

## **THE GENDERED FACE OF HIV/AIDS: The Move Towards Policy Implementation in Ghana**

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### **ABSTRACT**

HIV/AIDS is more prevalent in Africa than in any other part of the world <sup>26</sup>. In Ghana, the first case of HIV/AIDS was report in 1986. Since then there have been efforts at various levels to combat its spread. This paper examines the institutional and structural frameworks for dealing with HIV/AIDS in Ghana. Using concept analysis, it examines the frameworks for their gender and development implications. It finds that the social group most adversely affected by HIV/AIDS in Ghana is women. This is attributed to social, economic, cultural, and institutional obstacles. While efforts at fighting the disease by the Government of Ghana through the Ghana Aids Commission, donor partners and civil society are noteworthy, it is also clear that the frameworks applied do not adequately address the gendered nature of the HIV/AIDS epidemic. Consequently, it is argued that any meaningful effort toward combating the epidemic will involve the empowerment of women through changes in government policies and the socio-cultural systems and practices that limit women's options and choices. The role of women in developing national processes will be felt where women's needs are taken into consideration and addressed as one of the key to their contribution to national development.

**KEYWORDS:** Women's Empowerment, Socio-cultural Systems, HIV/AIDS, Policy Frameworks, National Development

### **INTRODUCTION**

At the recently held International Conference on HIV/AIDS in Mexico City in August 2008, world leaders and activists recommitted themselves to dealing with the epidemic by adopting new measures to combating the spread of the disease. The World Bank's efforts in dealing with the global epidemic was reinforced as it called on governments to institute policies that address the new challenges such as rising costs of drugs and high levels of poverty (World Bank, 2008).

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<sup>26</sup> UNAIDS. 2008. Regions. Available at <http://www.unaids.org/en/CountryResponses/Regions/default.asp> Accessed August 20, 2008.

Africa accounts for 10% of the world's population, yet is home to 68% of people living with HIV/AIDS, and stands out as the continent with the highest number of people living with HIV/AIDS. The 2008 UNAIDS Report shows that there has been a decline in the number of people with HIV/AIDS globally. It shows also that while the new rate of infections has fallen, the percentage of women with infections remains stable at 50%. The Report further reveals that 14 out of 17 African countries with the adequate data show that the percentage of women with HIV/AIDS has declined (UNAIDS, 2008). In spite of the decline, women are still the most affected on the continent. The number of newly infected cases increased from 13.1 million in 2003 to 13.5 million in 2005. It was estimated that at the close of 2005, there would be 3.2 million newly infected cases, of which 4.6% would be women and 1.7% would be men <sup>27</sup> (UNAIDS, 2005). In the latest report as at 2007, the estimates showed that there were 1.7 million new infections on the continent bringing the total number of infections to 22.5 million. Women accounted for 61% of all infections on the continent, the highest compared to any other region in the world. Despite the increase, some West African countries such as Ivory Coast, Mali and urban Burkina Faso witnessed modest stabilization (UNAIDS, 2007).

The first reported case of HIV/AIDS in Ghana was made in 1986(UNAIDS, 2004a). Looking back at past decades since the first case was identified, with the passage of time, major stakeholders such as national governments and international donors have played key roles in combating the spread of the epidemic. Such efforts have included the work of the United Nations Aids Commission (UNAIDS), the government of the United States of America (USA) and the National Strategic Framework (NSF II) of the Ghana Government through the Ghana Aids Commission (GAC). The incidence of HIV/AIDS infections in Ghana is patterned along sex, age, geographic area and to some extent rural-urban residence (GAC, 2005). In the case of Ghana, like many other African countries, HIV/AIDS is increasingly taking on a gendered outlook. Not only are more women being infected, but the burden of taking care of the sick and providing for the family falls heavily on the shoulders of women. In a report, the UNAIDS (2007) had noted that in the case of Ghana, the median range for women with HIV/AIDS attending antenatal clinics had ranged from 2.3% to 3.6% between 2000 and 2006.

