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Gender Issues in Relation to HIV and AIDS

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Introduction

This article discusses some of the religious beliefs, convictions and practices that reinforce pertinent gender inequalities and how they influence HIV vulnerabilities and risks. The discourse particularly provides a platform for religious teachers and leaders to conceptualize and interrogate gender perspectives and their impact on the advancement of their religious objectives and goals in this era of HIV and AIDS.

Gender here refers to the socially constructed and learnt roles and responsibilities for males and female. The concepts of 'sex' and 'Gender' are often interchanged, but, strictly speaking, "gender" is the human construct that establishes the moral and social implications of sexual differentiation. Gender roles vary depending on the place, time, and socio-economic, political and cultural context, but they are almost always present, and ultimately have a significant impact on vulnerability to HIV and AIDS.

Gender Dimensions of HIV and AIDS

Scholars have long recognized that gender inequalities drive HIV and entrench its impacts in every community in the world irrespective of social, cultural, political and religious affiliation. Gender inequalities are more inclined against women and girls. The inequalities between men and women that are created and reinforced by gender roles typically leave women especially vulnerable to HIV infection and its impacts, but it is also important to recognize that gender roles affect men's vulnerability as well. As a result of their societal roles and responsibilities, women and girls face a number of unique challenges that disproportionately affect their ability to protect themselves from HIV and its overwhelming effects. This is evidenced by the greater impact of the epidemic on women, especially in Sub-Saharan Africa and certain Caribbean countries, where the "feminization" of AIDS is most visible. Women carry the burden of care giving, and bear the greatest burden of HIV in terms of prevalence rates especially girls and women aged 15–24 years. One half of people living with HIV globally are women and 76% of all HIV-positive women live in sub-Saharan Africa. In this region, women are more likely to become infected with HIV than are men - 13 women become infected for every 10 men infected. Female-to-male ratios of new HIV infections range from 1.22:1 in West and East Africa to 1.33:1 in southern Africa. For every HIV-positive young man (15-24 years) there are three HIV positive young women.

Differentiated gender roles create unequal power relationships between men and women that influence their access to HIV information and related services, and their attitudes and practices affect their levels of vulnerability and risk to HIV infection and impacts. Attitudes, perceptions, beliefs and

behaviours portrayed towards men or women infected and/or affected by HIV are greatly influenced by the roles and responsibilities society has assigned to them. Gender roles dictate how each of the factors below differ between men and women:

- Masculinity and femininity
- Roles, status, norms and values
- Responsibilities and expectations
- Sexuality
- The division of labour, power and responsibilities
- The distribution of resources and rewards

Women's Greater Vulnerability to HIV

The consequences of gender inequalities in terms of low socioeconomic and political status, unequal access to education, and fear of violence, add to the greater biological vulnerability of women and girls being infected with HIV. This is evidenced by the "feminization" of AIDS mentioned above. There are several reasons for the feminization of AIDS.

1. Harmful Social Norms

Social norms about female sexuality and expected sexual passivity in women make it very difficult for women and girls to negotiate safer sex practices and access sexual health information and services because of a misguided fear that it will encourage sexual activity. Moreover, due to household obligations, limited mobility, and insufficient funds, women often face greater challenges to accessing health care services, including sexual and reproductive health services that could help protect from HIV. The same challenges exist for girls and women in accessing basic education which can empower girls to steer free from harmful social norms.

2. Economic Dependency

The power imbalance between men and women also translates into economic dependency for women on men as family heads in which most men have greater control and access to productive resources. For this reason women may feel pressured to stay in risky or abusive relationships with men; or feel forced to transact sexual favors for money or gifts; engage in sexual activities earlier than boys (early sexual debut), and often this sexual activity is with older men. More women than men live below the poverty live and this has similar effects.

3. Violations of Rights

Girls too often face greater violations of their rights (sexual violence, abuse and exploitation, discrimination, stigma). Women still bear the enormous stigma attached to being widowed by AIDS, and are often left to battle the discrimination alone. Forced and early marriages predispose young girls to STIs since their immature genitalia can easily lacerate or suffer lesions to facilitate viruses and disease organisms.

