

**GENDERED SEXUAL  
VULNERABILITIES IN THE SPREAD  
OF HIV/AIDS: CLAYFIELD (PHOENIX)  
AS CASE STUDY**

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# DECLARATION

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I hereby declare that this dissertation, unless otherwise indicated in the text, is my own original work. This research has also not previously been submitted to any other institution for degree purposes.

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A handwritten signature in black ink, appearing to read 'Parvathie Chetty', is written over a horizontal line.

# ABSTRACT

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This dissertation focuses on how important factors such as gender inequalities and gender vulnerabilities contribute to fuelling the spread of HIV/AIDS. The study focuses on a community in Phoenix, called Clayfield. The study examines aspects of masculinity, sexual relations, socio-economic vulnerabilities and domestic violence and demonstrates how these elements predispose women and girls to HIV infection. As a result of gender inequalities and imbalances, women are vulnerable to HIV infection. The study also explores how risky behaviour, by both men and women, can escalate women's vulnerability to the disease. The central argument engages discussion on crucial issues around gender imbalances and vulnerabilities. The study concludes with recommendations pertinent to challenging present gender-based initiatives and interventions, and suggests possible gender-sensitive strategies that could assist in curbing the spread of the disease.

**Keywords:**

Gender inequality; HIV/AIDS; domestic violence; gender imbalances; masculinity; sexual relations.

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# DEDICATION

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This study is dedicated to several people: my soul-mate, my husband Andrew; my eight-year-old son, Edwin-Cole for sacrificing his 'mummy-time' with me; my father, Sonny Govender, who never lost hope in the completion of my Masters; and my late mother, Sally Govender, who was my biggest fan and cheerleader when times were tough. I know she smiles at me as I wind up my studies.

# ABBREVIATIONS

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AIDS	Acquired Immuno-deficiency Syndrome
ARVs	Anti-retrovirals
DAW	Division for the Advancement of Women
HIV	Human Immuno-deficiency Virus
HAART	Highly Active Anti-Retroviral Therapy
MFC	Men For Change
MTC	Mother-to-child transmission
PTC	Parent-to-child transmission
NGOs	Non-governmental Organisations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organisation

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## CHAPTER 1

### INTRODUCTION AND PROBLEM FORMULATION

#### 1.1 Introduction

It is an undisputed fact that the impact of HIV/AIDS has sent the world reeling, leaving behind it a path of sheer 'destruction' and turmoil, most notably and visibly on the African continent (see Patton, 1997). Once referred to as an epidemic, HIV/AIDS has now developed into a catastrophic *pandemic* that has brought many developing nations to their knees (see for example, Abt Associates, 2000; Whiteside and Sunter, 2000). As at 2005, it was estimated that approximately 40.3 million people worldwide were living with HIV. The troubling reality is that – of this figure – an estimated 25.8 to 28.9 million of HIV-positive people reside in Sub-Saharan Africa (UNAIDS/WHO, 2005). It is disconcerting that South Africa not only falls within this region, but that we are also deemed to be the country where the epidemic is developing at the fastest rate (Walker *et al*, 2004). It is also alarming to note that of the entire population of approximately 46.9 million, there is an estimated total of 5.6 million people infected with the HI-virus in South Africa (Statistics South Africa, 2005), which makes it the country with the highest HIV/AIDS prevalence worldwide (Dorrington and Johnson, 2002).

The fact that interests me the most is that of the 46.9 million people living in our country, over 23 million of this total is women (Statistics South Africa, 2005). Women are the country's leaders, professionals, daughters and mothers. If women are deemed to be the caretakers of humankind then, in my opinion, not only is HIV/AIDS wreaking havoc on the human race, but as this pandemic relentlessly decimates our female population, it will also leave behind a void that the world, and certainly South Africa, will struggle to recover from.

The motivation for my research stems from a workshop I conducted on sexual harassment with the women of my church, which is located in Stonebridge (Phoenix). Stonebridge and Clayfield are neighbouring communities; hence, many of these women



were also residents of Clayfield in Phoenix. They were very vocal in expressing their views and opinions on the gender inequalities and sexual vulnerabilities that existed, especially in the Indian community. I was once a resident of Clayfield and through my interactions with the community, I became interested in exploring this aspect that was unknown to me, even though the community had been my home for almost six years.

This study employs a gender perspective (loosely defined as a critical consideration of what society constructs to be the assigned roles, responsibilities and personal identities of males and females in its cultural and social formation) to examine how gender and sexual vulnerabilities could contribute to fuelling the spread of HIV/AIDS in a community called Clayfield. Another factor motivating this gender perspective is the accuracy and adequacy of knowledge surrounding sexual education, especially pertaining to the transmission and prevention of the disease. Sexual education is widely recognised as the cornerstone of HIV prevention (Shisana and Simbayi, 2002:34).

It is important to understand the concept of vulnerability with regard to HIV/AIDS. Whilst vulnerability generally refers to a lack of power, opportunity and skills or ability to make and implement decisions that impact on one's own life, by focusing on women's vulnerability to HIV, it is not suggested that men are not vulnerable, but instead that women are *more* vulnerable (Tallis, 1998:9). In most societies women's gender vulnerabilities to HIV/AIDS is characterised by an unequal balance of power, with women having less access than men to education, training, healthcare and productive resources like land and credit (Sivard, 1995). Thus, the gender vulnerability experienced by the women in these societies make them more susceptible to HIV/AIDS.

The sexual vulnerability of women also needs mentioning. Women are more susceptible to HIV infections on each sexual encounter because of the vulnerability of the reproductive tract tissues to the virus (KANCO, 2000). Although the root of women's vulnerability lies mostly in the imbalance of power between men and women, biological and sexual practices play an important role in the more efficient transmission of HIV in women as compared to men (Abdool Karim, 1998: 18). Men are deemed to have greater decision-making power in the initiation, pace and orchestration of sexual activity,

sexual practices and safer sex decisions (Exner et al, 1997). This then underpins women's sexual vulnerability to the disease.

KwaZulu-Natal is a coastal province situated on the eastern seaboard of South Africa. The province is home to a total of 8.4 million people, and accounts for a fifth of the country's total population (Rutenberg *et al*, 2001). These figures could be further broken down as follows: Africans comprise 76%; Indians 14%; whites 7% and coloureds 3%. Indians comprise the second highest majority of the populace of KwaZulu-Natal. However, they are an under-researched group in South Africa with regard to HIV/AIDS. Hence, this study attempts to research an Indian community within KwaZulu-Natal.

Furthermore, Phoenix and particularly Clayfield are situated in KwaZulu-Natal. With an HIV prevalence of 40%, KwaZulu-Natal is the province with the highest HIV occurrence in South Africa (UNAIDS/WHO, 2005). Thus, researching a community in KwaZulu-Natal is strategic with regard to investigating the prevalence of the pandemic.

The Indian community, once perceived to be a sexually conservative part of South Africa's population, is also falling prey to HIV/AIDS. While living among the people of Clayfield, it was evident that gender inequalities and sexual vulnerabilities existed. What is interesting to note is that these factors could possibly be contributing to the spread of the HIV/AIDS pandemic. Since the development of a global response to the HIV/AIDS pandemic began more than a decade ago, remarkable strides have been made in our understanding of the nature, scope and impact of HIV/AIDS on individuals, communities and societies around the world. The most striking development is the recognition of the role that gender plays in fuelling the pandemic and influencing its impact (UNAIDS, 1999).

Gender has increasingly been recognised as one of the key elements of efforts aimed at transforming and improving the lives of people around the world (Airhihenbuwa *et al*, 2000:107). Gender is also increasingly recognised as a vital component in understanding HIV/AIDS, its effects and prevention (see, for example, Baylies and Bujra, 2000; Foreman, 1998; Gorna, 1996). Mendoza (1997:1) provides a

comprehensive definition of gender:

Gender is what it means to be a male or a female and how that defines a person's opportunities, role, responsibilities, and relationships. Gender is a sociocultural variable and refers to the roles, behaviour, and personal identities that the society or culture proscribes as proper for women and men. These attributes, opportunities, and relationships are socially constructed and learnt through socialization processes. Gender roles vary across determinants such as race, culture, community, time, ethnicity, occupation, age, level of education. While sex is biological, gender is socially defined.

According to the report by DAW *et al* (2000b<sup>1</sup>), gender analysis is crucial to our understanding of HIV/AIDS transmission and to initiate appropriate programmes of action. Key to this is an understanding of the socially constructed aspects of male-female relations that underpin individual behaviour, as well as the gender-based rules, norms, and laws governing the broader social and institutional context. Gender analysis forms the basis for the changes required to create an environment in which women and men can protect themselves and each other (DAW *et al*, 2000b). This study takes these cues in order to deepen the understanding of the common denominator(s) that exist between gender and the spread of HIV/AIDS.

According to Women Watch, a 'gendered' understanding of HIV/AIDS highlights the multiple and inter-related levels of inequality that shape vulnerability to infection, as well as delineating the personal, social and economic impact of the epidemic. As a result, gender may be viewed as an interconnected issue that has implications for all aspects of countering the epidemic. More significantly, the relationship between gender and HIV/AIDS suggests that the transformation of gender relations is fundamental to our ability to effectively address the epidemic.

The HIV/AIDS pandemic is fuelled by gender inequality and women's social and economic vulnerabilities. This intersection between HIV/AIDS and gender equality not only underscores the interdependence of sexual, cultural and economic inequalities, but also indicates that the failure to address these inequalities could intensify the violation of

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<sup>1</sup> A Report of the Expert Group Meeting in Windhoek, Namibia – indicated as [b] in the references

women's rights and thus render women even more vulnerable to HIV infection (Albertyn, 2000:46).

When one considers the role gender plays in exacerbating the spread of HIV/AIDS, the odds against women are still great: women still have to prove their worth by being married, bearing children and caring for their families, and they are often perceived as ill-equipped to assert themselves in a world that is predominantly controlled by men (Esu-Williams, 2000:125). Consequently, this study also aims to explore whether the women of Clayfield perceive their vulnerability, with regard to HIV/AIDS, to lie within the ambit of gender inequality.

Research into and analysis of knowledge about HIV/AIDS prevention conducted in 23 developing countries in the current millenium confirms that the levels of HIV/AIDS knowledge were, more often than not, always higher among men than women (Gwatkin and Deveshwar-Bahl, 2001:36). The figures showed that 75% of men, on average, possessed accurate information about HIV/AIDS transmission and prevention, compared to an estimated 65% of women (Gwatkin and Deveshwar-Bahl, 2001:36). This analysis prompted me to explore the link between HIV/AIDS knowledge (pertaining to issues of the transmission and prevention of the disease among the men and women of Clayfield) and whether this knowledge (or lack thereof) contributed to the spread of the disease.

In many countries, women and girls bear a heavier burden than men in terms of the rate of HIV infection, the stigmatisation that results from them being blamed for the spread of HIV/AIDS and the burden of family support and care (WHO/UNAIDS, 2000). The disclosure of a woman's HIV status is likely to lead to abuse or abandonment and a loss of rights with regard to children and property. According to WHO/UNAIDS (2000), certain cultural and religious practices, sex trafficking, and poverty, increase young women's vulnerability to infection.

Research and statistics indicate that women are at a greater risk of being infected and affected by HIV/AIDS, particularly since the female physiology makes them vulnerable to

infection (to be discussed further in **Chapter 2**). However, it is also the relative lack of power over their bodies and sexual lives, exacerbated by inherent gender inequalities and sexual vulnerabilities, that make women such a susceptible group to contracting and living with HIV/AIDS (UNIFEM, 2001).

The same gender roles and relations that magnify women's vulnerabilities to HIV/AIDS also increase some of the risks for men. Dominant practices of masculinity and a sense of "manliness", encourage men to demonstrate sexual prowess by having multiple sexual partners. Furthermore, according to the *Report on the Global AIDS Pandemic* (DAW *et al*, 2000a<sup>2</sup>), the consumption of alcohol and other substances that may predispose women or men towards sexual risk-taking and violence also contribute to the spread of the disease. Some of these practices or behaviours thus encourage men to see the direct provision of care as a woman's (rather than a man's) responsibility.

The extended family, the backbone of society in developing countries, is being decimated by HIV/AIDS. As AIDS affects those age groups that are most economically active, families are losing breadwinners. The burden of caring for the sick and dying drains families' physical and financial resources. Agricultural production is also threatened and children are withdrawn from school. Women and girls are particularly vulnerable within this context. Many families face an uncertain and impoverished future that further increases their vulnerability to HIV/AIDS (DAW *et al*, 2000a). The study thus explores whether the perceived roles of women as primary caregivers and homemakers render them vulnerable to HIV infection.

Through experience and evidence in the wake of the epidemic, it is clearly established that HIV/AIDS has gender-specific implications. Global contingencies have a significant impact on the regional and local experience of the pandemic, yet, at the global level, AIDS research, prevention, and treatment that targeted women was a marginal concern.

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<sup>2</sup> A Report on the Global AIDS Pandemic (DAW/WHO/UNAIDS, 2000) – indicated as [a] in the references

Had the case been different, women worldwide would now be benefiting from advances made in combating the HIV/AIDS pandemic (Bianco and Hunter, 2002).

In order to integrate a gender perspective into our understanding of the pandemic, it is important to consider the existing gender norms that result in the differing roles and expectations for women and men, as well as the dominant constructions of femininity and masculinity. These roles, expectations, and constructions, according to DAW *et al* (2000b), increase the vulnerability of women and girls to HIV/AIDS.

Furthermore, dominant constructions of femininity and masculinity influence three key dimensions of gender differences and inequalities. These key dimensions are sexuality and gender relations, social and occupational roles, and access to and control of economic and social resources. Gender differences and inequalities in each of these dimensions have important implications for HIV/AIDS and the spread of the pandemic (WHO/UNAIDS, 2000).

Beyond the statistics that illustrate sex-based differences in infection rates, there are profound differences to be found between men and women in terms of the causes and consequences of HIV/AIDS infection, which reflect differences in biology, sexual behaviour, social attitudes and pressures, economic power and vulnerability (Matlin and Spence, 2000:56). In many ways, the inequity that women and girls suffer as a result of HIV/AIDS serves as a barometer of their general status in society and the discrimination they encounter in all fields, including health, education and employment. It is for these reasons that HIV/AIDS is inherently a gender-based issue and must be viewed in this light if it is to be addressed effectively. According to Matlin and Spence (2000), HIV/AIDS will only be conquered when the effort to achieve gender equality is successful.