Women in Ghana have traditionally displayed great skills of organization and industry, despite the entrenched socio-cultural beliefs and practices, which subordinate them. Thus, for a meaningful end to HIV/AIDS or to be able to better contain the epidemic, this paper calls for the use of policies that do not merely profess to response to gender needs, but which actually focus on how to change the entrenched belief systems and practices which continually compound the vulnerability of women

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<sup>27</sup> It is important to note that these statistics are those of the previous years, thus it is not able to account for disparities in a timely manner since there could be more or less infections by the time the report is released.

and girls. The gendered impacts of HIV/AIDS should not merely be a checkbox for government policymaking and international donor conditions, but should be actualized through the maximization of the agency of women at the grassroots level.

While efforts have been made to deal with this epidemic globally, countries are at different levels in dealing with the situation, through government policy and the efforts of civil society organizations. It is estimated that few countries are able to provide anti-retroviral drugs and implement policies toward the prevention of mother-child infections. Overall, reports show that the levels of HIV/AIDS infections are falling globally, but new infections are being reported in other parts such as in the Southern African region, Indonesia, and parts of Europe (UNAIDS, 2008).

Since the first reported cases of HIV/AIDS around the world, governments, individuals and NGOs have played critical roles in trying to find a cure or reverse the damage done. Even though reports indicate that the number of people living with HIV/AIDS is declining, more needs to be done to curb the rising tide. Within the global framework of the United Nations, the recommendations have included the need for stronger political will on the part of leaders and an increase in financial resources to fund research and medication. At the national level, as at 2005, Ghana had no functional systems in place for dealing with the epidemic, such as monitoring and evaluation systems. However, as at 2008, Ghana has put in place some basic elements. It is expected that some modest improvements would be made toward reduction in the scourge of the epidemic in the country (UNAIDS, 2008).

The Ghana Aids Commission reports that the number of people reported to be living with HIV/AIDS in Ghana as at 2004 stood at 400,000, with this number expected to hit 500,000 people by the year 2015<sup>28</sup>. In the current 2008 UNAIDS Report, this number is reported to be 312,030 of all infected people as at 2007 (UNAIDS, 2008). This disparity could also be one of the problems hindering the ability of the government and other international agencies in dealing with the epidemic. In addition to meeting international standards such as those set by the UN, the Government of Ghana should move away from signing declarations to actually implementing and enforcing those declarations and agreements. Such activity on the part of the government calls for gender empowerment in the economic and social as well as legal and political spheres of life in Ghana. While this paper appreciates that behavioral change cannot take place overnight, it stresses that incremental change can go a long way to save one life at a time.

This paper first looks at the current discourse on gender and HIV/AIDS with particular reference to the power differentials ingrained in society and how those forces are driving forward or not efforts at combating the epidemic. Second, it reviews the current literature on what has been done so far in terms of policy and advocacy at both

<sup>28</sup> Ghana Aids Commission. 2004. Available at [http://www.ghanaims.gov.gh/gac/publications/nshow\\_det.php?recordID=54](http://www.ghanaims.gov.gh/gac/publications/nshow_det.php?recordID=54) Accessed August 20 2008.

the national and international level in combating the epidemic. Third, it examines the gendered grassroots strategies that have been instituted as part of the attempt to combat and or contain the epidemic and suggest ways for strengthening them.

Though this paper recognizes that the fight against AIDS has not only been focused on women as both transmitters and receivers of the disease, it is essential to recognize that women bear a disproportionate brunt of the effects of the disease. The Executive Director of UNAIDS (1998), Peter Piot, appropriately classified AIDS as a 'woman's epidemic' because the socio-economic, institutional and cultural constraints inherent in societies continue to marginalize women by increasing their already heavy burdens and predisposing them to infections and the vicious cycle of infections.

Consequently, this paper has been interested in the following questions: To what extent have women and men in Ghana been involved as equal partners through policy and education in dealing with the epidemic? How far have attempts by non-governmental organizations (NGOs) and local women's organizations forged alliances for solving the problems of power and other socio-economic differentials? What successes, if any, have been achieved so far? What lies ahead for women and HIV/AIDS in Ghana?

