figure represents a 16-year drop. In the absence of HIV/AIDS life expectancy in these countries would have been 63 years. What will the demographics look like?

Sparser population

In a recent study of the impact of HIV/AIDS on demography, conducted by the US Census Bureau in 23 countries, it has been stated that the most severe demographic effect of HIV/AIDS will be experienced by countries years after the epidemic has peaked. According to this report, life expectancy will drop to 40 years or less in 9 sub-Saharan African countries by 2010. According to the findings of the same study, AIDS will reduce population growth rates to less than half of their expected levels by 2010 and they may remain low or negative for many years. However, in most countries, population growth will remain positive because fertility rates

will remain high, except in three countries, Botswana, Guyana and Zimbabwe, where fertility rates may drop sufficiently to result in a negative population growth by the year 2010.

Many orphaned children

A corollary to shorter life expectancies is the increase in the number of orphaned children. According to the analysis of the US Census Bureau, by the year 2010 the numbers of children who will have lost their mothers or both parents due to HIV/AIDS will swell to 22.9 million. As a result, in sub-Saharan Africa there will be 12 times as many children under 15 as adults over 64. With this as the backdrop, the images of the epidemic in Africa are of families which have a cognitive unfamiliarity. We are already looking at families headed by children. The ailing old surrounded by children little aware of how to tend the old and the sick; communities on the brink of survival trying to cope with the demands of productive labour; or sick women tending sick children. These are the conditions and projections today for the 23 million people living with AIDS in this region.

The impact in Asia is projected to be worse than in sub-Saharan Africa. Though HIV was a late comer to Asia and the Pacific, its spread has been swift. Since 1994, almost every country in the region has seen HIV prevalence rates increase by more than 100 per cent. Today, 6.4 million people in Asia are believed to be living with HIV. Considering that this region houses 60 per cent of the world's sexually active population, one can only apprehend with horror what might be the course of the epidemic in this region.

In Latin America, 1.3 million people are living with HIV. The distinguishing factors of the pattern of development in this region are a high external debt, an equally high debt service ratio, a low food production capacity and very high urbanisation. This has resulted in problems of development that increase poverty and give it a feminine face. For poverty that is urban is rootless, is characterised by the growth of a low produc-

tivity informal sector (where women cluster for subsistence) and by rapid demographic changes reflecting the disintegration of families and communities. A special feature of the epidemic in this region is the high number of young people who are at risk, especially street children forced out of the security of a stable household as a result of the fast urbanisation. A survey in Rio de Janeiro revealed that 60 per cent of young boys aged 15–19 engaged in sexual intercourse. Rates as high as this have not been seen in samples of male teenagers in other parts of the world.

In recent decades, north Africa and the western Asian region have witnessed major political, social, economic and demographic upheavals, which have led to the exacerbation of existing, fairly large, gender disparities. The persisting Gulf War and other armed conflicts like the Iran-Iraq war, the oil conflict between Iraq and Kuwait, and civil wars in Algeria and Somalia have created mass displacement of populations. UNAIDS estimates that the region has 210,000 HIV-positive people, 20 per cent of whom are women. The epidemic is, however, not even in its spread and these figures need to be seen as averages. UNAIDS estimates that 75 per cent of the region's reported cases relate principally to five countries: Morocco, Saudi Arabia, Sudan, Tunisia and Djibouti.

In Eastern Europe, though the absolute numbers are lower, many countries have experienced the doubling or tripling of infections since 1994. As the epidemic advances in a geometric progression, what is it doing to the lives of men and women?

Women bearing a quadruple burden

Today, approximately 46 per cent of the 33.6 million adults living with HIV/AIDS are women, and the proportion is growing. Of the 16,000 new infections occurring every day, the percentage of women infected is 50 per cent. Following a trend observed in other countries, male to female ratios among HIV-infected persons have begun to equalise. In Brazil, the ratio stood at 16:1 in 1986 but the figures for 1997 indicate the ratio as 3:1.

Women's susceptibility to the virus has gradually been increasing.

In a perverse twist, the epidemic has led to a further exploitation of children in many parts of the world. Estimates of the number of child prostitutes in Thailand range from an optimistic 100,000 to over 800,000. Fifty to 80 per cent of these children, it is estimated, are already infected.