When trying to achieve gender equality in relation to HIV/AIDS, close attention must be paid to the language that is used to characterise issues (DAW *et al*, 2000b). All too often, the use of gendered language predetermines an attitude that blames or shames a specific group or sex, and these negative connotations need to be avoided, for instance:

- A more recent example is the use of the term “mother-to-child transmission (MTC)” to characterise the vertical transmission of HIV/AIDS. This focuses attention on the mother as the immediate source of the infection, yet it is well documented that the majority of women acquire their infection solely through monogamous relationships with their respective partners (UNAIDS, 2000). A more appropriate, gender-neutral term is “parent-to-child transmission (PTC)”.
- Frequent reference is made to “risk behaviour”. This can be very misleading and may misdirect attention. Behaviour may be *safe* in one circumstance and *risky* in another. A closer and more specific analysis is needed in many cases, with the emphasis shifting to appropriate behaviour in “risk situations”. The characterisation of a particular “risk group” tends to place the focus on them, begging the question of *who* they are at risk *from* (Matlin and Spence, 2000:58).

Gender, as we have come to understand, is not an abstract concept. There is no one solution to the question of gender and HIV/AIDS. However, the empowerment of women is essential to eliminating present gender imbalances, especially for women that live under conditions of poverty and lack of knowledge and accurate information regarding HIV/AIDS. For example, women need to be sufficiently knowledgeable about the transmission and prevention of the disease. Also, the socio-economic vulnerabilities that women experience make them prone to infection. We know more about what needs to be done than we know about how to do it (DAW *et al*, 2000b). For example, we acknowledge that women need to be conscientised with knowledge that improves their socio-economic status, yet we are often not sure how this information and knowledge needs to be disseminated. We are also aware that women should take charge of ensuring that they do not render themselves prone to infection, but we are not sure how they should go about doing so.

## 1.2 Problem formulation

Because women are more vulnerable to HIV/AIDS than their male counterparts, this study, as indicated, focuses on the contribution of gender and sexual vulnerabilities to

fuelling the spread of the pandemic. The project aims to identify and problematise gender inequalities and sexual vulnerabilities within a predominantly Indian community setting in South Africa. Ultimately, the study sets out to reinforce the understanding of the role that gender and sexual vulnerabilities play in contributing to the spread of HIV/AIDS. This is done with the view to improving and making recommendations regarding HIV/AIDS intervention and prevention strategies.

Effective intervention requires attentive communication strategies between men and women. For many couples, communication is difficult and even more complicated when the subject is sex (Esu-Williams, 2000:125). Interventions that are intended to tackle communication should be based on promoting general communication and problem-solving skills, rather than just focusing on sex. In view of this, the study focuses on whether women are able to openly communicate with their male partners regarding issues of sex and condom use.

While exploring the interaction between race, class, and gender in the context of HIV/AIDS-preventive-behaviour, Quinn (1993:49) found that social factors push risk behaviour outside certain individuals' control. For example, the use of condoms inadvertently assumes an equal distribution of power in sexual relationships. Although a woman may have the intention and self-efficacy to adopt this behaviour, the actual act requires the active co-operation of the male partner (Fee & Krieger 1993; Kashim *et al*, 1992; Quinn, 1993). Bandura (1992) asserts that poor women are especially vulnerable to being coerced by their male partners, since they are more likely to be economically and emotionally dependent on them.

Research on HIV/AIDS stigma suggests a gender paradox in that HIV/AIDS is still associated with sexual misconduct and promiscuity. While it is often acknowledged and accepted that men are much more likely to have multiple sexual partners, society's disapproval tends to be directed at women rather than men (Esu-Williams, 2000:124). It is against this backdrop that the plight of women lies; they need to advocate for condom use to prevent HIV/AIDS infection, yet when they do so with their male partners they are deemed to be promiscuous or unfaithful. This research investigates whether the women



of Clayfield have the clout to advocate for condom use in their sexual relationships, and whether they think that condom use in itself would reduce their risk of contracting the disease. I also investigate the relationship between condom use and HIV/AIDS prevention in Clayfield. For the purposes of this study, condom use refers only to the use of male condoms.

By using communication as a premise, the study also investigates the silences around HIV/AIDS within the community of Clayfield. Men define the qualities of a good woman according to their own needs and desires. Women, on the other hand, have tried hard to live up to what men perceive 'good women' to be. Men prefer women who can bear heavy burdens, be excellent caregivers, talented cooks, and – then – when all that has been achieved, provide sexual satisfaction on the man's terms alone (Esu-Williams, 2000:125). This study aims to better understand these interpretations regarding the role of women. Also, in keeping with this context, this study explores why the residents of Clayfield were almost "sworn to secrecy" when it came to speaking out about the disease itself.

It must be noted that not all women run the same risk of contracting HIV/AIDS. Economic status and ethnic background afford an explanation for the unequal distribution of the disease (Melkote et al, 2000:23). It is against this backdrop that this study is geared towards eliciting a deeper understanding of the interplay between the economic status of the women in the area of Clayfield and their vulnerability to contracting HIV/AIDS. The aim then is to ascertain, through the 'voices' of some residents of Clayfield, whether or not the economic status of the women contributed to the spread of HIV/AIDS.

This study hypothesises that by improving knowledge and information around issues of gender and sexual vulnerabilities, and by taking positive steps such as condom use and increasing women's social and economic independence, we could make a positive contribution towards possibly curbing, and maybe even reducing HIV infection and transmission among the women of Clayfield. This could also extend to women in other places where similar socio-economic and gendered factors exist.

### 1.3 Structure of the study

As mentioned previously, this study researches and analyses the interplay between gender and sexual inequalities, and vulnerabilities among the Indian men and women of Clayfield, and how these factors could contribute to aiding the spread of HIV/AIDS.

The overall argument is structured as follows: **Chapter 1** sets the stage and foundation for the study itself. The chapter motivates the entire study by identifying the central problem to be investigated and researched within the context of the broader aspects around gender, and sexual inequalities and vulnerabilities with regard to HIV/AIDS. The chapter explores the relevance of these factors in South Africa, and – more specifically – to the Indian community in Clayfield (Phoenix), who comprise my data sample.

**Chapter 2** focuses on a literature review that is relevant to enhancing and substantiating my argument that gender inequalities and sexual vulnerabilities contribute to fuelling the spread of HIV/AIDS. This chapter also provides an overview of the present situation in South Africa with reference to the issues of gender and sexual inequalities and vulnerabilities. These factors are then addressed with regard to my participant and study sample.

**Chapter 3** identifies the relevant and significant theoretical components and concepts that contribute to and motivate the interpretation of the data. This chapter also outlines the methodologies and procedures that I employed to collect data.

**Chapter 4** illustrates the case study I used for my research. Here, I identify and profile the community that was researched, as well as the study sample that was investigated and analysed. This chapter also provides an analysis of the data gathered and profiles my participants' responses. This chapter provides an investigation into the data with regard to participants' understanding of how gender and sexual vulnerabilities and inequalities could contribute to the spread of HIV/AIDS.

**Chapter 5** brings the study full circle by revisiting my hypothesis. In this chapter, due

attention is given to what the data revealed. The chapter also points to questions that emerge from my current study, as well as highlighting potential issues for future research. In this chapter I also offer some recommendations, which are relevant to gender and sexual vulnerabilities and inequalities with regard to the infection, transmission and prevention of HIV/AIDS.

I now turn my attention to a discussion and consideration of the literature review, which is relevant for the purposes of this study.

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 Introduction

The worldwide spread of HIV/AIDS has shown that the epidemic cannot merely be regarded as a public health issue. The pandemic has taken a toll on individuals, families, private sectors, public sectors, and national and regional economies (Bang, 2000). UNAIDS and WHO (December, 2005) report that in the new millennium, the worst occurrences of the AIDS pandemic are in Sub-Saharan Africa. This region of the sub-continent of Africa is deemed to be the world's poorest and most under-developed area. South Africa accounts for 10% of the world's population, yet this part of Africa constitutes 60% of all people living with HIV/AIDS – a total of 25.8 million. In 2005, an estimated 3.2 million of the region's inhabitants were newly infected. It was also reported that women were harder hit in Africa than men: among those aged from 15 to 24, an estimated 4.6% of women compared to 1.7% of men were living with the disease. Furthermore, UNAIDS/WHO (2005) reported that data from South Africa indicated that HIV prevalence among pregnant women has reached its highest level to date: 29.5% of women attending antenatal clinics were HIV-positive in 2004 (Department of Health South Africa, 2005). The prevalence of the disease was highest among women aged 25 to 34 years where one in three was estimated to be living with HIV. Among women aged 20 to 24 years, almost one in three was infected.

The latest data regarding HIV/AIDS in South Africa reveals an astounding feature of the epidemic: the alarming speed at which it has evolved. A national adult HIV prevalence of less than 1% in 1990 has rocketed to almost 25% within 10 years (UNAIDS/WHO, 2005). Furthermore this prevalence data also indicates that between 3 million and 3.6 million were women, and between 2.6 million and 3.1 million were men (Department of Health, 2005). Among pregnant women in their late teens (15 to 19 years), HIV infection levels have remained between 15% to 16% since 2000, while among their 20- to 24-year-old counterparts, those levels have indicated a prevalence of between 28% to

31% from 2000 to 2004 (Department of Health, 2005).

What was particularly striking about the latest data was the pronounced rise in HIV prevalence among older women, up to the age of 40 and older (Department of Health, 2005). HIV prevalence for women in this age category is unusual, since they are not deemed to be highly sexually active and are, more often than not, thought to be nearing menopausal age. It confirmed that women face extremely high odds of being infected with HIV when they forego protected sex. They usually engage in unprotected sex because they consider themselves to be in steady relationships or marriages and trust their partners, or because power imbalances deprive them of the ability to insist on safer sex (Marais, 2005:52).

According to Tallis (2000:3), the inequality between men and women, particularly when negotiating sexual relations, makes women especially vulnerable. I concur with Tallis that those women who contract HIV are more likely to face stigmatisation and social rejection than men, which further reinforces gender inequality. Women and their vulnerability with regard to HIV/AIDS seem to fall between the cracks when due consideration is given to the rate at which the disease is progressing. Meredith (1992:235) states:

Women are the 'hidden population' of the AIDS epidemic and comprise the fastest growing segment of AIDS cases.

A gender-based response aims to enable both sexes to protect themselves against HIV infection, to access proper care, and to generally cope better with the epidemic. A gender-based approach does not imply that men and women are interchangeable, but rather that opportunities in their lives do not depend solely on their biological sex. A gender-based response gives equal credence to men and women's knowledge, experiences, and values, which increase the quality and duration of their lives (UNAIDS, 1999).

Gender issues are linked directly to the efficiency and sustainability of HIV/AIDS interventions. There is a definite disparity in the effects that HIV/AIDS has on women, in

comparison to the effect it has on men, and minimising this difference can create more balanced participation and benefits for both sexes. It may also serve to lessen the gender imbalances that characterise many societies and communities (UNAIDS, 1999).

The HIV/AIDS epidemic manifests itself in three phases, each with a different impact. The first phase involves the rapid, invisible spread of HIV. In the second phase, when more and more people present symptoms of AIDS and die, the epidemic makes itself visible. The third phase is the non-medical, socio-economic impact of the disease, including the psychological effects of blame, stigmatisation and discrimination against people who have been infected. Because of gender inequality, HIV/AIDS affects women differently and more seriously than it does men (Panos, 1990a:12).

At first, according to Panos (1990b:24), the epidemic was perceived to be a gay male disease because it affected only homosexual men, but that notion is changing as the number of infected women has grown substantially. In fact, in countries and on continents where HIV/AIDS is spread through heterosexual contact, women now make up almost half of the total number of infected people. To understand why, and to explain the particularly negative impact HIV/AIDS has on women, their experience needs to be located within patriarchal gender relations (Tallis, 2000:3).

In patriarchal societies, most women, regardless of their race and class, are oppressed, discriminated against, and exploited on the basis of their biological sex. However, a 'new' form of oppression is on the increase – discrimination on the basis of HIV infection. Although HIV-positive people face intolerance, society by and large has chosen to blame women for the rapid spread of HIV/AIDS (Tallis, 2000:4). Hence, as the epidemic grows, so too does the blame, until women in general have become the scapegoats for the spread of the disease (Panos, 1990a:13). This can, in part, be attributed to the fact that researchers concentrate on women-only testing sites, such as antenatal clinics. These may be the most accessible sites, but their widespread use as focal points for surveillance has highlighted the growing number of infected women, without paying proper attention to the source of their infection – men.

In Sub-Saharan Africa women may have higher HIV prevalence than men because they

are more exposed to infected partners. The risk of exposure to an HIV-infected partner depends on the age at sexual debut, the number of partners, and the likelihood that those partners are infected (MAP, 2000:4). Reported age of sexual debut is similar for men and women, and even at young ages men generally report higher numbers of partners than women. Since HIV prevalence increases with age, young women's tendency to have older partners both within and outside marriage may increase their exposure to HIV-infected partners (MAP, 2000:4).

## **2.2 Socio-economic vulnerability**

Impoverished women are at more risk of contracting HIV than other classes of women; their limited or total lack of access to economic power and the resources necessary for development are mediated by gender inequality, and compound their oppression as women even further. This has been called the "feminisation of poverty" and is why the poorest of the poor are most often women (NOVIB, 1997:11). Women's lack of economic power often results in their dependence on men for shelter, food and clothing, especially in the absence of support from the State. This dependence makes them vulnerable. They are often not in a position to question or challenge their male partners for fear that they will be denied these basic needs. They lack control over their lives, including their sexual lives, and are more vulnerable to infection by HIV and sexually transmitted diseases (Panos, 1990a:8). In this context, HIV/AIDS can have devastating consequences for women.

Additionally, because women are more likely to wait for longer periods before seeking health services and treatment during the course of an illness, they are more likely to be at an advanced stage of HIV infection and related opportunistic infections before they actually seek out treatment (WHO, 2003). As a result, women are far less likely to take advantage of available treatments. They are also more likely than men to serve as the primary caretakers of others who are infected and to remain silent about their own health problems when other family members are in need of caring, whether ill or not (WHO, 2003). From data obtained in high prevalence settings in Africa, such as South Africa, it has been found that the combined physical and emotional burdens of caring for

sick family members and ensuring their food security under harsh economic conditions often takes a toll on women's own health and well-being (Danziger, 1994:23).