There are three underlying arguments of this research paper. The first is that the effective management of the spread of HIV/AIDS in Ghana calls for the re-examination of government policies towards gender and women in particular. Second, that AIDS can be better contained if women are empowered through the implementation of gender responsive policy and the work of gender equality/women's rights organizations and advocacy networks. The third is that masculinities should be linked to gender empowerment, since a failure to do so will not help in addressing gendered power differentials, which could potentially mar the whole process of women's empowerment. This paper posits the argument that female empowerment through the development of strong social and advocacy networks is key to solving the HIV/AIDS epidemic in Ghana.

## **REVIEW OF LITERATURE ON GENDER AND HIV/AIDS IN GHANA**

### ***Incidence and Trends***

The impact of the HIV/AIDS epidemic in Ghana as in many parts of Africa is not only limited to the health and well-being of the infected individual but also has implications for societies and nations. Specifically, in Africa, it has severe consequences on an already stalled development. The deployment of already inadequate resources in managing the disease (i.e., care and medications) and loss of labor hours due to illness and care have direct implications for productivity and national spending patterns. Thus, HIV/AIDS has the potential of reducing national incomes and productive investments, which further impoverish African economies. At the same time, the poverty situation in Africa has tended to impede efforts to control the spread of the

disease. Ankraah (1991) notes that poverty accounts for the speed with which HIV/AIDS has taken over the African continent since most people living with the disease are also facing nutritional deficiencies and lack access to adequate and timely medical care. The first case of HIV/AIDS in Ghana was reported in 1986; by December 2002, the number had risen to 64,316, implying an increase of about 3,783 cases annually.

Existing literature on the HIV/AIDS epidemic have addressed various causal variables and outcomes of the epidemic. While some have looked at the effects of the disease, others have examined the national and international policies put in place to deal with the epidemic. Various studies reveal that there continues to be a multiplicity of factors accounting for the current state at which the epidemic has reached on the continent of Africa. Cheru (2002) notes that under World Bank led Structural Adjustment Programs (SAPs), African governments have had to cut down on health spending and this has in many ways affected those living with HIV/AIDS. Elbe (2002) also notes that the high rates of conflict on the continent have also played a role in increasing the rate of infections. This has been mainly due to the use of rape as a weapon in civil and ethnic conflicts ranging from those in Liberia, Rwanda, and Sierra Leone. Writing from a gender perspective, Tallis (2000) argues that the power differentials between men and women could also be a factor why women continue to bear a high brunt of the epidemic than men. Tallis (2000) argues that traditional human rights standards are based on masculine norms and this is the reason why all policies continue to be gender blind. Thus, for there to be any gains in dealing with the epidemic, there will have to be the need to address these underlying gender inequalities. Dealing with the epidemic thus requires not only a policy orientation (Tallis, 2000), but the adoption of a holistic approach involving addressing the issues of faith and cultural beliefs and practices (Farley, 2004; Latre-Gato, 1999) and addressing the issue of gender inequality (Lesetedi, 2005; Walsh, 2005).

Esu-Williams (2000) addresses the long term effects of the epidemic on the social, economic, political and human resource demands of the continent. Looking at current statistics, the author notes that the consequences could be much deeper and wider than currently estimated. Molestane and associates (2003) point out that the gendered impact of the epidemic imply that women suffer more marginalization as they struggle to take care of sick family members and also be in charge of providing money and food for the family. Women tend to bear a disproportionate burden of the incidence of AIDS due to their vulnerability regarding the lack of negotiating power in sexual relations and/or as sex workers. Also, there is the tendency of blaming women for being infected with HIV/AIDS. Women are blamed not only for its spread but also as contaminated vessels that have condemned babies (Bassett & Mhloyi, 1991).

Oppong and associates (2006) argue that in the case of Ghana, the situation is further worsened due to changes in gender roles and the larger society. They cite the rate at which the country is undergoing social change as resulting in transformation with implications for gender relations and HIV/AIDS management. They identify the at-

tendant consequences of such social transformation to include exposure to foreign cultures, which affect the changing cultural norms leading to the increasing exploitation of women and girls especially, in the sex industry. The challenges of urban living and the incidence of female migration intensify sexual exploitation and sexual violence. Also, trans-border trade and migration present their own challenges which require shifts in management solutions.

### ***Causal Factors***

The causal factors for the spread of the disease have been well documented. They range from the biological/physiological, to the economic, social and cultural variables.

