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Seeing HIV and AIDS as a gendered pandemic

ABSTRACT

The article contributes towards seeing and understanding the nature and extent – the “bleak immensity” – of HIV and AIDS in South African society today. It argues that we are in fact in the midst of “a gendered pandemic” which has dire consequences for the lives of women (and children). The nature of this pandemic presents a particular challenge to the church.

FRAGMENTS FROM OUR CONTEXT

“When I was pregnant, my partner left me. Perhaps he was afraid that I was HIV because he was. I only found out just before my baby was born. I was given nevirapine. I have lost two jobs. First I was a domestic worker and then I worked in a laundry. The laundry boss forced all the staff to be tested. I knew it was against my constitutional rights, but what could I do? So I was dismissed unfairly. Last week I was walking home after looking for a job. Three youths attacked me. They pulled off my clothes. They wanted to rape me. The one said: “A man’s got to have a woman when it is raining”. I fought with them. They left me because a car came. They did not kill me because I said that I did not see their faces. But today I am so, so happy. I have just heard that my baby is negative. My child will have a life. God is good.”

Gloria, aged 26 years and still unemployed.

“He married me when I was only 18. He knew he was positive. I did not know until my baby was tested. Then I found out that I was also positive. I knew it was him. He married me because I was a virgin. He believed that if he slept with a virgin he would be cured. I walked out. Now I counsel women who are HIV positive. There is life after infection.”

Boniswa, a 35 year old AIDS counsellor.

“I only found out when I came across his medication. I was devastated. Fifteen years of marriage and two wonderful children and I never suspected that he was leading a double life. What a fool I have been! I thought we were a pretty good family. We go to church, we pay our taxes, we work hard. Now my life is shattered. I waited for a year. I was too afraid to go for a test. Last week I heard the worst. I am positive. My children are still so young. What will happen to them? I wonder where God is in all this? But I know that only he can give me the courage to pick up the pieces of my life.”

Judy, a 38 year old teacher.

Introduction

These fragments from the lives of three women reflect the central themes in this paper: violence against women, HIV and AIDS and poverty. In order to sketch the context in which they are told,

I shall briefly look at the magnitude of the HIV and AIDS pandemic in South Africa. This is followed by comments on the gendered nature of the pandemic. These reflections aim to open a perspective on the nature of the pandemic and thereby suggest a different approach for the churches in South Africa to pursue as they struggle with their role in combating the AIDS pandemic.

A “bleak immensity”¹: HIV and AIDS in South Africa

Speaking about HIV and AIDS in my context is fraught with apparent anomalies. It should be quite straightforward. Clinically speaking, HIV and AIDS is a sexually transmitted disease. The fact that it can also be spread by the transfusion of infected blood or blood products is incidental. As our pandemic escalates these means of transmission play an ever decreasing role. The AIDS virus is a weak virus that cannot survive exposure to the environment.² HIV and AIDS can only continue if the causal pattern of sexual behaviour is present. In the normal course of events people who do not exhibit such patterns of sexual behaviour run no risk of contracting AIDS. Unlike pandemics of past times which spread by means of droplet infection, AIDS isn't easy “to catch”.³ As I said, it seems quite simple. Yet the AIDS pandemic in South Africa is a complex mixture of issues. Gender inequality, attitudes towards human sexuality, the scarring and fragmentation of large sections of society, our history of migrant labour and uprooting of communities exacerbated today by increased poverty and unemployment and obfuscation in regard to the cause of AIDS by leading politicians, are all part of the South African AIDS story.

Statistics on the incidence of HIV infection are, like all statistics, problematic.⁴ This is particularly the case in the developing world, where stigma militates against reporting AIDS-related infections and deaths. It is generally accepted, however, that some 14 000 people are infected daily by the HI-virus of whom approximately fifteen hundred are South Africans, and that by the end of 2003 42 million people were living with the virus in their bodies. The pandemic has already claimed over 17 million African lives. Taking an average of the figures provided by UNAIDS and those in a recent South African research project (Nelson Mandela/HSRC Study 2002), it would appear that HIV prevalence among people in South Africa between the ages of 15 to 49 years is about 20 percent of our total population. Women have a higher HIV prevalence than men of about 4 percent.⁵ The Medical Research Council of South Africa calculates that 25 percent of last year's adult deaths were due to AIDS-related diseases in South Africa. Life expectancy is now at an average of 37 years and will drop even more before the pandemic peaks. At present some 600 people are dying daily from AIDS-related causes. Suffice it to say that even on the most conservative estimates, the scene looks bleak.