Women's economic vulnerabilities also expose them to graver consequences when faced with the stigma and discrimination typically associated with being infected with or affected by HIV/AIDS (WHO, 2003). When faced with the social ostracism and abandonment that often results, women frequently have to cope with tragic consequences because they lack the necessary economic resources to survive (Nyblade and Field-Nguer, 2000:31).

Engaging in multiple-partner relationships, which are accompanied by gifts and tokens, can be a key survival strategy for many poor women. Driven by poverty and the desire for a better life, many women and girls find themselves using sex as a commodity in exchange for goods, services, money, accommodation and other basic necessities (UNAIDS, 2004). This is indicative not only of men's superior economic position and access to resources, but also of women's inability to meet basic needs, as well as the cultural value placed on men having multiple sexual partners.

One of the defining features of Southern Africa, the worst affected part of the world, is its social and economic inequality, not just between rich and poor, but also among the poor (UNAIDS, 2004). According to a joint report by UNAIDS and The Global Coalition on Women and AIDS (2004), the relationship between HIV prevalence and socio-economic indicators is highly complex and not easy to understand.

Sex between young women and considerably older men is common, and this "arrangement" is one of necessity, as older men often help the girls' families to pay for school fees, transport costs, and groceries. Nevertheless, the hidden costs can be high. Men in their late twenties and thirties are more likely to be HIV infected, while the dependencies built into these relationships limit women's abilities to protect themselves from HIV infection, especially when the perception of younger women as being "pure" encourages men to avoid using condoms (UNAIDS / The Global Coalition on Women and AIDS, 2004:5).



Poor women are especially vulnerable to being coerced by their male partners since they may be economically dependent on them. These women are more likely to be constrained when making decisions about relationships and living situations than middle-class women. Concerns regarding food, shelter and care of their children may overshadow concerns about HIV/AIDS (UNAIDS, 1999).

In a newspaper article in the *Sunday Tribune Herald* entitled "Teen Sex Shock", the reporter (Langry, 2002:2) interviewed experts and school pupils on issues of teen sexual behaviour and practices. In this article, a 16-year-old female pupil from a school in Sydenham (a district north of Durban, South Africa) stated that young girls "preyed" on men who had money and owned cars. She also mentioned that "school girls" liked older men who have cars and money because they take the young girls out "in fashion" and buy them trendy clothes, make-up, and jewellery.

In the same article (Langry, 2002:2), Marlene Wassermann – a sex therapist – mentioned that it was very possible for young people to be competitive when it came to sexual partners. She stated that young girls want attention and want to be noticed and tend to use their bodies as tools to elicit such attention. This behaviour is risky and could inadvertently perpetuate the contraction and ultimately the spread of HIV/AIDS. Many women are, from an early age, practicing the 'art' of exchanging sex for material gain with little or no regard for their health and well-being. This type of risky behaviour, coupled with a sense of competitiveness for sexual prowess and material gain, is what eventually contributes to exacerbating the spread of the HIV pandemic.

Social norms impose a dangerous ignorance on girls and young women, who often are expected to know little about sex and sexuality (UNAIDS, 2004). This lack of knowledge magnifies their risk of HIV infection. Around the world, and especially in Sub-Saharan Africa, the epidemic's escalating impact on women is occurring within the context of profound gender and class inequalities, to name only a few (UNAIDS, 2004).

In the abovementioned newspaper article (Langry, 2002:3), a 16-year-old female from Chatsworth (a district south of Durban) commented on sexual relationships while waiting

outside a clinic to collect contraceptives. She had in her arms her two-year-old child. When questioned about her early motherhood, she commented:

I realise what I did was wrong, but that hasn't stopped me from having sex. I'm just more careful now. But having a boyfriend is the best. It is a status symbol – especially if you are sexually active – you are considered one of the cool people around. Having sex with your boyfriend is not something you keep quiet about. You tell it to everyone besides your parents.

This young woman's comments show that sexual activity is considered a symbol of social status, and for this reason teens boast about their sexual prowess to everyone, except their parents. This admission reveals that young people often find it difficult to speak to their parents about sexual behaviour and practices. In a later chapter where I analyse the data collected from my study group, I will revisit and unpack the concept of 'secrecy' around sexual behaviour and practices in relation to HIV/AIDS.

In the industrialised areas of Southern Africa, about one-quarter of people living with HIV are women; HIV has become increasingly lodged among women who belong to marginalised sections of the populations (UNAIDS, 2004). In many places, HIV-prevention efforts do not take into account gender and other inequalities that shape people's behaviours and limit their choices. According to the UNAIDS Report (2004), many HIV strategies assume an idealised world in which everyone is equal and free to make empowered choices, and can opt to abstain from sex, stay faithful to one's partner or use condoms consistently. In reality, however, women and girls face a range of HIV-related risk factors and vulnerabilities that men and boys do not, many of which are embedded in the social relations and economic realities of their societies. These factors are not easily dislodged or altered, but, until they are, efforts to contain and curb the AIDS pandemic are unlikely to achieve sustained success (UNAIDS, 2004:11).

Migrant labour systems, especially in Southern Africa, have aggravated women's economic dependence on their male partners to a much greater extent than in other parts of the African continent, where women are more prominent in market trading and other forms of commercial activity. Across this subregion, income-earning opportunities for women with low levels of education are particularly scarce (UNAIDS, 2004).

Industrial sectors in which female workers dominate have been hard-hit by job losses related to changes in tariffs and subsidies. This has further weakened women's economic status, aggravating gender inequalities and possibly heightening women's vulnerability to HIV (Hunter, 2002:31).

In South Africa, there are indications that within the context of widespread impoverishment and high levels of unemployment (as well as in the absence of affordable recreation), sexual relationships often serve as opportunities for enhancing self-esteem and peer status, and are used as a possible method to counteract boredom. It is important to recognise that sex also plays other social functions and is entangled in people's need to seek and express trust; in their search for status and self-esteem, and to escape loneliness and relieve boredom (UNAIDS, 2004:12). According to the UNAIDS Report (2004), what makes these quests dangerous for so many women is that they occur not only in situations where HIV has a firm foothold, but also under circumstances marked by glaring gender inequality where men tend to hold the upper hand, and where social norms and legal frameworks often assist that hand.

Later on in life, women may be particularly vulnerable to violence as a result of economic insecurity and (in some societies, such as South Africa) diminished social status. Violence against older women can include rape and violence between intimate partners, both of which pose a risk of HIV transmission.

### **2.3 Physiological vulnerability**

HIV/AIDS affects men and women differently, and in many countries the disease affects more women than men (Parker *et al*, 1998:18). The explanation for this disparity is partly due to physiological factors. The greater surface area of the vagina and the penetrative nature of sexual intercourse result in greater contact with the HI-virus. Sexually transmitted infections (STIs) are also difficult to detect in women since women are often asymptomatic, or exhibit only minor symptoms. The same holds true of HIV infection, which may be asymptomatic for months or years. Due to the asymptomatic nature of most sexually transmitted infections in women, these infections spread rapidly.

Some of the STIs are initially so mild that they are often disregarded (UNICEF *et al*, 2002). Consequently, a greater number of women have untreated STIs, including HIV infection, and the long-term complications of these STIs for women are more serious than for men (Berer, 2000:8).

In South Africa many STIs remain untreated. Over 50% of the women attending antenatal clinics have been found to be infected with at least one type of sexually transmitted infection. Furthermore, up to 15% of these attendees are diagnosed with syphilis (Whiteside and Sunter, 2000:49). This situation places women at dire risk of contracting HIV/AIDS, since STIs eventually causes sores in the reproductive organs and tracts and these sites could serve as entry points for HIV into the bloodstream during unprotected sex.

Additionally, on average, men have more sexual partners than women do. HIV is more easily transmitted sexually from men to women, since women are the 'recipients' of sex: the semen is deposited inside the woman. A man with HIV is, therefore, more likely to infect more people over a lifetime than an HIV-positive woman (UNFPA, 1999). The very act of penile penetration puts women at risk of contracting STIs and HIV/AIDS. Thus, heterosexual intercourse, especially when the act is unprotected, is never safe for women (Wilton, 1997; Doyal, 1994; Patz *et al*, 1999).

For very young women, susceptibility to HIV infection may be particularly high due to the immaturity of the genital tract and lacerations of the hymen during first sexual intercourse (MAP, 2000:5). Hence, this exposure to vaginal trauma because of the smaller size of their genital tracts, coupled with the tearing of the hymen during onset of sexual activity render young females especially vulnerable to the transmission of STIs and HIV/AIDS (Parker *et al*, 1998:21).

The risk of becoming infected during unprotected vaginal intercourse is greater for women than men, and the risk for young girls is greatest because the lining of the neck of the womb is not fully developed (UNAIDS, 2004). In South Africa, women and girls often get infected with HIV almost as soon as they start having sex. There is substantial

evidence to support the fact that the age gap between partners increases the probability that young women will become infected (UNAIDS, 2004). The women in the Southern African region are physiologically four times more susceptible to HIV infection, and are contracting the virus at a faster rate than men, and at a younger age (UNFPA, 1999).

## **2.4 Condom use**

In Sub-Saharan Africa, where the HI-virus is spread predominantly through heterosexual intercourse, the number of young women becoming infected outnumbers the number of young men contracting the disease (UNFPA, 1999). Varga (2000:12) argues that because there is no pending cure for HIV/AIDS, emphasising changes in sexual behaviour, such as the practice of 'safe' sex, is one of the few potentially practicable intervention options open to us. However, condom use remains a complex issue, which is dictated by multiple, and often conflicting factors.

Cultural constructs and socially shaped gender roles influence sexual decision-making around condom use and related issues that impact on HIV risk and prevention (Weeks *et al*, 1996:37). In most societies and communities, gender determines what men and women are expected to know about sexual matters and how their attitudes towards sex are shaped. For example, condom use assumes an equal distribution of power in sexual relationships. The woman may have the intention and the will to adopt this behaviour, but the actual act requires the active co-operation of the male partner (UNAIDS, 1999).

Negotiating safer sex usually depends more on the woman's ability to convince her partner that it is in their mutual best interest to use a condom, without changing the basis of the relationship. Yet the very act of proposing condom use introduces an assertiveness and confidence that male partners may not welcome (Ray and Maposhere, 2000:29). Women who are economically vulnerable are also less able to negotiate the use of a condom, even with a non-monogamous partner, since they lack bargaining power and fear abandonment and destitution (UNFPA, 2002). A number of women in high-risk relationships perceive the short-term costs of leaving a relationship as much greater than the long-term potential health implications (Weiss and Rao Gupta,

1998:42).

Research into behavioural factors and parity between males and females pertaining to infection rates increasingly shows the Sub-Saharan epidemic to be almost exclusively heterosexual, which is a unique global phenomenon (Caldwell, 2000:6). The existence of even one epidemic of this type (that is, a heterosexual epidemic) is surprising because the HIV transmission rate during one act of vaginal intercourse, between otherwise healthy persons, is very low: a one in 1000 chance from the female to the male partner and a one in 300 chance from male to female (Caldwell, 2000:8). The epidemic has thus been made possible due to various intersecting factors, one of them being a low level of condom use.

Although it is critical to empower women so that they are better able to protect themselves from HIV/AIDS, prevention interventions for women must also address men's behaviour, as well as communication between the sexes. Global research data consistently demonstrates that many women's risk of contracting HIV stems from their partner's unsafe sexual practices, not their own. According to the Female Health Institute, in most societies and communities, men still have greater control over sexual decision-making than their female partners. Thus, negotiating safer sex and, therefore, the use of condoms during sexual intercourse becomes a practical nightmare for women.

## **2.5 Culture**

When exploring culture it is important to differentiate between cultural values and beliefs, stereotyped images created out of oppression, and actual behaviours (Weeks *et al*, 1996:38). During the course of my fieldwork, I came to realise that many of the male interviewees (and a few female interviewees) confused culture with stereotypical male behaviour. Some of the male respondents were of the opinion that Indian wives were expected, by virtue of their cultural affiliation, to be submissive receptors of sexual intercourse, even if it meant that they were unwilling participants. Some of the male respondents expressed that they thought it was wayward of me, as an Indian female, to

even be questioning them about sexual practices and ideologies.

The male respondents generally held the cultural belief that men cannot 'survive' without sex and, as such, should demand sex from their wives and female partners. Consequently, women are afraid to deny their husbands and partners sex, fearing that they will react like "possessed beings". Shefer and Ruiters (1998: 39) express this viewpoint as follows:

[...] the notion that real men need sex; are focused on sex; are ever ready to have it; and that it is ultimately a biological urge outside their control.

It is also believed that 'real' men should accentuate their manliness by having multiple sexual partners. Women, however, are deemed to be promiscuous, and are even labelled as "whores" should they engage in similar practices. This form of double standard appeared to be prevalent among the males that I conversed with during a Training of Trainers Workshop on HIV/AIDS and Sexual Harassment that I conducted in 2004. Many of the males at this workshop even believed that women who dressed in short skirts and cropped blouses were inadvertently seeking out the sexual prowess of their male counterparts. Most of the men at this workshop felt that males were better capable of handling multiple sexual partners than women. Some even thought that men were entitled to have multiple sexual partners and that women should accept this as a given norm. This belief is dangerous because men engage in sexual intercourse with multiple partners, which significantly contributes to the spread of HIV/AIDS in Africa (Baylies and Bujra, 2000:54).

This double standard also extends to the belief that women are expected to remain virgins until they are married. In an attempt to deepen my understanding of my area of research, I held conversations with Grade 11 and 12 (2004) students from Crystal Point Secondary School located in Unit 13, Phoenix. One of the views expressed was that men 'know' when a woman is not a virgin. Another common belief is that a woman who is a virgin will always bleed during her first sexual encounter. It is commonly accepted (according to the male students at least) that if the female does not bleed during her first sexual encounter, then it implies that her hymen has already been ruptured and she is

not a virgin. When I attempted to explain that the hymen could sometimes rupture during the playing of vigorous sport, for example, and not necessarily sexual activity, the male students thought that this was an absurd idea. Furthermore, the male students were of the opinion that as long as the hymen was ruptured, even in the absence of sexual activity, the woman was not a virgin. In this regard, Scorgie (2002:65) states:

Where sexual responsibility for sexual abstinence is placed so unambiguously on the shoulders of young girls, the implication that they are therefore also responsible for the spread of the disease is only a short step away.