First, from the economic perspective, the argument is made that the spate of migration for work has often led men to leave their families behind to work in other places, often urban areas where they are predisposed to new lifestyles (Anarfi, 1991). The result is that these men engage in extramarital affairs which predispose them to infections. When such men return home, they pass their infections on to their wives and other relations. Women on the other hand have often been characterized as transmitters of the virus, especially in the case of sex workers and migrant women. Sex workers but also returned migrants from other West African countries have often stigmatized for spreading HIV/AIDS. Anarfi (1991) notes that most of the infected women in Ghana, during the 1980s, were returned migrant and/or sex workers from other parts of the continent, especially, neighboring Ivory Coast. However, in recent years that in-country female migration (kayayoo) and child streetism have been on the rise, such women and girls have become another category of stigmatization.

Second, socio-cultural beliefs and practices such as the practice of polygamy tend to predispose women, compared to men, to infections at a higher rate (Umeh, 1998; Aniekwu, 2002). On one hand, the fact that a man can have more than one wife means one man is able to infect between two to three women with whom he is legally married to under customary law. On the other end of the socio-cultural continuum is the fact that the discrimination and stigmatization women who are infected with the virus face often leads to them keeping a tight lip on their health for fear of being ostracized by society and their families. The result then is that such a healthy looking woman is able to infect more partners before her situation becomes obvious.

Third, the lack of, or inaction on the part of political leaders both at the national and international levels has accounted for the spread of the disease (UNAIDS, 2008). Altman (1999) in his analysis of the disease notes that HIV/AIDS, despite its international dimension, has not received much analysis in globalization and political economy literature. Thus, the lack of a genuine and concerted effort by world leaders, despite the political rhetoric and commitments they claim to make, accounts for the continued spread of the epidemic.

Fourth, in the case of Ghana, like many parts of the developing world, the low level of human capital evidenced by the large number of the illiterate population further worsens the situation. The gendered nature of the illiterate, with women in the disadvantage, heightens their vulnerability. Takyi (2000) argues that the use of rational choice models in explaining the use of contraception among women could go a long way to determine the risk factors for women. It is especially the case that women also account for a large chunk of those without any form of formal education and therefore unable to read the literature or understand the medical dynamics of the disease.

Fifth, is biological with social implications. The gendered sexual politics and the limitations it puts on women regarding decisions about their body results in their vulnerability to aids. Patriarchal and phallogocentric norms that construct women's bodies as objects of desire also limit their participation in the process resulting in their loss of bodily integrity. The objectified and sexualized female body becomes the target of male pleasure. These same norms give men almost unlimited powers to use and even abuse the female body physically, psychologically and sexually. Women's bodies become targets of various forms of violence. This manifests in the widespread gender-based violence such as domestic violence, sexual harassment and assault including rape (Latre-Gato, 1999; Tallis, 2000; Elbe, 2002). Heise and Elias (1995) argue that "women often have too little power within their relationships to insist on condom use, and they have too little power outside of these relationships to abandon partnerships that put them at risk." The lack of control by women in deciding when to have sex and what form of protection to use often means that women are at the mercy of the male partner who can decide when and if he is ready to wear a condom or not. It is therefore necessary to question the choices and options for women in controlling their bodies and preventing infection. Cohen (1998c) notes that it is a matter of choice and options, that which women tend to lack, which dictate the chances of infection.

The analysis above attributes causality of the spread of HIV/AIDS in Ghana to largely socio-cultural factors. It also shows that gender is an important function of vulnerability, which suggests that although the disease defies all barriers, the levels of vulnerability differ. UNAIDS (2008) reports that the prevalence and spread of the disease varies by location and the relative position in society (UNAIDS, 2008). For women, their subjugated position in society presents a specific form of vulnerability. Women, compare to men, are more vulnerable. Belief systems and cultural practice limit women's access to resources and decision-making powers that are critical protective tools. Even among women, those who are educated and financially independent are less-prone. There is the high probability that they will be informed about the disease and treatment options as well as have the means of accessing medication and requisite nutrition in managing the disease. Thus, economic capabilities or the lack thereof may determine the risk of infection of both the poor and the rich. Despite this equal landing upon which infection may take place, the dynamics of gender, social class, and economic factors determine who lives and who dies since the rich are in a

better position to get information, better nutrition, and healthcare to live better and healthier lives than the poor are.