“There are no longer *any* South Africans who do not know someone or of someone who has died of AIDS or is living with HIV.”⁶ Over the next ten years 35 percent to 46 percent of medical

1 This phrase is borrowed from Wole Soyinka, *Art, Dialogue and Outrage: Essays on Literature and Culture* (New York, Pantheon Books, 1993), p.16.

2 See Alan Whiteside and Clem Sunter, *AIDS: The Challenge for South Africa* (Cape Town, Human and Rousseau, 2000), p. 10 for modes of infection.

3 Willem Saayman and Jacques Kriel, ‘Towards a Christian response to AIDS’, *Missionalia* 19:2, 1991, 154-167.

4 Figures quoted here are a combination of estimates published by the United Nations health agencies and the National Department of Health.

5 Nelson Mandela/HSRC Study of HIV/AIDS, 2002, p. 45.

6 Whiteside and Sunter, *AIDS*, p. 134.

schemes' expenditure will be directed towards coping with AIDS-related diseases. Our fragile economy will buckle under the ravages of AIDS in the work force; productivity and growth rate will decline.⁷ We are, in the words the General Secretary of the United Nations Kofi Annan, facing "a tragedy on a biblical scale".⁸

My contention in this paper is that at heart HIV and AIDS is a gendered pandemic exacerbated by poverty. As such it requires a theological response that is prepared to wrestle with the implications of gender inequity in our traditions and our practices as well as the reasons for continuous grinding poverty in sub-Saharan Africa. Furthermore the question of HIV and AIDS raises profound ethical questions about human sexuality and relationships between women and men. I simply cannot do justice to poverty as a theological theme in this paper other than to connect it to the story of HIV and AIDS, neither can I deal with the question of human sexuality. As I said at the outset, this paper is a preliminary effort to raise awareness on the issue of gender and HIV and AIDS for further consideration.

HIV and AIDS – a gendered pandemic

African theologian Teresa Okure startled her hearers at a theological symposium on AIDS held in Pretoria in 1998, by saying that there are two viruses more dangerous than the HI-virus because they are carriers enabling this virus to spread so rapidly.⁹ The first virus is the one that assigns women an inferior status to men in society. According to Okure, this virus fuels the sex industry in which young women, themselves, the victims of abuse, become infected with HIV and then pass it on to others, even to their babies. This is the virus that causes men to abuse women. This is the virus that is responsible for the shocking fact that in many countries in Africa the condition that carries the highest risk of HIV infection is that of being a married women.

The second virus that enables the HI-virus to spread at a devastating rate is found mostly in the developed world. It is the virus of global economic injustice that causes dreadful poverty in many parts of the developing world. Capitalist market economies are thrust on societies that are not geared for them as well as structural adjustment programmes that are designed to meet the requirements of the developed world rather than those whose need is the greatest. Global economic systems disrupt traditional societies, displace economic and educational infrastructures and the market demands of such systems and make access to prevention and treatment of disease difficult and expensive. It is ironic that international organisations like UNAIDS and the United Nations call on countries to restructure their spending in order to ensure that "national budgets are reallocated towards HIV prevention", when these very countries are most often hamstrung by crippling foreign debt. Peter Piot, executive director of UNAIDS, pointed out that in the year 2000, African countries were paying US\$15 billion in debt repayments and that this was four times more than they spend on health or education.¹⁰ Before moving on from this brief resumé of Okure's

7 The World Economic Forum's Africa Competition Report, released in July 2000, states that 40.77% of South African firms rank HIV and AIDS as having a moderate to major impact on their health care costs and 30.07% say their training costs have increased considerably, *Sunday Times Business Times*, July 2, 2000.

8 Accessed at www.un.org/news/press/docs/2000.

9 See Kevin Kelly, 'Conclusion: a Moral theologian faces the new millennium in a time of AIDS' in James F Keenan (ed.) *Catholic Ethicists on HIV AND AIDS Prevention* (New York, Continuum, 2000), p. 325.