Another response from the male students that illustrated double standards in action was the response that they felt that men could engage in sexual intercourse as many times as they wanted to and with as many different partners that they could before marriage. However, when they are ready to marry, then they definitely wanted to marry a virgin. They also stated that women are like cars; one needs to 'test-drive' as many as possible before deciding which one really appeals to you. This view indicated to me that, in many respects, women were indeed treated as mere sex objects.

The female students stated that they dared not even mention the word 'sex' at home, especially not in the presence of their parents. The male students concurred that the mere mention of sex to their parents created the impression that they were sexually active. The girls also mentioned that once they reached puberty, their parents were stricter and more vigilant concerning their activities. The boys stated that the contrary was applicable to them; as they got older they were given more leeway and freedom to socialise with their friends. I will explore these conditions in more detail in **Chapter 4**, where I analyse the feedback and responses of my sample group.

The male and female students agreed that there exists a shroud of silence around the topic of sex and any form of sexual activity. Accordingly, most of the information around sexual practices is gleaned from the media, from conversations with peers, and from popular literature such as magazines and newspapers. It is for this reason that most of the students that I conversed with saw sexual activity and sexual contact as being alluring and an exploration of the unknown. This made the concept itself adventurous



and exciting. The silence in their homes and families around sexual activity is disconcerting. In **Chapter 3** I explore the aspect of *silence* further as it relates to gender and the spread of HIV/AIDS.

Manderson (1999:45) asserts that in order to be truly successful in eradicating the spread of HIV/AIDS, as well as other STIs, we need to pay equal attention not only to social dimensions, but also to the cultural understandings of sex, gender, and sexuality.

## 2.6 Conclusion

After reviewing relevant and selected literature and some empirical evidence pertinent to this study, as well as engaging in some discussions, it is evident that women are more vulnerable than men to HIV infection and transmission. HIV affects men and women differently. In an attempt to examine gender vulnerability and inequality insofar as they fuel the spread of HIV/AIDS, this chapter considered the interplay and intersection between factors such as socio-economic vulnerability, culture, physiology, and condom use.

I acknowledge that these factors and elements are not the only ones that contribute to the spread of the pandemic, but they are, nevertheless, significant to how gender vulnerabilities and inequalities assist in the progression and transmission of HIV/AIDS. Thus, an exploration and extensive consideration of the factors outlined in this chapter could assist in developing gender-based and gender-sensitive interventions and strategies. In **Chapter 5** I attempt to recommend a few of these interventions and strategies. In the following chapter, I identify relevant and significant theoretical components and concepts that contribute to and motivate my study and the interpretation of the data. In this chapter, I also outline the methodologies and procedure that I employed to collect data.

## CHAPTER 3

### THEORETICAL FRAMEWORK AND RESEARCH METHODOLOGY

#### 3.1 Theoretical framework

##### 3.1.1 Introduction

For the purposes of this study, a 'theory' suggests a collection of ideas, concepts and principles that afford an explanation for, or analysis of, a particular hypothesis or phenomenon. Glantz *et al* (1997: 21) offer a definition of a theory as:

[A] set of interrelated concepts, definitions and propositions that presents a systematic view of events or situations by specifying relations among variables in order to explain and predict the events or situations.

The above citation suggests that a theory is the interface between various concepts, ideas and variables, which affords an explanation of a particular situation or phenomenon. Accordingly, this chapter examines some of the theoretical concepts and components relevant to gender vulnerabilities and inequalities, and how these elements contribute to the spread of HIV/AIDS. These concepts include: gender, gender inequality, masculinity, sexuality, patriarchy, power, gender roles and responsibilities, gender vulnerability, sex, sexuality, HIV/AIDS. The argument set out in this chapter highlights and outlines how these concepts influence our understanding of the spread and transmission of HIV/AIDS.

In South Africa, the rapid escalation of HIV/AIDS infection rates results in, *inter alia*, gender inequality being recognised as an area that demands urgent attention. Gender relations could even be considered the cornerstone of social and cultural constructs and interactions, and, accordingly, an investigation into HIV/AIDS vulnerabilities needs to take gender inequalities and vulnerabilities into serious consideration. The chapter illustrates the relevance and significance of gender within these social and cultural constructs, which aid and contribute to the spread of HIV/AIDS in a predominantly

Indian suburb called Clayfield. The respondents of this study are located within this community.

### 3.1.2 Gender and sex

By discussing the aspect of gender, I will distinguish between the concepts of 'gender' and 'sex'. Sex is best defined along the lines of biology. The physiological and biological differences between males and females are clearly distinguishable. Helman (2000) highlights that the division of mankind into either male or female by way of biology is relatively simple, since this distinction can be empirically verified. Gender, on the other hand, takes into consideration the roles of men and women within social and cultural constructs. Pollard and Hyatt (1999:2) define 'gender' as:

[...] a much broader range of variation in how people in societies all over the world understand the social and cultural roles, values and behaviours of men and boys, and girls and women.

Although, by definition, sex and gender are distinct, these aspects are nevertheless complex, and incorporate various social and cultural facets. From a practical point of view, this makes it difficult to draw an absolute distinction between the two concepts. Pollard and Hyatt (1999) state that the interaction between biology and culture is so multifaceted and complex that attempting to draw an absolute distinction between 'sex' and 'gender' in practice is often difficult, if not impossible.

Gender relations also incorporate interactions between men and women. These interactions comprise those associated with sexual desires, preferences, and practices. They also express and embody relations of power and dominance. Gender, thus, comprises multi-dimensional ideals and interactions that assign *value* to kinds of sexual behaviours and relationships. The concept also imposes codes for 'traditionally' acceptable and forbidden roles and behaviours (Weeks *et al*, 1996).

In a newspaper article that appeared on December 1, 2002 in the *Sunday Tribune Herald*, reporter Tasnim Langry interviewed experts and school pupils on issues regarding teen sexual behaviour. In this article, a 17-year-old female student from

Asherville (a community north of Durban, South Africa) stated that it seemed as if traditional gender roles were, in some cases, being reversed with the result that girls were 'chasing' boys. This response indicates that the commonly perceived notion, in terms of gender roles, is that boys or men pursue girls or women. By implication then, it is not accepted in this culture for women to pursue men.

### **3.1.3 Gender inequality**

Gender inequality makes women more vulnerable to being infected by HIV/AIDS than men because women lack power and control over their lives. According to Mann *et al* (1992), there are three types of vulnerability to HIV/AIDS, namely: personal, programmatic and societal.

Personal vulnerability refers to both cognitive and behavioural factors that place people at risk. These include:

- A lack of access to information on HIV/AIDS and sexuality. Many women are not exposed to accurate and relevant information.
- Personal characteristics, such as individual attitudes towards HIV/AIDS, and perception of personal risk. Many women deny that they are at risk – the “it will not happen to me” syndrome.
- A lack of personal skills, such as the ability to negotiate safer sex.

Programmatic vulnerability refers to the contribution of HIV/AIDS programmes to reducing or increasing vulnerability. Many programmes, whether run by the State or by the voluntary sector, often neglect to integrate an awareness of how gender inequality contributes to the spread of the disease. This is essential – right through from the needs analysis, to the planning and design, and in the implementation and evaluation – or programmes will fail to assist women to reduce their vulnerability (Mann *et al*, 1992). For example, one of the main messages of prevention campaigns is “use a (male) condom”. But for many women, perhaps even the majority, it is their male partner’s

decision whether or not to use condoms.

What many programmes fail to address is whether, and to what extent, women can ensure that their partners use condoms, and when they are unable to use condoms, what they can do to reduce the risk of HIV infection (Panos, 1990a). Societal vulnerability refers to the broader context of women's lives, including their political situation, culture, tradition, gender relations, attitude towards sexuality, religious beliefs, and poverty.

### **3.1.4 The intersection between sexuality and masculinity**

Sexuality is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances and with what outcomes (WHO, 2003). It is a multi-dimensional and dynamic construct, and explicit and implicit rules imposed by society, as defined by gender and age, profoundly influence an individual's sexuality (Zeidenstein and Moore, 1996; Parker and Aggleton, 1999).

The imbalance in power created by differential access to productive resources translates into an unequal balance of power in sexual interactions, in which the satisfaction of the man is more likely to supersede that of the female. As a result, men have greater control over their sexuality (WHO, 2003). The balance of power in any sexual interaction determines its outcome. In worst cases, this power imbalance plays itself out in the form of violence against women. An understanding of individual sexual behaviour or sexual risk necessitates an understanding of gender and sexuality as constructed by a complex interplay of socio-cultural and economic forces that determine the distribution of power (WHO, 2003).

The differences in people's attitudes towards women and men with HIV or AIDS, and patterns in the provision of care for people suffering from AIDS are related to dominant versions of masculinity and femininity (Rivers and Aggleton, 1999). Expectations of female and male sexuality also differ greatly according to cultural contexts. A clear dual

standard exists with regard to the sexual behaviour of women and men in most cultures; while men are often encouraged to have many sexual partners, women are expected to remain faithful to one sexual partner. In addition, male sexuality is widely perceived as unrestrained and unrestrainable. Women who become infected with STIs or HIV are often viewed as blameworthy. Of course, blame is less likely to be ascribed to men, who are assumed to have little control over their sexual urges. Moreover, women traditionally provide care for family members who are sick, while a caregiving role is not consistent with dominant or hegemonic versions of masculinity (Rivers and Aggleton, 1999).

While traditional roles render women less able to control the nature and timing of sexual activity, men are more able to determine how, when and with whom sexual intercourse takes place. Despite this, dominant ideologies of masculinity, which emphasise male sexual pleasure, value the display of sexual prowess and encourage men to have multiple sexual partners; this then exposes men and their partners to a greater risk of contracting HIV and AIDS (Rivers and Aggleton, 1999). While women may be prepared to take measures to protect themselves from HIV infection, and while men have some investment in protecting themselves, their partners, and families, women's desire for safer sex frequently runs 'into a wall of unco-operation from men' (Meursing and Sibindi, 1995).

Connell (1995:67) argues that research has failed to produce a "coherent science of masculinity". In his view, masculinity is not a static and unchanging social norm, but rather has its place in gender relations and the practices that men and women engage in, as well as the effects of these practices on roles and behaviours.

Notions of hegemonic masculinity help to explain why certain versions of masculinity become the most successful and powerful in particular environments. Men who do not meet the 'standards' set by hegemonic masculinities (which can and do change over time), are viewed as unsuccessful and powerless. Within a particular society one or more forms of masculinity is likely to be 'culturally exalted'. Men do not necessarily conform to the dominant versions of masculinity that circulate at any one moment in

time, however, those who do not, often find themselves discriminated against (Rivers and Aggleton, 1999). Despite this, all men probably share in what Connell (1995: 82) has called the “patriarchal dividend through which men gain honour, prestige, the right to command and, material advantage over women.”

It is not an easy task to challenge dominant ideologies of masculinity and their consequences for women and men. Like any other hegemonic ideology, dominant beliefs about what ‘real’ men are like, seek to incorporate all alternative images, accounts and explanations within their sphere of influence (Rivers and Aggleton, 1999). Thus, hegemonic masculinities legitimise not only unequal roles and relationships between men and women, but also among men themselves. They encourage us to see men who do not live up to the ideals of hegemonic masculinity as being effeminate, weak, subservient, or immature. They also seek to deny men an active role in changing prevailing gender vulnerabilities and inequalities for the better (Cornwall, 1997).

According to the International Centre for Research on Women (1996), in many cultures and societies, including those represented in this study group, women are expected to preserve their virginity until marriage, while young men are encouraged to gain sexual experience. As a result, having had many sexual relationships may make a man popular and praiseworthy in the eyes of his peers (Abdool Karim and Morar, 1995). So, while a lack of knowledge and sexual inexperience remains highly desirable for young women, men may be stigmatised if they cannot demonstrate a wide repertoire of sexual experiences (Rivers and Aggleton, 1999). While there may be differences present in prevailing definitions of masculinity, a greater degree of freedom, power and control continues to characterise male sexuality across a wide spectrum of different cultures. Women, furthermore, are mostly economically dependent on men and, therefore, their ability to make decisions about sex may be most restricted. This reinforces the importance of economic development for enhanced levels of gender equality (Rao Gupta *et al*, 1996).

In order to avoid the problems that stem from failing to conform to dominant gender stereotypes, women risk the damage associated with conformity, like being ostracised or

scorned by men (Overall, 1993). Men, on the other hand, may find that by conforming to stereotypical versions of masculinity, they place themselves and their partners at an increased risk of contracting HIV/AIDS. These contradictions need to be exposed in order to show how men and women will benefit when existing gender roles are transformed or cease to be adhered to (Rivers and Aggleton, 1999). As Cornwall (1997: 12) articulates:

If gender is to be everyone's issue, then we need to find constructive ways of working with men as well as with women to build confidence to do things differently.

### **3.1.5 Gender-based violence within patriarchal societies**

In South Africa, gender-based violence is rampant, and is rooted in the historically unequal relations (social, economic, cultural, and political) between men and women. Furthermore, the patriarchal societies within the country also contribute to these unequal relations and, ultimately, to gender-based violence.

Gender-based violence takes many forms, and can include physical, emotional or sexual abuse. While both men and women can suffer from gender-based violence, studies show that women and children are most often the victims (UNIFEM, 2001). Gender-based violence can include rape and sexual assault, and the most pervasive form is violence committed against a woman by her intimate partner.

A newspaper article that was featured on 28 February, 2003 in the *Sunday Tribune* highlighted a survey that was conducted with 450 Durban school-boys. The survey suggests that sexual aggression against their female counterparts has become the norm. A staggering two-thirds of the secondary school-boys questioned admitted to sexually abusing girls under 18, and a further 17% of them had gone as far as rape (Power, 2003).

The study also examined the group's attitudes towards violence. The results clearly indicated that sexual aggressors were more likely to adopt attitudes and beliefs supportive of sexual and physical violence (Power, 2003). Professor Steven Collings,



then the Associate Professor of the School of Psychology at the former University of Natal, stated that the evidence uncovered in the survey indicates that attitudes that support violence are actually more predictive of sexual abuse than inaccurate rape myths and beliefs.