### **Current Policies and Their Gendered Implications**

Since, the HIV/AIDS disease was first reported, several efforts and proposals have been sought in its management. Medical, spiritual and social approaches have been offered. Currently, there seem to be significant paradigm shifts in not just understanding but also the management of HIV/AIDS. These paradigmatic shifts in the fight against AIDS have ranged from the focus on treatment, countering discrimination, prevention and now a human rights approach which states that women's rights are human rights (Bayliss & Bujra, 2000). The human rights framework of analysis has tended to focus on the questions on power and voice.

Rights-based analyses of gender and the gendered impact of HIV/AIDS tend to view women as "powerless" and voiceless in the fight (Lauer, 2007; Ankrah, 1991; Bassett & Mhoyli, 1991). Bassett and Mhoyli (1991) view it in terms of women's lack of control in relationships. While this may be true, it is important to recognize the agency of women as autonomous and powerful instruments for fighting all forms of gender-based discrimination. This paper argues that for there to be progress in women's fight against HIV/AIDS in Ghana and other parts of Africa, it will be necessary to avoid essentialism and its attendant victimizing framing, which portrays women as passive recipients.

In her analysis of HIV/AIDS discourse in Ghana, Lauer (2007) argues that whether at the national or global level, women have been the unfortunate victims as their wombs have been targeted in population management and disease control. This unfortunate targeting, she suggests, creates victims out of women, a situation attributable to the patriarchal structures and systems, which deliver gender meanings even in the management of such a devastating disease as HIV/AIDS. Though women tend to be highly vulnerable due to biological, physiological and socioeconomic factors (WHO, 1995), it is necessary for current research to focus on the capabilities and agency of women in fighting the epidemic. This can be done through the adoption of advocacy and trainings, which view women as agents of change and development. The tendency to view women as powerless and vulnerable creates victims rather than agents of change. The psychological and social implications of victimizing theories jeopardize the struggle for change.

Elson (1995) rightly notes that the structural frameworks that exist in developing countries which produce, reproduce and solidify gender inequality are not only limited to the area of development processes but also in government policy, legislation, religious beliefs and practices. While agreeing with Elson, it is also noteworthy that the fight against the gendered impacts of HIV/AIDS should aim at empowering women not only economically and socially, but should begin with psychological em-

powerment. There is no doubt that there exist strong power differentials between men and women in the public and private spheres, with women at a relative disadvantage in negotiating the terms of such relationships. Furthermore, it is true that such power negotiations cannot be overcome by macro level institutional change and policy making only. It is for these reasons, among others, that it is necessary to engage academic theorizing and practical methodology, which examine sexual politics, gendered power relations and seek to increase women's power in such circumstances.

It is clear that the economic and socio-cultural conditions in most parts of Ghana play a grave role in determining such outcomes. Indeed, women are often not positioned to forcefully negotiate with men. However, at the micro level, education on instilling some understanding of and awareness on the need for men to recognize women's agency in relationships is imperative. Bayliss and Bujra(1995) argue that the top-down and externally-led approaches and initiatives to fighting the epidemic have still not achieved much and they argue for the need for women to be viewed and recognized as actors with power, influence and capabilities. Despite the focus by feminists and advocacy groups, such power differential approaches have yielded limited fruits and much more remains to be done.

Heise and Elias (1995) argue that the traditional care-giving roles of women will not only be a means of providing support for women in the burden of taking care of the sick, but will also be an avenue for changing the perceptions and socialization as a means to empowering and educating women. Though this may in the long run have some positive outcomes, du Guerny and Sjoberg (1993) are careful when they refer to such interventions as "gender traps." They suggest that empowering women in the traditional domains for reproductive delivery whether within the public or private without the critical assessment of their gendered implications runs the risk of reversal of gains. They argue that attempts at women's empowerment could lead to the entrenchment of existing social inequalities by increasing the burden women already bear in the caring of the sick and providing for the family. Despite this argument, it is worth noting that the empowerment of women could also lead to empowerment in asserting their rights.