The report on the global epidemic issued by UNAIDS in June 1998 reports a cumulative total of AIDS deaths in sub-Saharan Africa of 9.6 million, leaving behind 7.8 million orphans. South and south-east Asia record a cumulative total of 7.3 million deaths due to AIDS and a cumulative number of orphans of 200,000. If these numbers of AIDS orphans are juxtaposed with the rising numbers of women living with HIV, the crippling burden of care on women's lives and livelihoods becomes a glaring reality. We will keep witnessing shifts in the status of women and assaults on their dignity and rights unless we take cognisance of their multiple roles in society. Women have been bearing the triple burden of production, reproduction and management of the household resources. The HIV epidemic has created a situation, which has exacerbated this burden. Women today are carrying the quadruple burden of sheltering and caring for orphans.

The changing family system

'The extended family in Africa is far better than the West about taking in relatives', says Mark Loudon. 'There is no formality about taking care of cousins. They slip right into saying mom. In Africa, you can have 30 moms. The problem is that AIDS just doesn't take one woman in a family. It tends to take all the wives of the brothers because the brothers tend to behave similarly.' The epidemic in Africa has confronted development workers with a dilemma – the dilemma of a silent breakdown of an informal social institution, the extended family. Will the extended family continue to act as a social security net for people affected by HIV/AIDS? Unfortunately, in some parts of Africa, it is already showing signs of nervous vulnerability.

'Edith and Khuzini Banda lived with their aunt for about a year after their mother died in 1994. But then the aunt said her home was too crowded. She sent the girls, then 13 and 14 years old, to live alone in their own house. The girls make do by renting out half of the two-roomed house for \$15 a month and begging from their neighbours when food runs out.' The message from this state of affairs is clear.

The escalating costs of caring are increasing the demands on women's unpaid labour within the family. The economic costs of care in actual terms by way of medicines and treatment are also very high. In Kerala, in India, it has been estimated that the monthly costs incurred by the family for the treatment of opportunistic infections for an HIV-infected child is thrice the monthly income of the family. In Haiti, Marie Ange Viaud, 24 years old, was living with HIV and the cost of the ten medications prescribed for her was well in excess of \$10,000 per year.

Female-headed households

How then will households cope? Community-based research has shown that the socio-economic impact of the epidemic on families has different repercussions depending on whether it is the man or the woman who dies. The epidemic is now at a stage of maturity in some countries of Africa where deaths as a result of AIDS are escalating, particularly among men. A significant finding of a study on the socio-economic impact of HIV on rural families in Uganda by Daphne Topouzis is that there are far more women who have lost their husbands to AIDS than men who have lost their wives. In Tororo, Helen Onyango of TASO reported that only 5 of her 62 clients were widowers. The rest were young widows from 15–35 years of age. The epidemic is therefore contributing directly to an increase in female-headed households.

Studies by the Food and Agriculture Organisation in Uganda and East Africa show that the main problem for many AIDS affected female-headed households is access to food and the consequent malnutrition.

'Jane, 23, has two children, four and two years old, and lives in Bumanda village in Tororo. Her husband, a farmer, died of AIDS. Both her children have been sick for a long time and she believes that they are also infected. Jane has not been able to work in the shambha for the last three months due to her husband's illness and the fact that the family has lost three other members in the last month. Her husband has been dead just a month and she is already experiencing food shortages. About once a week she prepares only one meal a day. The family diet consists of cassava and millet bread, occasionally eaten with smoked fish. She says she has no money to buy salt and cooking oil.

Another constraint is labour shortage and a negligible flow of cash income, which follows. According to Gabriel Rugalema, the most immediate need recorded by widows in Tanzania was credit to establish small projects that could combine farm and domestic work.

Women today are experiencing a sudden change in their roles in agricultural production. They are finding themselves lacking in the requisite skills and experience to respond effectively to the new challenges that confront them in their new roles. In Zimbabwe, women are having to move into industries that were previously dominated by men, for example carpentry, with little or no resources to cope with this shift. A direct consequence is a sudden decline in productivity. This is, in fact, the female face that poverty is acquiring in countries affected with HIV/AIDS. This feminisation of poverty is different from earlier trends. This poverty is often new for some households, and there is a potential danger of it becoming intergenerational and deep-rooted.

Exacerbating poverty

Studies have shown that the impact of HIV/AIDS on a specific demographic group depends on that group's awareness about the disease and the way it is transmitted, and the susceptibility or vulnerability of the group to high-risk situations. Studies investigating these issues were supported

by the UN Development Programme/Asian Development Bank in India and Sri Lanka. The studies found a strong positive correlation between education (with a component of sex education) and income levels, and awareness about HIV/AIDS. In short, the evidence from these studies suggests that, at least anecdotally, the disadvantaged will be disproportionately affected by the epidemic. Women all over the developing world form a large majority of this group.