It is dangerous, and indeed a cause for concern, if young men are in fact maturing into adults who believe that sexual abuse and aggression are the norm and, therefore, acceptable. These beliefs persist into marriages and intimate relationships, which ultimately contributes to the social and cultural degradation of women. The perpetuation of sexual abuse and aggression against women will inadvertently contribute to the spread of HIV/AIDS.

Gender-based violence also contributes to HIV transmission in situations of rape, where the victim may experience bleeding and tearing of the genital area. This can create passageways for HIV to enter the bloodstream. Furthermore, conversations about safer sex, HIV status, or HIV risk reduction are unlikely to take place in situations of rape, particularly when the rapist has a weapon (UNIFEM, 2001).

Additionally, violence between intimate partners often contributes to HIV transmission by harming their ability to communicate openly about safe sex, their HIV status, or ways to reduce the risk of infection.

### **3.1.6 The use of condoms**

Condom use still has a long way to go to curb the Sub-Saharan Africa AIDS epidemic. Inhabitants of this region seem to be against the use of condoms, in contrast to people in many other major regions of the world (Caldwell, 2000). In situations where partners cannot speak freely about safer-sex practices, condoms are not likely to be used. Some women may even avoid speaking about condoms with their partners for fear of violent retaliation.

Wilton (1997) offers interesting insights into the reason why condom use may be so

unpopular among men. I concur with her when she suggests that masculinity itself is threatened by condom use. There are several reasons for this: first, if condom use is requested by a woman, this allows women to define the terms of sexual engagement; second, condom use may involve men having to de-prioritise their own sexual pleasure; third, for men to demonstrate a degree of control over sexual behaviour may be feminising, since male sexuality is most usually understood as uncontrollable; and, finally, risk-taking in itself is considered to be typically masculine. Wilton (1997) further points out that non-penetrative sex is rarely an option in heterosexual relationships, since vaginal sex tends to be understood as 'adult sex', and other forms of sexual pleasure may be seen as a kind of 'back-sliding' into adolescence. Wilton's work is important because it emphasises the importance of working with men as well as women to deconstruct stereotypical gender roles, in an attempt to reduce HIV transmission.

Meursing and Sibindi (1995) state, that condoms are not consistently popular with men, especially when engaging in sexual intercourse with their wives. Men may interpret their wives' requests for condoms as a betrayal, or an attempt to deprive them of their rights in sexual decision-making within the relationship (Amamoo, 1996). Women see themselves as being unable to act upon what they know about HIV/AIDS for fear of implying, through condom use, that a partner is not loved or trusted. Such requests disturb the intimacy, which is central to many relationships and marriages and can result in violence, abandonment, or rape (Ankrah and Attika, 1997).

### **3.1.7 Fidelity versus multiple partners**

In many societies the dominant ideal of femininity emphasises uncompromising loyalty and fidelity in relationships and marriages. We have been told that this 'ideal' distinguishes a 'good' woman from a common 'woman in the street'. According to this ideal, sexual practices that are linked to reproduction are moral, and those that are linked to pleasure are immoral (Rao Gupta and Weiss, 1993).

In sharp contrast, in many societies and communities, it is believed that a variety of sexual partners is essential to men's nature, and that men will inevitably seek multiple

partners for sexual release (Weiss and Whelan *et al*, 1996). Results from sexual behaviour studies from around the world indicate that both married and single heterosexual men have higher reported rates of partner change than women (Rao Gupta and Weiss, 1993). By recognising and condoning men's need for multiple sex partners, but not doing so for women, society sets a double standard for sexual behaviour that seriously challenges the effectiveness of HIV prevention efforts, which require men to be faithful and reduce their number of sexual partners (Rao Gupta, 2000).

Moreover, men's inability to live up to certain masculine norms, such as providing for their families, can result in them boosting their self-esteem by fulfilling other masculine norms, such as engaging in sex with multiple partners (Silberschmidt, 2001). This underscores the need for HIV/AIDS prevention efforts to actually change the gendered norms of sexuality, if interventions are to be effective (WHO, 2003).

### **3.1.8 The effects of HIV/AIDS on women**

The risk of HIV infection plagues women on several different levels. Women risk being infected by their male partners because they do not have the power to negotiate safer sex with them. When they suspect that they have been infected with HIV/AIDS, they have to wait three to six months to determine their status, which increases the trauma that they experience. Yet during this period of anguish, they are still expected to fulfil their roles as mothers and wives. A speaker at the Tenth Annual Conference on AIDS and STDs, held in Abidjan in December 1997, summed up women's vulnerability by asking: "How many women face sex encounters with no free will, especially in their youth? For how many does this continue all their lives?" Many women, especially those belonging to marginalised groups, have not been exposed to HIV/AIDS prevention and education messages. Thus, unaware of the risks, they are most vulnerable of all (Tapper, 1998). Mothers who are themselves HIV positive, risk transmitting HIV to their children, either during pregnancy, during birth, or through breast-feeding, particularly if a mother is unaware of the risk, or unable to feed her baby with formula (Panos, 1990a).

Women who are HIV positive and those who are living with AIDS have to deal with complex emotions, social issues, and financial constraints. Many women are rejected by their partners, ostracised by their communities and denied insurance. The psychological consequences for many HIV-positive women include low self-esteem and insecurity.

Many mothers fear that their adult children could become infected with HIV, but lack the skills to openly discuss this with them, especially in sexually conservative cultures. When their children or partners become ill, mothers often find themselves in the role of caregiver, particularly when the public health sector is under-resourced. They may also have to deal with the psychological and emotional trauma of the death of a partner or child. If a partner dies, this may also mean that they lose their livelihood (Panos, 1990a).

Women are increasingly taking up the burden of caring for people with AIDS, informally and formally. The bulk of AIDS care happens in the home, where women look after their infected partners and children. Grandmothers often have to take care of their grandchildren when their parents no longer can, or have died. The majority of volunteers and AIDS workers are also women. The burden of HIV/AIDS on women, HIV positive or not, is heavy and affects all aspects of their lives. HIV-positive women carry their burden alone, if they are afraid to disclose their HIV status (Tallis, 2000).

### **3.1.9 HIV and violence against women**

Violence against women is a worldwide scourge, and an immense human rights and public health challenge, one which also increases women's vulnerability to HIV infection (UNAIDS, 2004). Research has uncovered strong links between sexual partner violence and increased likelihood of HIV infection (Heise *et al*, 1999). In addition, the fear of violence, not just from partners, but from the wider community, prevents many women from accessing HIV information, from getting tested and seeking treatment, even when they strongly suspect that they have been infected (UNAIDS, 2004).

The most common form of violence committed against women is violence at the hands of their intimate partners (UNAIDS, 2004). Women often have no legal recourse in countries where laws to prevent domestic abuse are absent or poorly enforced. In antenatal clinics in Soweto, South Africa, HIV infection was found to be more common in women who have been physically abused by their partners than in those who were not physically abused (UNAIDS, 2004).

### **3.1.10 Education and health care**

The imbalances of power women experience within relationships mirror wider societal inequalities that limit women's autonomy and opportunities (UNAIDS, 2004). In most African countries (South Africa included), great strides have been made in expanding education opportunities, especially for girls. However, despite such progress, wide gaps remain. Along with other factors, including deepening poverty and unaffordable schooling expenses, AIDS is threatening those gains in the hardest-hit countries (UNAIDS, 2004).

Downward trends in education also hold serious implications for the epidemic's growth. Education is a key defence against the spread of HIV (UNAIDS, 2004). Research in South Africa has shown that higher education levels correspond with increased awareness, knowledge, and condom use, as well as better communication on HIV prevention between partners (Human Rights Watch, 2001).

Women are more likely than men to contract HIV from a single act of unprotected sex with an HIV-infected partner. But, whether or not women engage in sex, or whether that sex is protected or not, often depends on their male partners' decisions and behaviour (UNAIDS, 2004). Unfortunately, a female-controlled prevention method is not yet widely available. Female condoms offer protection to increasing numbers of women, but they still require some degree of negotiation and male co-operation. They are also significantly more expensive than male condoms and, despite indications of increased uptake, they remain neither widely available, nor socially accepted (UNAIDS, 2004).

Microbicides, which have anti-HIV activity, come in the form of gels, creams, suppositories and rings, and offer great promise for female-controlled prevention. Several countries are now involved in trials of candidate microbicides (UNAIDS, 2004). These microbicides can allow women to take control of their reproductive health, while efforts continue to be made to address underlying inequalities.

Generally, men tend to have better access to AIDS care and treatment in places where AIDS treatment is provided, mainly within the private sector and through drug trials. Again, this is a marker of the many other advantages that men enjoy. In Sub-Saharan Africa, overall access to treatment for both men and women remains distressingly low (UNAIDS, 2004).

Access to voluntary counselling and testing still poses a significant challenge for girls and women who do not seek reproductive health services. A similar situation exists for men, who are generally less likely to use public health facilities than women are (UNAIDS, 2004). As treatment programmes are expanded globally, there is a justifiable concern that many women may miss out on opportunities to learn their sero-status and receive treatment, because they fear that if they discover they are HIV-positive, their partners will also become aware of their HIV status (UNAIDS, 2004).

### **3.1.11 An increasing burden of care**

Generally, in Southern Africa, women and girls provide the bulk of home-based care, and are more likely to take in orphans, cultivate crops, and seek other forms of income to sustain households. In South Africa, a three-province survey found that almost three-quarters of AIDS-affected households were female-headed, a significant proportion of whom were also battling AIDS-related illnesses themselves (WHO, 2004).

Poverty and faltering public services in many areas are combining with AIDS to turn the burden of care for women into a crisis that has far-reaching social, health and economic implications (UNAIDS, 2004). Women pay a price beyond the immediate toil and distress. As their time and energy is increasingly absorbed by care duties, their

opportunities to advance their education, achieve some financial independence through income-generation, and build skills steadily fade (UNAIDS, 2004).

Entire families are also affected when women are diverted from other productive tasks by their caregiving roles. Most of the surveyed households in South Africa were already poor, some extremely poor, before AIDS appeared. The epidemic, however, has now compounded their predicament (UNAIDS, 2004). They reported an average two-thirds loss in household income as a direct result of having to cope with AIDS-related illness (Steinberg *et al*, 2002).

In many countries, female-headed households, including those run by elderly women, are much more likely to take in a greater number of orphans than male-headed households (UNAIDS, 2004). As the effects of the epidemic intensify, more grandmothers are now caring for orphans than they did a decade ago.

Social welfare systems in the countries hardest hit by HIV/AIDS (South Africa included) are not properly constructed to relieve these burdens (UNAIDS, 2004). As a result, poor households, especially the women and girls therein, have very little possibility of accessing external support that could protect them against the brunt of the epidemic's impact. Families, communities, and governments cannot rely on women's fortitude and resilience alone to provide sustainable safety nets. Whether tending to the sick, tilling the fields, earning an income, or volunteering help, women's work is an essential part of household and national economies (UNAIDS, 2004).

## **3.2 Research methodology**

### **3.2.1 Research design**

As mentioned earlier in this chapter, this study hypothesises that gender vulnerabilities and inequalities could be factors attributed to fuelling the spread of HIV/AIDS. The research methodology employed is qualitative in its structure and design. This type of research methodology best utilises the perceptions, understandings, and experiences of

individuals to provide an in-depth understanding, as well as a critical analysis of the crucial issues and factors relevant to the relationship and interplay between gender and HIV/AIDS. In this regard, quantitative research would have merely served as a generalisation by providing numerical and statistical data analysis.

Qualitative research was identified as the research methodology for this study because it seeks an in-depth understanding and views social phenomena holistically (Ulin *et al*, 2002). This is achieved by uncovering information by using the experiences and voices of real active participants rather than 'mere' subjects. Additionally, a qualitative approach utilises and identifies social processes that are integral to understanding the effects of HIV/AIDS and in considering HIV intervention and strategies (Ogana, 2005). A qualitative research design also enables me to better understand how gender vulnerabilities and inequalities are at play within social and cultural settings. This understanding is best gauged when individuals' interactions with each other are observed within their respective society and community.

Furthermore, critical factors and elements that enhance an understanding of gender, such as masculinity and femininity, sexuality, power, sex, and individual attitudes and perceptions, are best analysed and demystified using qualitative methodologies. To merely ascribe statistics and numerical data to such concepts would shroud the voices of experience and knowledge that emanate from one-on-one contact with individual participants. Although quantitative data analysis is important, the perceptions and attitudes of individuals are complex and varied and cannot be accurately assessed using statistical data alone (Baumgartner and Strong, 1998).

Qualitative research enables the researcher to 'see' through the eyes of the participants. This type of research examines interrelated events along a developmental continuum. This characteristic of qualitative research is integral to understanding how prior events play a role in the individual's thoughts or behaviours (Struwing and Stead, 2001). When one considers attitudes, behaviours, and perceptions around HIV/AIDS, and more specifically gender vulnerabilities and inequalities, it is essential that these phenomena are dealt with holistically, taking into consideration prior events and social and cultural



'conditioning'.

The advantage of a qualitative approach is that it makes possible a measurement of the individuals' reactions. This approach produces a wealth of detailed information about people's experiences and perceptions by examining individual cases. This increases an understanding of the relevant cases and situations under investigation, thereby reducing generalisations and assumptions (Patton, 1990). However, generalisations could be asserted, if so required. UNAIDS (1999a) points out that, qualitative data could be generalised by identifying the forces that motivate individual and group behaviour. Generalisation in my study is important for the purposes of widely applying what this study is hypothesising: that gender vulnerabilities and inequalities in other Indian suburbs with similar socio-economic and cultural settings could aid in fuelling the spread of HIV/AIDS.

### **3.2.2 Project area**

As already mentioned, this study was undertaken in a community called Phoenix, which is located in the province of KwaZulu-Natal in South Africa. Phoenix is located approximately 35km north of Durban. The community I focus on in Phoenix is called Clayfield, and is also referred to as Unit 5 by residents. The study investigates and researches the role that gendered vulnerabilities play in the spread of HIV/AIDS, particularly within the Indian community of Clayfield.

Clayfield is regarded as being one of the oldest communities established in Phoenix, and its residents are thought to be the pioneers and stalwarts of Phoenix. This community was established in early 1975 and has been in existence for approximately 31 years, as at 2006.