10 Trengove Jones, *Who Cares?*, p. 15. Harvard economist Richard Parker commented in 1996 that "we have begun to understand the perverse consequences caused by specific models of economic development (most often imposed from above) that have in fact functioned to produce and reproduce

views, I suggest that the first virus related to the HIV and AIDS pandemic is not only about women's questionable status in society but more specifically about the disordered nature of relationships between women and men as expressed sexually and emotionally.

I also want to add a third virus to Okure's list – the virus of denial. I have no trouble understanding people who, suspecting that they may be infected with HIV, refuse to be tested because the prospect of disease and death is simply too shattering. Neither do I blame people who are HIV positive for remaining silent about their status. Who wants to add the burden of stigma to an already fraught situation? Sadly, these kinds of denial do not assist in changing patterns of behaviour or in protecting those who are uninfected and consequently the virus' progress becomes more rampant. More pernicious than individual denial has been years of denial by the South African state that its citizens are trapped in a pandemic. As the world watched in dismay and people died daily, president Thabo Mbeki and his cabinet spent more than two years debating "scientific questions" in regard to HIV and AIDS, opinions which were greatly informed by dissident views on the subject, while refusing virtually free treatment to pregnant women which would greatly reduce the number of infected babies born.

It is no coincidence that 90 percent of people infected with HIV live in developing countries. Here, according to Lisa Sowle Cahill, 800 million people lack access to clean water and are wanting for basic health care and perinatal care, primary education, nutrition and sanitation, all of which grievously affect their physical well-being and make them vulnerable to disease. Not only do people living in poverty suffer general loss of health but they are forced to adopt survival strategies that expose them to health risks.¹¹ Families break up as men seek work in cities where they meet women, themselves under economic duress, who are willing to trade sexual access for a roof over their heads and some financial support. Inevitably less money reaches families back in the rural areas and poverty spirals.¹²

*The HI-virus causes AIDS.*¹³ But it does not act alone. In southern Africa HIV and AIDS is in reality a pandemic that has everything to do with gender relations and conditions of poverty. South Africa is a society in which cultural traditions of male dominance, bolstered by a particular understanding of the place of men in the Christian tradition,¹⁴ has resulted in continued inequity for women. Poverty, both in the rural areas and in the informal settlements surrounding our cities, is a further grinding reality. Understanding this unholy alliance should be at the heart of all HIV

structures of economic dependence and processes of social disintegration", see Richard G Parker, 'Empowerment, community mobilization, and social change in the face of HIV and AIDS', paper presented at the XI International Conference on AIDS, Vancouver, July 1996, 4,11.

11 Lisa Sowle Cahill, 'AIDS, justice, and the common good', in Keenan, *Catholic Ethicists*, pp. 282-283.

12 In order to assist in this crisis, \$57 million was donated by the Bill and Melinda Gates Foundation to the United Nations Population Fund; Ted Turner of AOL Time Warner has promised to donate \$100 million over ten years to assist UN-led programmes in combating HIV and AIDS. Jeffrey Sachs proposed a global trust fund supervised by the World Health Organization and UNAIDS to answer the need for resources in the poorer countries. Sachs estimates that between \$7 and \$8 billion is needed. He says "The US is a \$10 trillion economy, so \$1 billion is about one cent out of every \$100 in our economy – which to save 5 million lives a year and a continent that is dying, is an incredibly modest effort." *Business Day*, 7 March 2001.

13 This statement is necessary in the face of the damaging denial of the South African state president and members of his cabinet. See Whiteside and Sunter, *AIDS*, p. 3 for the four key elements used to bolster belief that HIV does not cause AIDS. Today the majority of the world's leading virologists believe that the HIV hypothesis is correct.

14 This is illustrated by the fact that there are churches in South Africa which are part of mainline denominations, in which communion is served in the following order: first the men, then male adolescents, then women and lastly female adolescents – as a confirmation of the headship of men, eg. refer 1 Cor.11:3.

and AIDS programmes whether located in the churches or in state structures. Gender inequality and the snail-like pace at which poverty is being tackled are the main problems blocking effective HIV and AIDS prevention. By this I do not mean that HIV and AIDS does not have devastating consequences for *all* South Africans, regardless of age, race, class or economic status. Of course it does. But for South African women and children the AIDS pandemic is particularly perilous.¹⁵ While it is cutting a deadly swathe across the educated classes in the 20 to 40 age group, its greatest impact is on the most vulnerable members of society: *the poor, the marginalised and the displaced*. This makes HIV and AIDS a crisis for women, particularly poor women in rural areas and those struggling to survive in shacks on the outskirts of cities.¹⁶ It goes without saying that when women are affected, children suffer.