Gender empowerment is a concept which has many positive results for the extended family system, a concept which most people in the West do not necessarily identify with and will be quick to condemn it as robbing women of their empowerment or setting the clock back in attempts to fight the burden women face in light of the epidemic. Ankrah (1991) points to the need to engage masculinities in the fight against HIV, so that men may be 'intellectually and emotionally released from the cultural entrapments that require the female to be submissive.' Many other governmental, non-governmental, and intergovernmental agencies have called for work aimed at changing outmoded gendered socio-cultural notions, which derive largely from the socialization processes. More work needs to be done to challenge the gendered notions and should begin with women changing their resign that they are powerless and

for men to realize that in the fight against AIDS, absolute power surely absolutely corrupts.

One of the major developments for women and gender activists in Ghana has been the recent passage of the Domestic Violence Act (2007). The Act, (2007) could also provide an avenue for empowering women and reducing their susceptibility to violence and consequently HIV infection. Having said that, it is important to note that the Domestic Violence Act is yet to be effectively implemented, hence it is only a matter of time before we see any positive outcomes. The Ministry of Health notes that the epidemic has declined from 3.6% to 3.1% in 2005, showing that there is some positive occurrence.

### **Ghana's HIV/AIDS Policy**

In response to the spate of the HIV/AIDS, the Government of Ghana established the National STDs/AIDs Control Program (NACP) under the auspices of the Ministry of Health in 1987 to deal with issues relating to the disease. Later, the Ghana AIDS Commission was established in 2002 with the President as the Chairman. Due to budgetary challenges, funding for realizing the goal of research, education and awareness creation have come largely from external donors. These donors include the Canadian International Development Agency (CIDA), United States Agency for International Development (USAID), the European Union (EU) and other German and Japanese foundations (Anarfi et al, 2004).

The creation of the Ghana Aids Commission through an Act of Parliament (Act 613) as a national body dealing with the control and mitigation of the epidemic constitutes a significant effort in the fight against HIV/AIDS. The Commission has since worked closely with donors, civil society organizations (CBOs) and faith-based organizations (FBOs) in attempts to find common solutions to the problem. Under its mandate, the Commission developed National Strategic Frameworks (NSF 1 and II) for engaging in policy creation and implementation.

The National Strategic Framework (NSF 1, 2001-2005) which preceded (NSF II, 2006-2010) was a project implemented by the Government of Ghana to deal with the epidemic by providing "improvements to the supporting environment, preventing infections, targeted behavior change programs to the general population as well as specific vulnerable groups, treatment, care and support, and combating stigma and discrimination" (Ghana AIDS, 2005:1). The framework first recognized the debilitating effects of the epidemic on national development processes and therefore adopted a multi-faceted approach to dealing with the problem. Among the approaches adopted was the need for the respect of human rights, accessibility of information and services to those infected, effective coordination and mobilization of organizations and communities involved with dealing with the epidemic and, mobilization of adequate resources both financially and human resources to deal with the problem.

Among the different methods adopted in dealing with the problem has been the focus on seven key intervention areas; namely, policy, advocacy and the creation of an enabling environment, coordination and management of decentralized responses, mitigating the social, cultural, economic and legal impacts of the epidemic. The other methods are the emphasis on prevention and behavioral change, provision of treatment, care and support, conducting research, surveillance, monitoring and evaluation and last but not the least, mobilization of resources and funding arrangements (Ghana Aids Commission, 2005). The pitfalls that were identified in NSF 1 such as the inadequacy of monitoring and evaluation mechanisms were some of the issues addressed in NSF II.

Despite the laudable attempts by the Government of Ghana to deal with the epidemic as national crises, a look at the NSF shows that there is no particular provision(s) relating to women and the particular problems confronting women as the most vulnerable group. This shortfall raises the all-important question of central interest in this analysis: What are the gendered implications of HIV/AIDS policies currently in place in Ghana? No satisfactory answer can be found in these national frameworks, but some modest answers may be found in the interventions of some partners that have been engaged in the eradication and containment of the epidemic.