Clayfield was selected as the site for the study because it is located in KwaZulu-Natal. This province has the highest prevalence of HIV in South Africa (UNAIDS/WHO, 2005). Furthermore, I sought to research the Indian community of Clayfield because it is my opinion that the Indian community is under-researched with regard to matters relating to

HIV/AIDS. Also, the community of Clayfield is close to my heart since I have been a resident of this community for approximately six years, up until 2001.

### **3.2.3 Study sample**

I individually interviewed a total of 20 residents from the community. Clayfield was once a notorious community, where violence and drug dealing were prevalent. These conditions made it difficult for parents to raise their children without fear that they may succumb to drug addiction or the high level of crime in the area. Such conditions also served as a breeding ground for teenage pregnancy and the spread of STIs.

This is a community I grew to know intimately, having established many friends and networks during my earlier six-year residence. In this way, I could describe myself as a 'cultural insider' of the community. Hence, a relationship already existed between this community and me. It was from this perspective (as well as being beneficial to the research itself) that qualitative research was undertaken. Also, having known most of the residents of the community on a personal level, it was relatively easy for me to engage in one-on-one interactions with them in order to elicit information relevant to the study.

Clayfield was selected as the site for this study and research because of its prevailing unemployment levels among men and women. UNAIDS (2004) reports that females are more vulnerable to poverty, sexual exploitation, and sexual violence. These factors are common in Phoenix, of which Clayfield is a part.

### **3.2.4 Data collection methods**

As mentioned earlier in this chapter, a qualitative approach to data collection was employed to better understand, through the 'eyes' of the individuals, how gender vulnerabilities and inequalities contributed to the contraction and transmission of HIV/AIDS. Furthermore, qualitative research was carried out to carefully examine and understand the various experiences, beliefs, and values within Clayfield. In order to

gain deeper insight into these intangibles, it was essential that I undertook to interview the residents of the area on an individual basis.

One-on-one interviews enabled face-to-face discussions with the participants of my study group. I developed a questionnaire, which consisted of both closed and open questions. This combination of questions was decided on since closed questions do not tire people with too much speculation and elaboration. Yet the inclusion of open questions allowed my interviewees to provide their own views and explanations, which were crucial to the research. The variation of questions being asked and the time given for answering also prevented subjects from getting bored and disinterested during the interview process, and I believe that this format facilitated the collection of data. Once individuals become bored and tired, they tend to answer inaccurately. This would inadvertently have affected the accuracy of data collected and the summations based thereon (Ulin *et al*, 2002).

Closed questions tend to be used to elicit answers about fixed facts. They do not require much speculation and are important since they are employed to extract short, exact answers. This approach lets the individuals know that they can be precise, yet still provide crucial information. This type of questioning also breaks the monotony of long-winded responses (Ulin *et al*, 2002).

However, the challenges associated with closed questions are that they limit interviewees' responses, and do not enable them to think deeply or test their real views, feelings and/or values. Open questions give the researcher a very good idea of the variety of ideas, feelings, and views that people have, since they enable the interviewees to think and talk for longer, and to explore and express their opinions and feelings comprehensively (Ulin *et al*, 2002). Thus, by utilising a mixture of closed and open questions, the individuals in my study group were also free to express their views and perceptions around issues of gender, sexuality, and HIV/AIDS. Some of the respondents even saw this line of questioning as an avenue to air their frustrations with their personal relationships and marriages. They regarded the interview as an opportunity to voice their grievances and anguish. Most of the respondents felt at ease

doing so since they knew me on a personal level.

However, open questions are not as easy to quantify as closed questions are. For this reason, I had to read through all the comments and responses and categorise them. These responses could merely be reported on in terms of their diversity, and general statements emanating from these responses could then be made.

The interviews undertaken with the residents of Clayfield were all embracing and intensive. I interviewed each of the 20 participants on an individual basis and meticulously recorded each person's response. I took care to ensure that the responses were recorded verbatim so as to capture the essence of their experiences and perceptions around gender vulnerabilities and inequalities, and how these factors could aid in the transmission and contraction of HIV/AIDS. I also ensured that the interviews were taped (with approval from participants) to ensure that I did not misconstrue or inaccurately record the individuals' responses (see also 3.2.6).

As mentioned previously, a relatively small sample of 20 people was interviewed, and this gave us enough time and freedom to explore issues at length. This method was vital to the research, since – unlike a survey – I did not end up with a mere generalisation of the issues (as would be the case with a large group of people), but, rather, the small number of people interviewed allowed for easy analysis of their various beliefs, experiences, opinions, and actual feelings. The size of the sample group was sufficient for the information to be representative of the views and perceptions of the community of Clayfield, while also allowing for maximum interaction with the individuals on a more detailed level. This detail is of crucial importance since it gives credibility and worth to the study. It also offers a perspective on those factors that the people of Clayfield consider to be crucial in contributing to the spread of HIV/AIDS from a gender perspective.

It must be noted that there is no blueprint for conducting qualitative research. However, the availability of rigorous methods for qualitative inquiry can help us to understand life in ways that consider the views, feelings, and lived experiences of other people (Ulin *et*

*al*, 2002). It should be noted that although qualitative analysis can answer questions about how people make sense of the world, it can also address many objective dimensions of human action and interaction, relating these findings to the context in which they occur (Ulin *et al*, 2002).

### **3.2.5 Data analysis**

In Clayfield it emerged that the problems central to the study of sexual relations are deeply embedded in people's cultural context. Each individual is constantly confronted with decisions and challenges that are conditioned by their "membership" to this community and the Indian community at large. The issues of whether or not to engage in protected sex, to use contraception, and how to provide young people with the skills and confidence they will need to achieve and maintain a healthy adulthood, had at their core the pervasive influence of gender; a theme that constantly resonated in the voices of men and women that were interviewed as part of this research.

The fact that people differ in the ways that they interpret and act on ordinary everyday situations has profound implications for sexual and gender research, especially in the field of HIV/AIDS. If it is true that what people define as real, is also real in its consequences, then applied research into sexuality and gender relations should have the capacity to uncover multiple perspectives into understanding the implications for sexual decision-making (Ulin *et al*, 2002).

As with the research undertaken, I deduced that qualitative research accepts that there are always two key players: the participant who contributes and provides the information, and the researcher who, as learner and co-interpreter, guides the process towards the knowledge that is being sought. Together they form a partnership that explores different social understandings of reality. Creating a qualitative research partnership requires a high level of skill. It also carries with it profound ethical obligations because it is a relationship based on trust and mutual understanding of a common goal (Ulin *et al*, 2002).

The interview questions (**Annexure 2**) were devised in such a fashion so as to elicit responses from interviewees with regard to their perceptions of gender and sexuality and what role(s) these aspects played in contributing to the spread of HIV/AIDS. In the next chapter, I will go into a detailed analysis of the data that was uncovered from my one-on-one interviews with the residents of Clayfield, Phoenix.

### **3.2.6 Research ethics**

Due regard was given to privacy and confidentiality in the undertaking of my research as well as to its execution and data collection. Thus, the ethics of research undertakings, such as those mentioned, were adhered to at all times. I explained the notion of “in-depth” to the interviewees, as well as the reasons for such research. Interviewees then consented to being part of the research being conducted and to being interviewed by filling in and signing an ethical clearance document (**Annexure 1**) stating that they were indeed residents of Clayfield and that they had no objections to, and/or reservations to being interviewed and re-questioned (if necessary).

It was further explained to the interviewees that should they be quoted in this study, that a pseudonym would be used to articulate their viewpoints. The actual questionnaire that was used did not require the participants’ real names to be revealed. Only the “Ethical Clearance” document required that the participants acknowledge and agree to be a part of the study. None of the participants had any objection to signing the ethical clearance document. They also had no objections to their interviews being voice-recorded. The voice recordings did not divulge the names of the individuals either. Pseudonyms were used for each person that was interviewed. Thus, the ethics of privacy, confidentiality and anonymity (Neumann, 1997) were strictly observed at all times. I also ensured that even in situations where I interviewed both husband and wife, that each was interviewed privately, without the other being within earshot. Ensuring these confidential conditions and setting was crucial in order to elicit ‘honest’ responses, but also to ensure that neither of them felt intimidated, or feared victimisation because of their responses, and how their respective spouses would perceive these responses.

By explaining the purposes of my study to the group, as well as explaining the importance of their responses, they were provided with information that allowed them to give me “informed consent”, with which to continue interviewing them. “Informed consent”, as opposed to mere “consent” is crucial to a research study since participants need to be given details and information that allows them to make an informed decision to be a part of a study, or not. Refusal to be a part of a study is always the individual’s prerogative, and should be respected as such.

Ethical considerations are also crucial, even after the study is finalised. I assured my study group that once my dissertation was complete and the data findings were recorded, I would report back to them. In the following chapter, I focus on an analysis of collected data.

## CHAPTER 4

### DATA ANALYSIS AND DISCUSSION

#### 4.1 Introduction

This chapter offers a discussion of my fieldwork, and my interactions with the residents of Clayfield, with particular reference to data collected on gender vulnerabilities and inequalities, and how these factors contribute to aiding the spread of HIV/AIDS. The chapter draws largely from the intensive interviews conducted with my focus group in Clayfield. These in-depth interviews allowed me to interact closely with the study group (who were residents of Clayfield) and to elicit their thoughts and perceptions around HIV/AIDS from a gender perspective. In order to best reflect and illustrate the experiences, ideologies and perceptions of the respondents, their responses are cited verbatim. Since the community of Clayfield comprises predominantly residents that belong to the Indian community, all of the individuals that were interviewed for the purposes of this study are of Indian descent.

In order to gain a better understanding of the contraction and transmission of HIV/AIDS from a gender perspective, it is necessary to grant due consideration to socially and culturally constructed norms and roles. These elements of gender relations go hand in glove and can, therefore, not be divorced from one another if the aim is to achieve a holistic understanding of gender roles and constructs. This chapter explores the following aspects: gender equality; the use of condoms and the practice of 'safe sex'; sexuality and masculinity; access to healthcare; domestic violence, and the 'silences' around HIV/AIDS.

#### 4.2 The prevalence of gender inequalities and vulnerabilities

My in-depth interviews and interactions with the participants of the study revealed the history of gender roles and constructs within Clayfield. Men were raised to be the breadwinners of the families and women were raised to be the primary caregivers, to



raise the children, and be submissive wives. However, the younger generation of respondents disagreed that this is still the case. They contend that gender roles have evolved. The escalation in the cost of living has made it necessary for both parents to work, and now mothers are not only caregivers, but in some instances, also the co-breadwinners of the families. The following interviews reflect the actual spoken words of participants, and have not been edited for grammatical accuracy.

It was interesting to note that some of the male respondents were of the view that 'gender' referred to females only:

Interviewer: Do you think that gender roles and responsibilities are important in understanding how HIV/AIDS spreads?

Deva: Why you asking me about gender when it's women's issues. You must ask the ladies that, they know better about these things.

Shane: We men can't answer questions about women. This gender thing is about the woman folk, isn't?

Eighty percent of both the male and female respondents interviewed felt that men and women are still treated differently. They are of the view that men still want to be seen as the stronger sex, and as a result they are treated as such. Furthermore, the majority of the respondents felt that men still hold positions of authority and status professionally, in comparison to women, and subsequently they feel that they should be shown respect for being sole breadwinners:

Siva: Men are still given more powers than women. Men are still given top posts at work.

Amy: Men are always given everything of the best. Sometimes they are treated like gods, their wives must just bow down to them.

Lolly: Because men are physically strong they think that they are like kings in their homes. We must just worship them and whatever they say us to do.

Michelle: Men always think they are the boss and women are their servants. We women must learn to stand up for ourselves.

Sue: Men are always classified as the superior being. In regards to the norm of life men always feel that they can dominate women. I feel that women should now take a stand. Sometimes I feel that some men need a good kick to put them right.

Women are still expected to be "barefoot and pregnant and chained to the kitchen sink",

as one resident expressed. The problem is that women have allowed men to define and dictate what a 'good woman' should be, and women dedicated their time and energy to living up to this male-constructed definition. Furthermore, if a woman decides to work and become more economically independent, then she is regarded as being domineering and wanting to undermine her husband:

Deva: No wife of mine is going to work. My father managed to support us and my mother and we turned out okay. Just now, when you let the woman folk work they think that they are like the man. Then they want to ride on your head [meaning that they would overpower the man].

This view illustrates the subservient role that women are still expected to fulfil. Some men would rather endure the hardships of 'making ends meet' financially in their homes than allowing their wives to work, earn an income, and positively contribute to the financial status of their families.

Some of the women expressed the view that because women are not as physically strong as their male counterparts, that men misconstrued this as being a weakness on the part of women. Female respondents felt that being emotionally strong far outweighed physical strength. They also felt that they were not respected enough in their homes as homemakers and caregivers:

Devi: Men think that women are weak and can't be independent, that's why they treat us badly. They don't know how strong we can be. Maybe we can't pick up heavy things like them, but they must try giving birth to a child, then they know what being strong really is.

Lolly: Women are better and stronger emotionally. We can endure more pain than any man can.

However, some of the responses indicated that all may not be lost and that the tides are slowly changing; women are in fact seeking to empower themselves and stand up for their rights:

Diane: Some females are no longer standing behind a closed curtain. Women are now starting to take a stand in whatever they do or say.

Michelle: Men can't carry on thinking that they are always the boss. Things are changing. Women are standing up for their rights and are becoming more career wise and

standing up for themselves.

Vani: Women are starting to get empowered these days. I will tell my daughter that she must study and get an education so that she can stand on her own two feet so that no man can treat her badly and kick her around.

As cited above, the female respondents, in particular, echoed that in order for there to be gender equality, education was of paramount importance. They felt that as long as young women and girls could educate themselves, then they would be independent. This empowerment would result in them being treated with dignity and respect. Education also affords women opportunities to release themselves from abusive environments, and female respondents also felt that if the men in their lives knew that their female partners were educated, then they would not take them for granted.

I concur with Eka Esu-Williams (2000: 124) when she states:

The reality of the situation is that women's vulnerability to HIV/AIDS and the impact of HIV/AIDS on their lives spans across nearly their entire lives.

I recognise that men and boys also face economic and cultural pressures, and that these factors also put them at risk of contracting HIV/AIDS. But they experience these forces alongside their mothers, sisters, and wives, who tend to be affected even more than them. Because society places fewer restrictions on men and is 'kind' enough to afford them opportunities to find solutions to these problems, their lives are much easier than those of their female counterparts (Esu-Williams, 2000).