Probing beyond the statistics, it appears that women's vulnerability to HIV and AIDS occurs on a variety of levels: biological, social, individual, maternal and care-giving. For instance, an HIV positive pregnant woman runs the risk of transmitting the virus to her child, either during pregnancy, during birth or after birth through breast feeding.¹⁷ Rural women who have little or no education and who live in traditional patriarchal relationships, have scant access to information on HIV and AIDS, and generally lack the skills and the power needed "to negotiate safer sex".

Strategies to deal with HIV and AIDS have failed these women because they insist on preventive behaviour which they, the women, have little power to implement. There is a growing body of well-documented research in the social sciences that shows that women in patriarchal societies are "unequipped for sexual negotiation".¹⁸ Research on teenage girls found that many experienced their first sexual encounter as coercive.¹⁹ In the province of Kwazulu-Natal, 72 percent of teenage girls attending clinics related that they had refused to have sexual relations with their partners but were usually unsuccessful at doing so and that attempts at refusal could result in physical abuse, termination of the relationship or financial hardship.²⁰

Women who are HIV positive are at the receiving end of stigma, social ostracism and violence. Countless women in South Africa who are HIV positive have, like Tamar in the Old Testament story,²¹ been the victims of sexual violence, perpetrated within a cultural order in which power is

15 For statistics, see Quarraisha A. Karim, 'Women and Aids: the imperative for a gendered prognosis and prevention policy', *Agenda* 39, 1998, 15-25. See also Whiteside and Sunter, *AIDS*, p. 12 for a discussion on mother-to-child transmission.

16 See Hilda Adams and Anita Marshall, 'Off target messages - poverty, risk and sexual rights', *Agenda* 39, 1998, 87-93.

17 See Gill Seidel, 'Making an informed choice: Discourses and practices surrounding breastfeeding and AIDS', *Agenda* 39, 1998, 65-81.

18 See *inter alia*, A Kline, E Kline and E Oken, 'Minority women and sexual choice in the age of Aids', *Social Science and Medicine* 34, 4, 1992, 447-457; D Lear, 'Sexual communication in the age of Aids: the construction of risk and trust among young adults', *Social Science and Medicine* 41, 9, 1995, 1311-1323; L Miles L, 'Women, Aids, power and heterosexual negotiation', *Agenda* 15, 1992, 14-48; I Orubuloye, J Caldwell and P Cardwell, 'African women's control over their sexuality in an era of Aids', *Social Science and Medicine* 37, 7, 1993, 859-872.

19 See Human Rights Watch Report, *Scared at School*, p. 27 for a report on a recent Gauteng study in which nearly 50 percent of male youth said they believed a girl who said "no" to sex meant "yes" and 24 percent thought a girl who had been raped had "asked for it". Nearly a third of both men and women surveyed said that forcing sex on someone you know is not sexual violence.

20 See Rachel Jewkes, C Vundule *et al.*, 'Relationships dynamics and teenage pregnancy in South Africa', *Social Science and Medicine* 52, 2001, 733-744. See also Christine Varga and Lindiwe Makubalo, 'Sexual non-negotiation', *Agenda* 28, 1996, 33.

21 See my follow-up essay on "Tamar's cry: reading an ancient text in the midst of a contemporary pandemic" elsewhere in this volume.

abused and women are used for male purposes. The results? Once their status has been verified, they are often ostracised. Tamar knew what it was like to be soiled goods, a status conferred on her by the abuse of power in a patriarchal order.