Research on the impact of HIV/AIDS on the household is being undertaken in a number of countries but few studies have examined gender as a variable in measuring the household and community impact of the epidemic. The little that has been explored has come up with the following findings:

- ❖ In communities where women are responsible for subsistence farming, when they become infected the cultivation of subsistence crops falls, resulting in an overall reduction in food availability in the household;
- ❖ When opportunistic infections begin to occur, in the absence of access to medicines, sickness is prolonged and girls are often pulled out of school before boys to fulfil household duties when help cannot be hired due to the depletion of household economic resources;
- ❖ As a result of the loss of income from a male income earner when he falls ill, women and children are required to seek other sources of income. Research has shown that adolescent girls may be particularly vulnerable as a result of bartering sex for cash or other resources.

Other evidence suggests that the epidemic is contributing to a downward trend in the age of marriage for young women, as men seek younger wives to protect themselves from infection and families seek the economic protection of marrying off their daughters to economically stable men. This phenomenon has far-reaching consequences in terms of access to education by young girls, diminished access to productive resources, economic

dependency on the male partner and poor reproductive health as a result of early intercourse and childbearing.

In instances where the male head of household has died, studies have shown how women face a tragic set of circumstances in terms of loss of social support from family members, ostracism from the community and lack of legal protection of their right to inherit land and property. Instances have been cited where a husband's family may blame a widow for the death of her husband and refuse to accept her or her children into the family support system. Other instances have been cited where family members encourage a husband who is asymptotically HIV-positive to leave his wife who is also infected and find another woman.

Reprioritising national spending

There is thus a potentially important synergy between AIDS mitigation and anti-poverty programmes, especially those anti-poverty programmes that are gender sensitive. Rural development programmes aimed at improving women's access to sustainable livelihoods are likely to lessen the impact of the epidemic. For example, access to clean water is likely to have a marked effect on the amount of time women have for other productive activities and for the care of the sick and orphans. Access to labour saving technologies such as fuel-efficient stoves and food-grinding machines will similarly increase the amount of time women have to be able to shoulder new burdens.

The World Bank finding that each adult death depresses per capita food consumption in the poorest households by 15 per cent, implies that in responding to the epidemic, national governments will need to use adult death and household dependency ratios as a targeting criteria for poverty alleviation programmes. And as we reprioritise our national spending, we will need to do it even more critically with a gender lens. Women in Asia living with the virus are today silently expressing a need for support to break abusive relationships.

They need support for their children to be placed in foster homes, access to housing, hospices and, above all, access to a stable means of livelihood.

Living positively

Women living with HIV today are challenging existing norms around sexuality. There is a firmness and conviction in the statements being made. Says Lydia, who for eight months weathered bouts of diarrhoea, fought herpes zoster, lived with a horrible persistent cough, vomited most of what she ate and bore drenching night sweats and ulcers:

The Kenyans should stop cheating themselves about this disease. Let us stop pretending about the problem. The problem is real. I am a living example. There are thousands suffering out there. The disease is spreading like wild-fire every day and night. So why all this pretence? Many people are engaging in promiscuous behaviour as if there is no AIDS. AIDS is here with us. The sooner we face the reality as individuals and as a society the better for us all.

In Uganda, Agnes, living with HIV, is successfully resisting wife inheritance. 'Poverty is not an excuse for wife inheritance', she says. She thinks that women can resist being inherited but such self-assertiveness largely depends on how they are raised and on the type of relationship they had with their husbands.

Patricia, in Tororo village, is working towards setting up a group in her village to encourage girls to develop life skills so that myths around sexuality can be exploded and create income-generating opportunities that would keep them away from bad company, as she put it.

But the voices of Lydia or Patricia or Agnes, though firm, are not yet loud enough to close the yawning gap between people's beliefs, which have been imbibed over a long process of socialisation, and the appropriate sexual behaviour that is essential to stop the spread of HIV/AIDS. Each

year thousands of men fall into this gap and thousands of women are dragged in with them. Because of gender socialisation processes, the need to prove themselves masculine propels men towards risky behaviour. Abstinence is seen as unnatural and refusal to use condoms is rationalised in many ways: 'It is only really sex when you ejaculate into a woman', says a Zimbabwean man; "*real men*" do not get sick', says a Brazilian adolescent. Mexican sociologists Jose Aguilar and Luis Botello point out that condoms represent safety and are therefore unmasculine. And as more and more men conform to these stereotypes, women's susceptibility to the epidemic continues to increase.