In addition to the national policies created under NSF 1 and II, the Government of Ghana is also pursuing the eradication of the epidemic as part of its commitments to the UN Millennium Development Goals (MDGs). Goals 3- 6 are more clearly geared towards women and could have wider gendered implications. Goal 6 deals with combating HIV/AIDS, malaria and other diseases. Goal 3 deals with promoting gender equality and empowerment of women, Goal 4 deals with reducing child mortality, while Goal 5 deals with improving maternal health.

At the Africa regional level, Ghana was been also part of the 2000 Abuja Declaration that dealt with, among others, HIV/AIDS, Tuberculosis and other infectious diseases. In its forty point declaration, the heads of states clearly stated under declaration 7 the "*We recognize that biologically, women and girls are particularly vulnerable to HIV infection. In addition, economic and social inequalities and traditionally accepted gender roles leave them in a subordinate position to men*" (emphasis mine). The governments went further to recognize that the epidemic is a global crises requiring immediate attention as it adversely affected the development prospects of the continent.

## **IMPACT OF HIV/AIDS ON DEVELOPMENT**

The initial attempts at combating the AIDS epidemic were carried out along public health lines. It entailed the aggressive engagement by the Ministry of Health in educating the public about healthy sexual lifestyles. However, the focus has changed, with statistics showing that about 600,00 (4.6%) of the Ghanaian population are in-

fectured with the virus, out of which 2.7% of all pregnant women who visited antenatal clinics and tested were positive (Anarfi & Appiah, 2004).

The effects of the HIV/AIDS epidemic are varied and numerous, in the first place, it is stated that the life expectancy will drop to 57 years from 62 years due to HIV/AIDS (Anarfi et al, 2004), thus stalling the development process. Secondly, the fall-out of death among adults, parents and the dependable population will be the number of orphans and misplaced children who will not have had any good parental care, love, and upbringing. The children who are supposed to be the leaders of the future will be less developed psychologically and in education to be able to see to the development of their societies and the nation at large.

At the national level, the incidence of the epidemic is putting a strain on the already overburdened government budget. Most of the money allocated for dealing with the epidemic comes from foreign donors such as the Global Fund for Aids, which gave the government of Ghana \$15 million in 2004 to deal with the epidemic. With increased costs in health care and the management of HIV related infections and diseases, the Government of Ghana is increasingly having to provide more subsidies for people who cannot afford the medications needed to treat them. This is therefore shifting the budgetary allocation from other equally important sectors such as education and infrastructure development, into the health system, which, unfortunately will not lead to much improvements in the lives of those infected. The national economy will be greatly affected since most of the gross domestic product comes from exports of agricultural goods such as cocoa. Also, as more and more people in the rural areas are infected, agricultural production will go down and consequently, lead to a decline in export crop production and thus a fall in the national revenue.

Demographically, the AIDS epidemic has now become a developmental issue, since most of the infected are in the prime of their developmental and reproductive years. Statistics show that men within the 30-35 age group and 36 per cent of the total number of infected people and women within the 25-29 age group account for 63 per cent of those who are being infected (UNAIDS, 2007). The result is that the youth are dying leaving behind the aged who do not have much to contribute to societal development, on the other side of the scale is that new born babies are also being HIV infected, thus, endangering the future of the nation.

Economically, those who are strong and able to work are being less productive because they are sick and in most cases cannot go to work to earn incomes for themselves and/or their families. In the particular case of women, female-headed households, or even in cases where both partners contribute to the upkeep of the family, women who are sick because of HIV/AIDS do not receive as much support as men do. This is attributable to women's traditional roles as care givers.

Though there is still no cure for the disease: what has been done so far in attempts to combat or mitigate the spread of HIV/AIDS in Ghana? Efforts have taken the form of the creation of the Ghana Aids Commission, the institution of the AIDS Awareness Day and provision of free screenings. There have also been partner efforts by non-governmental organizations (NGOs), faith based organizations (FBOs), the international community and local communities in generating awareness and conscientization. These attempts have included the use of the mass media, and education of the populace through both formal and informal means. Despite all these laudable activities and actions, the disease is still spreading at an alarming rate. Why have so many different efforts still yielded less impact?