Tamar's cry "...for such a thing is not done in Israel" is ignored. In a patriarchal system women's cries of distress are insufficiently heard and they often disappear under a veil of silence. Breaking the silence about one's status can be life-threatening. Gugu Dlamini became South Africa's first AIDS martyr when, in December 1998, she was stoned to death for speaking out about her HIV status. HIV and AIDS is nourished by silence in South Africa. The dark mystery that lies at the heart of the pandemic in this country is the stubborn multi-layered silence or what is called "the denial" by professionals. Suzanne Leclerc-Madlala, a medical anthropologist, comments that this silence "has much to do with heterosexual power, sexual life ways, the structure and meanings of which are contoured by what is often termed 'culture'".²² Wrestling with the stubbornness of the silences around HIV and AIDS in our part of the world, Leclerc-Madlala states:

...well-documented social science studies ...point[s] to high levels of premarital activity, extramarital relations and sexual violence, making African societies, taken as a whole, more at risk for both STDs and HIV and AIDS than those in other parts of the world. In many communities women can expect a beating, not only if they suggest condom usage, but also if they refuse sex...

Until such time as our leaders, like those in Uganda, speak out clearly and unambiguously about the causes and nature of HIV and AIDS, we will "continue to re-enact the high risk sexual culture and the silence that enshrouds it".²⁴ As Piot insists:

...no amount of dollars can make a difference if there is not concerted leadership, at all levels from the head of state to the district level, involving government in partnership with non-governmental organisations, communities and the private sector.²⁵

What emerges from present research into HIV and AIDS in sub-Saharan Africa is the fact that the role of men needs to be addressed, particularly attitudes and behaviour that are sexually irresponsible and that result in a certain death sentence not only for themselves, but also for millions of women and children. Given the powerful role of men in society, HIV and AIDS interventions and strategies targeting men will have a substantial impact on reducing the vulnerability of women to HIV. The theoretical and practical implications of the growing awareness of men's role in the HIV and AIDS pandemic are now being tackled by social scientists on our continent.²⁶ Heavily male institutions such as the military, sports clubs and trade unions are

22 Suzanne Leclerc-Madlala, 'The silences that nourish Aids in Africa', *Mail and Guardian* August 11 to 17, 2000.

23 *Ibid.*

24 *Ibid.*

25 From Trengove Jones, *Who Cares?*, p. 31.

26 See C Baylies and J Bujra, *Aids, Sexuality and Gender in Africa: The Struggle Continues* (London, Routledge, 2000); J Bujra, 'Risk and Trust: Unsafe Sex, gender and AIDS in Tanzania', in P Caplan (ed.) *Risk Revisited* (London, Pluto Press, 2000); K Carovano, 'HIV and the challenges facing men', Issues Paper 15, New York, UNDP HIV Development Programme; K Nkosi, 'Men, the military and HIV AND AIDS in Malawi' in M Foreman (ed.) *AIDS and Men* (London, Panos Publications/Zed Press, 1999).

being focussed on for HIV prevention.²⁷ Suffice it to say that the need to deal with inequities within relationships and society remains a central concern.²⁸ This does not imply that I am negating the importance of other strategies for dealing with HIV and AIDS such as advocating closed sexual relationships, the use of preventive measures, the need for appropriate treatment such as post exposure prophylactics, AZT, or nevirapine for pregnant mothers.²⁹ I am simply saying that gender relations exacerbated by poverty, are powerful contributing factors to the present pandemic in South Africa.

IN CONCLUSION

In a report to the World Bank, Peter Piot executive director of UNAIDS, said in November 2003:

Globally, more than half of all persons infected between the ages of 15 and 49 are women. In Africa, the proportion is reaching 60 percent. Because of gender inequality, women living with HIV/AIDS often experience more stigma and discrimination. And since women are the main care givers and source of household labour, their illness means the collapse of family community care systems and household production.

Such is our reality. Gloria, Boniswa, Judy and countless other women know the particular burdens of this disease. Their stories cry out to be heard, their lives, in which both suffering and hope are present, demand to be seen, affirmed and nurtured, particularly by those of us who call ourselves Christians. For the Body of Christ to reach out to these women, and indeed to all who suffer, it will have to acknowledge its own role in perpetuating gender discrimination in its traditions and practices, so that it can become renewed community of justice and care. Then the reality of HIV and AIDS can become a vehicle for God's love and mercy to be tangibly present in actions *with* and *for* one another in a church that understands its mission as standing alongside the victims, and ministering to them in their need.

27 See also Janet Bujra, 'Targeting men for a change: AIDS discourse and activism in Africa', *Agenda* 44, 2000, 6-23.

28 Karim, 'Women and AIDS', 23.

29 See Whiteside and Sunter, *AIDS*, pp. 147,148.