4. Sexual Violence

Sexual violence against women and girls can enhance vulnerability to HIV directly, as well as indirectly by limiting women's autonomy and access to prevention information and services through fear and intimidation.

5. Burden of Care Giving

Women and girls contribute to household chores or income generation and provide home-based care, take in orphaned children, tend to the family's fields. These responsibilities can limit their own opportunities for advancement.

Practices and Attitudes that Increase Men's Risks of HIV Infection

Masculinity emphasizes sexual domination over women as a defining characteristic of male-hood and shapes boys and men into self-reliant, high-risk takers. They are conditioned not to show their emotions and not to seek assistance in times of need or stress (WHO 1999). This expectation of invulnerability encourages the denial of risk, poor health-seeking behaviors and low risk perceptions.

Traditional roles and societal values related to masculinity encourage boys and men to adopt risky behaviours, including excessive alcohol use, multiple and concurrent sexual relationships, sexual favors and cross generational sex, and drug abuse, all of which increase their risk of acquiring and transmitting HIV. Societal expectations and social norms about masculinity often assume that men are knowledgeable and experienced when it comes to sexual issues. This can have the negative effect of preventing men from seeking sexual health information or admitting their lack of knowledge about HIV risk reduction.

The archetypal image of the strong, virile, aggressive male also contributes to widespread homophobia, leaving men who have sex with men to struggle with fear and stigma. This can often compel men who have sex with men to keep their sexual behaviour secret and avoid accessing services or seeking information that can help them adopt behaviours to protect themselves and their sexual partners (whether male or female) from HIV transmission. This is extremely dangerous in societies like Kenya where studies show that over 60% of MSMs are bisexuals.

Intersection Between Gender, HIV and Religious Teachings

The governance of the church, its procedures and approaches and sometimes its messages mirrors the gendered attitudes, practices and perceptions of the socio-cultural background of its membership. Many women gain a substantive proportion of their informal education and information from religious gatherings.

The control and subjugation of women by men is too often permitted when it is based on religious principles of morality. The Christian is not encouraged to assert any rights over his/her body because Christian teaching insists that

s/he has no autonomy over his/her body; it belongs to her partner. Therefore use of condoms particularly by women in cases their spouses have multiple sexual partners is out of the question.

A Christian woman is not expected to negotiate for safer sex even in instances when she knows her spouse has been unfaithful. While it is admirable for one to demonstrate faith by praying for divine intervention so that one does not contract HIV from an unfaithful partner, as emphasized in religious dogma, how many Christian women get infected as a result?

Based as much on patriarchal thinking in African culture as doctrine, do Christian leaders who emphasize submission and meekness make women an easier and more willing victim of sexual abuse, vulnerable to STIs and other forms of injustice? Women are not encouraged to actively take responsibility for protecting themselves from contracting HIV nor are they expected to demonstrate any inclination towards understanding and exercising their sexual reproductive rights. In many instances, sermons fail to address the specific needs, fears and concerns of congregants, of which women form the majority.

In some instances, women who are married to dishonest religious leaders are often worse off than other congregants because they feel they have to keep up appearances and they often find no support system within the church. The general assumption is that church leaders are beyond reproach.

For married women the church prescribes fidelity and yet married women often have non-believing husbands who do not subscribe to the teachings of the church regarding fidelity and moral uprightness. The scenarios above are quite deadly, given the percentages of discordance (a state where one partner is HIV positive and the other partner is HIV negative).

For most women, being cheated on is humiliating but for Christian women, the experience also casts aspersions on them as believers because people question where their God was when her husband was practicing infidelity. As has been observed amongst Zimbabwean women, Christianity is not just a religion - it is also an escape route. Attending church, following the routine and keeping religious observances have become a form of escapism for many women in the age of HIV as they try to apply Biblical teachings to their marriages, relationships and lives at a time when hypocrisy has become a prevalent trend in most churches.