Poverty and HIV/AIDS are linked and mutually reinforce one other. Since women tend to be poorer than men, they are at the lower end of the bargaining table when it comes to dealing with the epidemic. Thus, this paper notes that for any meaningful progress to be made in mitigating, preventing, and slowing down the epidemic from a sociological point of view, women must be empowered and equipped not only with decision-making capacity, but also economic and social empowerment. It recognizes that the institutional, structural, economic and socio-cultural constraints to the fight against HIV/AIDS but concludes on an optimistic note by recognizing that women, who comprise half the population of Ghana, can serve as active participants in the prevention of the spread of the epidemic. How do we go about achieving this?

## **RECOMMENDATIONS**

The following recommendations aim to provide a leeway to ensuring a collective approach and simultaneously gendered effort in mitigating the epidemic.

***“Pharmaceutical Genocide” must be stopped.***

The role of developed countries, especially the United States in the prevention and control of the epidemic can lead to great strides. However, due to the lobbying of pharmaceutical companies, the government is increasingly ignoring the call for making generic antiviral drugs available and affordable to people in the developing world to afford. On the reverse is the fact that much research and development is not taking place to find a cure because these pharmaceutical companies not do see themselves making profits by investing time and money in the development of drugs. Despite the recent talk about the development of microbicides specifically for women, it is sad to note that although some tests are currently underway, estimates show that it will take about five to seven years before the drug is fully developed.

### ***Intensification on Policies and Frameworks***

National governments and policy makers need to increase the drive for eradicating and curbing the spread of the epidemic. Despite the efforts made so far in Ghana through the establishment of the Ghana AIDS Commission, the disease is still

spreading like wildfire. Lessons may be learned from the case of Uganda, by declaring the epidemic a national crisis and increasing the budgetary allocation for education and activities geared towards female empowerment.

### ***Civil Society Advocacy***

Civil society and gender advocacy groups should also play a critical role in addressing this issue by increasing knowledge, self reliance, and lobbying for gender equity in laws and policies dealing with women and HIV/AIDS. Grassroots mobilization should focus on women as a strong and vibrant source for dealing with the epidemic.

### ***Integration of Masculinities***

The need to involve masculinities in collective action in finding solutions to the problem is also very important. Ulin (1992:67) notes the need for bringing in masculinities "nevertheless, women's empowerment is only half the solution: men too must acknowledge their joint responsibility, and all members of the society must be willing to redefine sexual roles in relation to the health of the family and the community".

### ***Targeting of Socially Excluding Factors***

The factors and avenues of social exclusion of women should be addressed, such as, ignorance due to illiteracy, social injustice due to lack of political will, religious and cultural fanaticism, which leads to atrocities such as female genital cutting. Questions on gender based violence, sexual politics and women's empowerment need to be made central in the policies and strategic frameworks.

## **CONCLUSION**

In this paper, I have argued that government policies in dealing with the epidemic should have a gendered focus if there is to be any meaningful impact on women. I demonstrate, first, that despite the laudable efforts such as the establishment of the Ghana Aids Commission in 2002, the engagement in other regional and international attempts at dealing with the epidemic and collaborative efforts by donors and civil society, a lot more remains to be done in the fight against the HIV/AIDS. Second, gender power relations, patriarchal structures and the flawed masculinities will play vital roles in dealing with the prevalence of the epidemic among women. Third, for there to be an effective collective and multidimensional approach to eradicating, controlling or curbing the spread of the epidemic, there must be female empowerment economically, socially and culturally. The existing gender norms, beliefs, and practices cannot change overnight, but it is necessary that such action begin now. Concentrating on women as powerless victims can lead to the situation whereby policy formulation fails to take into account the full capacity of women to engage in ending the epidemic.

While, recognizing the existing structural inequalities and power relations between men and women which continually subordinate women, this paper argues that for there to be a meaningful impact on the gendered outcome of HIV/AIDS in Ghana, gender theorizing and policy formulation should focus on the agency of women and avoid characterizing women as powerless victims. Policy makers, civil society groups and other major stakeholders should continue to act together in order to find short, medium, and long-term solutions to the scourge of HIV/AIDS on women in Ghana.

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