#### **4.3 Condomising and ensuring that sex is safe**

Women's avoidance of condoms may be interpreted as a psychosocial and economic strategy to maintain self-esteem and economic stability in their homes. By denying the risk of HIV infection and shunning protected sex, women create both a public and a personal image of being in secure, trustworthy, and monogamous marriages and sexual relationships. By admitting that condoms are required, women would in fact be alluding to their steady partners' and husbands' infidelities, and this would lead to the women's personal humiliation and loss of dignity (Varga, 2000).

A total of 85% of the individuals interviewed were of the view that it is primarily the women that are responsible for ensuring that sex is safe. Some remarked that men did not care whether sex was safe or not, as long as they were 'getting' it. One female respondent remarked that if women did not take the initiative to use contraception, then "every time [they] engaged in sex" she would fall pregnant.

Devi: Women are responsible for decision-making when it comes to matters of sex. A man can't be bothered whether you fall pregnant or not, he just wants to have sex all the time. I planned all three of my children. If I left this decision to my husband I would fall pregnant every time we engaged in sex. I think that men just don't care about these things.

Others felt that men were of the opinion that it is the woman's duty to ensure that sex is safe, and if she does not do so, then it is assumed that she has no problems with unprotected sex.

Lolly: Men lack the responsibility to initiate safe sex, so it is the woman's duty to make sure that she is having protected sex. If the man doesn't wear a condom it means that the woman is also fine with that.

The status accorded to women in Indian societies makes it difficult for most of them to speak openly about sexuality, and to make empowered decisions about safer sex. Many women have also been conditioned to have negative perceptions about their own sexuality (Kaur, 1994).

A total of 80% of the individuals interviewed were of the view that Indian men are not amenable to using a condom before engaging in sexual intercourse. They cited that men feel that the condom hinders their sexual performance:

Jaya: Condoms just spoil the whole action. When men use condoms they don't perform to their best. The condom stops a man from giving it his all. He is not in top performance.

Vani: I feel that if you ask a man to use a condom then you must be ready to accept that he is not going to be at his best with you. A condom is just clumsy and it stops the man from going all out for you.

The male respondents also felt that they could not sufficiently satisfy their partners

sexually if they wore a condom, because then the women would not be able to “feel [them] as men”. Furthermore, the men that were interviewed felt that the use of a condom did not give them adequate sexual gratification. As a result, if their partner insisted on them wearing a condom before engaging in sexual intercourse, they would seek sexual gratification from someone who did not insist on the use of a condom:

Shane: Hey, I don't like wearing a condom at all. I feel that the touch issue is very important. If my woman can't feel me as a man, then she can't be satisfied. That's why I don't smark [meaning like] using a condom. Also, I reckon that if my woman asks me to use a condom then I rather go by someone who wants to feel me directly. You know what I mean?

This discovery has far-reaching implications for the spread of HIV/AIDS. If these men do indeed engage in unprotected sexual intercourse, their potential to infect their partners is phenomenal, and this is further exacerbated by their disregard for faithfulness to one sexual partner (even if it is their own wife). Women's subordinate positions (both economically and sexually) in their households and relationships means that they are often willing to accept their partners' statements of faithfulness at face value, and this expectation of trust contributes to women's reluctance to request and insist upon safer sex (Manderson, 1999). Their economic responsibilities to other members in their families and their children may also force them to make decisions that are sometimes detrimental to their health and well-being. For example, women who fear desertion and abandonment by their husbands or partners may feel that they are in a weaker position to negotiate safer sexual practices.

One female from my study group believed that she could tell, just by looking at her husband, whether or not he had an STI or HIV/AIDS:

Premi: My husband is very clean. If he has any of those diseases, even AIDS, I will be able to tell by just looking at him.

The view expressed by this participant illustrates just one of the many misconceptions and inaccuracies surrounding HIV infection. This statement suggests that some people believe that physical appearances can confirm whether or not a person is infected by the disease. Such a fallacy is potentially dangerous because women or men may

engage in unprotected sexual intercourse after 'gauging' the outward appearance of a person to assess their HIV status.

Manderson (1999: 84) echoes the sentiments 'voiced' in the above citation when he writes:

[...] women and men both frequently claim to be able to choose 'clean' and 'healthy' sexual partners, and believe that infection can be visually detected on the external body. Choice of partners and preparedness (or not) to use condoms by men as well as women is influenced by beliefs that STDs are visible or can be determined by personal familiarity with prospective partners or by their appearance (being clean and well-dressed).

Women often cannot negotiate safer sex or leave their partners because of social and cultural norms, as well as economic dependency. Those norms that promote motherhood as the ideal form of self-worth and identity for women increase their vulnerability to HIV infection. It also constrains reproductive choices for HIV-positive women. Double standards about chastity and fidelity means that many monogamous married women have been powerless to avoid being infected by their husbands (UNAIDS, 1999).

#### **4.4 The right to say 'no' to sex**

An alarming total of 75% of the individuals (both male and female) interviewed believed that women could not refuse to have sex with "their" respective men, or dared not refuse for fear of the consequences of such refusal. Women were afraid that if they refused to have sex with their partners, the men would seek sexual gratification elsewhere. This has the potential to be very hazardous, since these men were – in all probability – having unprotected sex and could infect their sexual partners with HIV, should the men themselves have been infected:

Siva: If I want to have sex then my wife knows that she can't say 'no' because that's like she is being rude to me and this makes me very cross [meaning angry]. She knows that a wife can't say 'no' to her husband; it's like she is telling me to get lost. If she did this then it can make my head turn and I don't know what I might do to her if she turned me down.

Michelle: Men are egotistical and because of this women are afraid to say 'no' to sex with

their husbands. Even if she doesn't want it, she rather pretend like she wants it because otherwise her husband might hit her sometimes. That's why most of the time the woman just agrees. She feels that she rather pretend than saying 'no' because if she says 'no' her husband won't think twice about going somewhere else to get sex. We do it mostly just to keep our husbands from going to other women for sex. Men have to have sex. We women can do without it.

The women also felt that they could not refuse their partners sex. Such refusal would result in the men questioning their faithfulness and questioning whether they were getting sex elsewhere. In their minds, if their wives or girlfriends were in fact 'sleeping around', then that would explain why they were not interested in having sexual intercourse with them. The men interviewed did feel that if their partners refused to have sexual intercourse with them, then that was an indication that they were being unfaithful. The men also felt that their partners' refusals to engage in sexual intercourse would ultimately lead to the men seeking sexual gratification from other sources.

Vani: Most women just have sex with their men to please them. If she says 'no' he might think that she has someone else. This can cause a lot of problems. If the woman says 'no' all the time the man might think that she has outside interests.

Shane: If I am constantly turned down by my wife then I'll find it somewhere else, because if she is saying 'no' to me then she must also be cheating on me, so why can't I do the same. This is what leads men to have affairs out of their marriages.

Lolly: If you refuse to have sex with your man you can bet that he'll get it from someone else. Then he'll get infected with AIDS and infect you. That is why sometimes sex becomes an obligation in a marriage; whether you want to do it or not, as women you just give in to avoid problems.

As indicated in the quotes above, most of the women of Clayfield felt shackled when it came to refusing to have sexual intercourse with their partners. Their partners were then liable to seek sexual gratification and fulfilment from other women, and if they were engaging in unprotected sexual intercourse, this form of risky behaviour could result in the men infecting their partners with HIV, in the event that they had themselves become infected.

#### **4.5 The prevalence of domestic violence in the community**

In addition to the culture of silence surrounding sexuality and HIV/AIDS, violence within relationships and marriages also exposes women and girls to a higher risk of HIV

infection. Violence against women in Southern Africa is deeply embedded in the history of the subregion. It is rooted in poverty and political instability, in the legacy of civil wars, apartheid, and indigenous patriarchy (UNAIDS / The Global Coalition on Women and AIDS, 2004). Clayfield, by admission of my study group, is for all intents and purposes still a patriarchal community where the man, as one respondent puts it “runs the show”.

We acknowledge that violence and HIV are mutually dependent. Violence can lead to infection, either directly through the act of rape, or indirectly by predisposing women to risk-taking behaviour later on in their lives (UNAIDS/The Global Coalition on Women and AIDS, 2004). Given the high incidence of sexual violence in South Africa, the implications are devastating. Throughout the subregion, evidence suggests that abused girls and women are much more likely to engage in high-risk sex. Thus, engaging in risky behaviour is seen more as a cry for help. The blame that they encounter for such behaviour is outweighed by their need for help (UNAIDS/The Global Coalition on Women and AIDS, 2004). One respondent submitted that, if a woman is physically abused at home, she may indulge in risky behaviour just to spite their husband:

Shane: I can say that domestic violence is not very high in this area. But if a man assaults his wife she might 'sleep around' just to spite him. Sometimes this could result in her getting HIV/AIDS and then giving it to her husband.

A total of 90% of the respondents interviewed were of the view that domestic violence in the community was moderate. They did, however, acknowledge that such a view could be misleading since people in the community were relatively private, and that the prevalence of domestic violence in the community would not be common knowledge.

The respondents did agree that domestic violence has the potential to exacerbate the spread of the epidemic. If a woman is constantly abused, be it physically or emotionally, she will seek solace elsewhere. This could also include sexual solace, which would then have the potential to contribute to the infection rate of HIV/AIDS:

Devi: Domestic violence in this area is not very high. But if a woman is physically abused all the time then she might try to find comfort somewhere else. This could mean that she will be with another man [meaning that she will engage in sexual



intercourse with another man]. Like this she can even get HIV/AIDS and then give it to her husband.

Some female respondents indicated that if a husband constantly assaults his wife, becomes frustrated with her, and eventually grows to detest her, he will seek sexual gratification elsewhere:

Lolly: When a man constantly physically abuses his wife, even if she did nothing wrong, he becomes so frustrated that he just seeks a sexual outlet somewhere else whilst the poor woman is left at home to deal with being abused. This means then he abuses her physically by hitting her and he then abuses her emotionally by sleeping around.

There are instances where females are held responsible for the violence they suffer. They are blamed for dressing provocatively or for 'inviting' rape and abuse by being too 'modern' in their demeanour (UNAIDS/The Global Coalition on Women and AIDS, 2004). A respondent made the following remark:

Siva: Sometimes women ask for it [meaning sexual abuse]. They dress up with short skirts and tops. They know that this drives men wild so I think that they are asking to be raped or abused. I am sure that they [women] are also aware of this, but they don't care. So they end up getting what they deserve and asked for. Decent women don't dress up showing half their bodies.

Women are also blamed for provoking violence when, for example, they neglect their household chores, do not pay sufficient attention to their children, or refuse to have sex with their husbands or partners. When asked whether there are any circumstances or conditions that justify domestic violence, one male respondent stated that he thought that women should just "do as they are told by their husbands," if they did not wish to be beaten. This, he remarked "[...] included refusing to sexually satisfy her husband". He concluded by stating "that is their lot in life as women and they should just accept it". When asked whether he physically abused his wife, the same respondent replied: "Not up until now, but I cannot answer for what lies in the future."

This response is disturbing, since it indicates that – for this household – there is a potential for domestic violence in the future. It is rather unfortunate that some men feel that in order to assert themselves with their wives and partners there is a need to resort to violence. Effective communication skills are an avenue that is evidently not

adequately explored as an option to solve problems and address disagreements.

Men's need to assert themselves and feel like 'real men' is covered in the next section on masculinity.

#### **4.6 Masculinity and the need to 'feel like a man'**

This section outlines men's and women's views and perceptions regarding the male image and men's need to be dominant. Men tend to wear their masculinity and 'macho' images like badges that are coveted. If anyone threatens this image, then the consequences are almost primal; the man acts like a wild animal jealously guarding its territory.

Ninety percent of all the individuals interviewed echoed a similar sentiment, that it was important for a man to uphold this 'macho' image in his community. He needs to feel like and be treated as the head of his household, and be the boss or the king of his own little kingdom – his home and family. It is important to men that their community perceives them as men who are in control of their environments and 'subjects'. Some of the respondents remarked that the macho image that men try to uphold is also a personal mindset, which is determined by how often they are able to engage in sexual intercourse:

Shane: Men have to make others know that he wears the pants in the marriage. This gets him the respect of others. It is embarrassing for a man if others think that there is 'petticoat government' in his house [implying that the woman is in charge].

Amy: A man wants to always feel like his on top so that all the women will fall for him. Once the women start falling for him, then he will sleep with as many of them as he can.

Jaya: It's important for a man to show that he has authority over his wife and his house. This is a status symbol that will make others respect him. This is what I call 'manly pride' and it is very important to a man – it is what makes him a man. So if anyone threatens his image a man can even become violent.

Some of the female respondents felt that men have an uncontrollable sex drive that knows no bounds. They felt that men cannot survive without sex, and the more they

engage in sexual activity, the more they feel like 'real' men. McDowell (2002) asserts that sex is not a primal response, but that the action is constructed in our minds. It is not an involuntary response to a primal instinct; instead, we process the choice of engaging in sexual activity in our brains. He, therefore, argues that sex is not an uncontrollable urge, but is actually a choice. Lolly expresses her view that sex is an uncontrollable urge for men as follows:

Lolly: To a man his image is everything. He walks around with the 'I'm the man' attitude and the more often he has sex, the more of a man he feels like. Men just cannot do without sex. It is an urge that they have no control over and we women pay the price.

At a workshop on sexual harassment that I conducted in Durban in 2004, a male participant voiced his opinion that there is a part of the male brain that conditions a man to think and feel that he is unable to survive without sex and sexual gratification. He stated that women "give off" a certain pheromone that initiates a chemical reaction in a man's brain, and which makes sex an irresistible urge. I was amazed, to say the least, that this trend of thought existed with regard to the perceptions around male sexuality and the male libido.

Foreman (1998) holds the view that men drive the global HIV/AIDS epidemic. He submits that because men have more sexual partners than women, and because men tend to control the frequency and 'form' of sexual intercourse – coupled with women's physiological susceptibility to the virus – it is men's behaviour that determines how quickly, and to whom, the HI-virus is spread. This does not imply that men are responsible for the AIDS pandemic; men are also at risk of infection since they cannot transmit the virus to others unless they contract it themselves.