Misapplying the proverb, ‘a foolish woman destroys her house with her own hands’ may cause a wife to feel that she must ensure that her house stands. Such a woman believes she must take the blame for her husband’s infidelities – “giving the Devil a foothold”. Therefore she resorts to fasting and prayer, failing to realize that she is the victim and not the villain. The “reasonable” response for the average Christian woman is a spiritual one, that is, prayer and fasting to counter the spirit of adultery in her spouse. When a spouse confesses and acknowledges infidelity, the expected response is

forgiveness and business goes on as usual. No one takes the initiative to know HIV status of the other before engaging sexually. And if they do get tested for HIV, couples prefer to test and receive results individually and not as part of "couple counseling and testing". The very real threat posed by HIV is not addressed in all this spiritual abstractness. The problem is further compounded by the fact that Christians often blame the devil for all the wrongs and fail to take responsibility for their own actions.

Addressing delegates at a SAFAIDS workshop held to commemorate 16 Days of Activism Against Gender Violence in 2009, an exasperated Edinah Masiyiwa, the Executive Director of the Women's Action Group (WAG), stated that some Christian doctrines were harming efforts to combat gender violence and curb the spread of HIV.

"We run all these awareness campaigns and yet it appears that things get worse instead of better. You talk of condomising and then to your surprise you find grown women uttering silly statements like "ini handishandise condom nemurume wangu ndinongonamata kuti Mwari ngaave condom rangu" (I don't need to wear a condom because I just pray for God's protection)," charged Masiyiwa.

So while women "in the world" may perceive themselves as being at risk of contracting HIV and take measures to protect themselves, the women in the church are exhorted to pray, fast and "confess the blood of Jesus" over themselves.

Conclusion: Observations and Recommendations

Christians must investigate their attitudes towards women in positions of leadership. Are they controlled by cultural settings or by biblical teachings? These attitudes influence the valuing of women and treatment of them. Religious leaders, venues and gatherings are suitable for communicating HIV messages because of the esteem and unswerving loyalty congregants accord religious leaders, the numbers that attend religious gatherings, and the frequency of the gatherings. Needless to say, religious leaders are best placed to address issues of discordance and related STIs and HIV vulnerabilities alongside the emphasis they place on fidelity and submission. Christianity may offer uniquely effective structures and mechanisms for mitigating the social impact of the epidemic on society, and especially on its most vulnerable segment - poor women.

We must be bold to challenge cultural traditions practiced in churches that predispose both female and male congregants to the vulnerabilities and risks of HIV infection and its effects. We must provide concrete suggestions for

change in the teaching and practice of the church. Missionaries must make attempts to understand local attitudes and come up with friendly and relevant approaches of responding to HIV and AIDS. Religious teachers need to come out clearly on the way forward regarding the following issues:

1. Teachings on submission and sex with regard to STI/HIV.
2. HIV sero-discordant couples, the desire for childbearing, and the dilemma of risking STI/HIV infection.
3. In-vitro fertilization as an alternative means of conception for discordant couples.
4. Male participation at household and family levels in view of the increased burden of care for women and changing roles.

There are several ways that churches can help their members and communities deal effectively with HIV and AIDS.

1. Promote Prevention of Mother to Child Transmission (PMTCT).
2. Because men commonly have more sexual partners and more control over decisions regarding sex than women do, prevention efforts targeting fiancé, suitors, husbands and bridegrooms by religious leaders are crucial, not only to promote their own health, but also the health of women and girls.
3. To turn the epidemic around, men will need to take responsibility for their actions, and change begins with the ways that boys are raised. This means addressing certain cultural attitudes and beliefs that have traditionally encouraged risk-taking and discrimination against women. This reeducation is most effective when carried out in schools and religious institutions.
4. Encourage church-based clubs for positive women and men through which psychosocial support can be channeled.
5. Focus more on topics such as sexual gratification in marriage with a view to preventing potentially errant spouses from going astray.
6. Promote church-based Voluntary Medical Male Circumcision (VMMC) programmes and anti-Female Genital Mutilation (FGM) campaigns.
7. Integrate ‘Gender, Sexuality and HIV’ in pastoral counseling training.
8. Provide on regular basis skills training on sexual communication to churched couples.