#### **4.7 Equality in the way children are raised**

A total of 80% of the individuals interviewed were of the opinion that the boys and girls in the community are raised differently. On the one hand, most of the respondents felt that boys are given more leeway and freedom to socialise and go out with friends. Girls,

on the other hand, are raised strictly and granted very little freedom to socialise and go out with friends, especially after they reach puberty. Parents are afraid that if they grant their daughters the opportunity to go out, then the girls might fall pregnant and bring the family into disrepute:

Jaya: Girls are not given freedom like boys. Parents feel that boys are more capable of taking care of themselves. Boys are boys they can rough it out. When girls are given freedom they can go and get themselves pregnant, that is why you must be strict with them. Boys can't bring this shame to their family.

Michelle: You can't trust today's girls. They can just sleep around and fall pregnant, then they are left with the baby and the boy doesn't want them anymore. That is why girls must be brought up very strictly so that they will not bring this shame to the family name.

Some of the respondents felt that girls are raised with the notion that 'sex is inherently bad'. The girls are indoctrinated with this perception, with the result that they investigate for themselves whether or not this notion is true. The very idea that was intended to deter girls from engaging in premarital sex in the first place has the opposite effect, and instead promotes sex. The girls are curious to find out for themselves whether or not sexual intercourse is pleasurable.

Vani: Our girls are brought up very conservatively where they are taught that sex is taboo and you don't even speak about it to your parents. If you spoke to your parents about sex then to them it meant that you were in fact sleeping around. In this way girls were victimised and they got their revenge by falling pregnant before getting married.

Shane: Girls are brought up thinking that sex is bad. Boys are given more freedom. They can go out 'til late hours partying with their friends. But because the girls are brought up so strict, when there is a chance for them to go out then they over do it. When they go out to school functions, like debs balls, then they go out in the hired taxis and experiment with sex. This can be dangerous, since they can get infected with HIV and also fall pregnant.

These views illustrate that the parents' attempts to raise their daughters strictly, often results in the opposite occurring. The girls experiment with their sexuality, since to them unprotected sexual intercourse appears to be alluring and exciting. It is almost synonymous with an exploration of the unknown, a challenge to and a countering of socially constructed repression.

#### 4.8 Access to education and healthcare

Given their access to antenatal services, women are often the first to be tested for HIV. When women discover that they are indeed HIV positive, they are routinely blamed for introducing the disease into the household or community, even though their husbands or partners may have been the true source of the infection (UNAIDS/The Global Coalition on Women and AIDS, 2004).

Ninety percent of the respondents interviewed were of the view that both men and women have “more or less” equal access to education and healthcare facilities. The operative words in these submissions are “more or less”. When questioned what they meant, some of the respondents stated that “[...] there is equal access sometimes, (but) not all of the time.” These responses indicated that even though provincial healthcare facilities such as the local clinics and the Mahatma Gandhi Memorial Hospital were easily accessible, women still experienced barriers to accessing treatment and health care. The joint report by UNAIDS and The Global Coalition on Women and AIDS (2004) states that many women still face significant gender-based barriers to treatment, including stigma, discrimination, and even violence. The stigma attached to HIV/AIDS affects men and women differently. While both sexes are likely to face discrimination because they are living with HIV/AIDS, women are more likely to be held responsible for introducing it into their families and communities. Many women fear that stigma will lead to violence once their HIV-status is disclosed, and so avoid being tested or seeking treatment (UNAIDS/The Global Coalition on Women and AIDS, 2004).

However, even though there may be “more or less” equal access to the healthcare facilities in the community, some respondents felt that men generally shy away from having themselves examined at these institutions. This is possibly because they feel that this would be acknowledging that something physical is wrong with them and that this would cause them embarrassment in the community. They would then feel like lesser men. Some of the female respondents mentioned that the men lacked responsibility for their health and well-being:

Sue: Healthcare is easily available to both men and women. We have the clinics and the Gandhi Hospital near us. But the men folk don't like to have themselves checked up. They feel that a man should not get sick all the time and go to the doctors and hospital. They leave it until they get very sick then they go to the doctors or hospital.

Dianne: All of us in this area have easy access to the clinics and hospitals. Gandhi Hospital is just up the road and all the taxis drop you right outside the hospital gates, so no one can make the excuse that they can't go to the hospital. Gandhi's [meaning the Mahatma Gandhi Memorial Hospital] is also free of charge. But the men, I don't know, they are very funny with their health. They rather suffer and stay than letting others know that something is wrong with them. Even if they are going just to check themselves at the hospital or clinic, they feel that it is a disgrace if others find out. They rather take medicines and stay at home.

These quotes indicate that even ailing men seldom access readily available healthcare facilities in order to sustain an image of health and well-being. Should some men become infected with HIV/AIDS, they would not realise it during the early stages of infection because of their apathy towards their health. By implication then, they would wait for the symptoms to be severe before having themselves examined by a health practitioner. This indicates that certain men could be infected with the disease without knowing it, and could be engaging in unprotected sexual intercourse, and be infecting other innocent women.

Some of the women interviewed stated that even though healthcare facilities, such as the local clinics in Phoenix, and the Mahatma Gandhi Memorial Hospital, were easily accessible in terms of distance and availability of public transport, they could not just "up and go", since they had little children to care for while their husbands were at work. They saw their roles as mothers as a possible problem in readily and speedily accessing the services of a doctor or the provincial hospital. One woman emphatically commented: "Where am I to leave my child? I can't drag him with me to the hospital."

Manderson (1999) states that, women may not be able to readily seek medical advice or treatment, since they may lack the financial resources needed to cover transport and treatment costs. He also mentions that domestic responsibilities, including caring for children, could restrict women's mobility and the time available to them to seek healthcare.

Many Southern African NGOs report that stigma is often a prelude to violence, especially with regard to women who disclose their HIV status and are targeted for abuse, and even killed in some cases. One such case was Gugu Dlamini. This HIV martyr was stoned to death in December 1998 by her community in KwaZulu-Natal when she disclosed that she was HIV positive. This leads me to the next section in the analysis of data, which looks at issues relevant to the silences around HIV/AIDS, and also the disclosure of a person's HIV status.

#### **4.9 The silences regarding the disease**

The ethical principles of confidentiality and informed consent, which have private and public health benefits, should be clearly distinguished from 'secrecy', which is a state of affairs often resulting from fear, shame, and/or a sense of vulnerability (UNAIDS, 2000). Whether or not secrecy is maintained depends solely on the personal motives of those who hold the secret. Motives to maintain secrecy in the context of HIV/AIDS involve not only fear and shame, but also denial of possible infection and fear of rejection, as well as a fear of stigma and discrimination. When the degree of secrecy harms the infected and the uninfected, and undermines an individual's or community's ability to cope positively with the disease, it should be strongly combated (UNAIDS, 2000). UNAIDS and WHO are of the opinion that the secrecy surrounding the epidemic, the related stigma, denial, and discrimination, can best be countered by a greatly increased commitment to beneficial disclosure, ethical partner counselling, and appropriate use of HIV case-reporting.

Furthermore, fear, stress, depression, isolation, and feeling unable to cope, adversely affects physically healthy people. Moreover, people who are ill or find themselves in situations in which they feel that they have no control tend to shroud themselves in a cloak of secrecy. Women are particularly susceptible to stress and depression (Berer and Ray, 1993). The rejection and discrimination experienced by many people living with the HI-virus can exacerbate these problems, and often stops women from speaking to anyone or from seeking help (Berer and Ray, 1993).

The respondents felt that people refuse to be tested simply because they are afraid to find out what their HIV status is. An HIV-positive status would mean that they would be constantly demeaned and embarrassed. The community will ostracise them for “life”. Also, the Indian community does not readily speak about issues regarding sexual activity and STIs. If you do speak out about these matters, then you are considered promiscuous. In addition, people do not speak about the disease because they do not want to “rock the boat”. In this instance, ignorance is bliss.

Vani: We are brought up being taught that sex is taboo and you never speak about it, especially to your parents and elders. If you spoke about sexual things then you were thought to be loose [meaning promiscuous]. The same thing applies to HIV/AIDS, you don't speak about it, unless you want people to think that either you are loose or that you got the disease.

Dianne: Us being Indians, we just don't speak about these things. Sex and HIV/AIDS is something you just keep to yourself.

Shane: There is a lot of shame and embarrassment surrounding HIV/AIDS. Among the Indian community HIV is directly associated with sex and people shy away from speaking about anything that is sexual in nature. If a child, for example, speaks to the parent about HIV/AIDS then the parents automatically think that their children are sleeping around and having their own ways. They then feel like failures as parents for raising such bad children.

Jaya: The relationship that Indian children have with their parents is very restricted and you don't talk about sex and HIV/AIDS with your parents, let alone anyone else. So there seems to be a culture of silence that continues on and on.

Premi: HIV/AIDS brings with it a lot of shame. HIV/AIDS is considered to be a killer disease and people feel that if they even suspect that they could be infected and they then speak about the disease, then it is like they are already acknowledging death.

The above views indicate that the silences surrounding HIV/AIDS are deep-rooted and that people would rather live with the disease, and die of AIDS than seek help. Furthermore, it is taboo for parents to speak to their children about sexual intercourse and sexuality, since they are of the view that if such conversations and discussions are entertained, then their children will resort to promiscuous behaviour. The reality, however, is that by shying away from such conversations and discussions the opposite occurs and their children engage in unprotected sexual intercourse. The silence around sex and sexuality drives teenagers into the exploration of what they deem to be the unknown.



Some respondents voiced the opinion that people are afraid to speak out about HIV/AIDS because they are afraid of their own reactions should they discover that they are HIV positive. They might even become enraged by the news of their positive status and venture out to deliberately infect others:

Michelle: People are afraid to even mention HIV/AIDS, let alone their status. I feel that if they find out that they are HIV positive, then they might just go out and deliberately infect others out of anger and rage. The community even behaviours terribly towards HIV-positive people, thinking that if they even just sit with or talk to them they will become infected.

#### **4.10 The major cause of HIV transmission in the community**

A total of 90% of the respondents cited unprotected sex and infidelity as the major factors that fuelled the spread of HIV/AIDS in the community. However, they cited these factors as a result of gender imbalances. This refers to the fact that infidelity is dominant among men, while women are expected to remain faithful in their respective marriages and relationships. In this regard, 80% of the respondents were of the view that if men and women were treated equally, then issues such as male dominance and gender inequalities, even within families, could be addressed. This would then have a positive effect in reducing the contraction and transmission of the disease.

Premi: It is okay for men to have multiple sexual partners and women must remain faithful 'til they die. If men and women are treated equally then this would help to reduce the spread of HIV/AIDS. I am not saying that women should be allowed to sleep around and have multiple sexual partners, I am just saying that men and women should be treated equally. What is good for the goose should also be good for the gander.

Lolly: You find that men especially have extra-marital affairs. They sleep around and don't protect themselves. Then they get infected and in turn infect their innocent wives. But if the tables were turned and it was the wives that were having the affairs and infecting their husbands, all hell would break loose. I think that this double standards need to be addressed and men and women should be treated the same if we wish to fight this disease and win.

Michelle: Our sons and daughters are raised differently. So from an early age they are taught that it is okay for boys to do as they please and for girls to just accept this. The girls then grow up and the same thing happens in their marriages – their husbands do as they please and the wife must just stand by and watch. So even if he is sleeping around and having unprotected sex and comes back and infects her she must just accept it. This is nonsense in my opinion. I think that if we want to fight this disease then we need to begin with ourselves. First, we must raise our sons

and daughters the same, so that they would also grow up and be treated the same. They will be equal and you need this sort of unity in treatment if you want to beat HIV/AIDS. We all need to stand together as one. We cannot be fighting ourselves and fighting a killer disease at the same time.

The above views indicate that gender inequality is prevalent in this community. It was also expressed that for the fight against HIV/AIDS to be effective, boys and girls need to be raised and treated equally. Discrepancies relating to issues of gender inequality permeate throughout the lives of children. When they mature into adults, they continue to think that gender inequality is the accepted norm, since this is the way they were raised. In order for the disease to be tackled effectively, the very foundation of how children are raised needs to be addressed. We need to ensure that boys and girls are treated equally and are confident about their sexuality, aspects confirmed by the citations above which suggest that social construction and socialisation in particular plays an important role.

#### **4.11 Conclusion**

The Indian community, as may be deduced from this sample, tends to raise their sons and daughters differently. Boys are generally given more freedom and leeway to socialise and go out with their friends, while girls are raised very conservatively, especially once they have reached puberty. Parents are afraid of unwanted pregnancies and marry their daughters off to the father of the baby as soon as possible after they realise their daughter is pregnant.

Girls continue to explore their freedom and seek their true identities without their parents' knowledge. Parents in turn are disgusted with any form of behaviour that results in others perceiving their daughters as being promiscuous, and they are sometimes so consumed with what "others would say and think", that they raise their children (especially their daughters) in a manner that could paradoxically have serious negative repercussions, for example teen pregnancy.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

As mentioned throughout this study, women are particularly vulnerable to the contraction and transmission of HIV/AIDS because of factors such as gender inequalities and vulnerabilities, which contribute to the spread of the disease. South Africa has been identified as the epicentre of the HIV/AIDS pandemic, as well as being the country where the epidemic is developing the fastest in the world (Walker *et al*, 2004). South African women, in particular, are therefore susceptible to HIV infection.

At the end of the fifth International Conference on women held in Beijing, China, a document was drawn up that endorsed women's rights to have control over and make responsible decisions with regard to matters relating to their sexuality, including sexual and reproductive health, discrimination, and violence (AIDS Law Project, 2004). The fight against HIV and AIDS can only be successful, if women's rights are respected and the position of women in our society is strengthened.

According to Tallis (1998), the inequality between men and women, particularly when negotiating sexual relations, makes women especially vulnerable. I concur with Tallis that those women who contract HIV are more likely to face stigmatisation and social rejection than men, and such treatment further reinforces gender inequality. By tackling these inequities, the voluntary sector needs to adopt new approaches when implementing programmes to combat the spread of the disease. This should include a shift from generalised education about HIV/AIDS, to programmes that target specific groups, such as rural women, women from poor to medium-class suburbs (like Clayfield, Phoenix), and all groups of men.

From the outset, this study discussed and critiqued how gender inequalities and vulnerabilities contributed to fuelling the spread of HIV/AIDS, and more specifically how these factors aided in the spread of the disease in an area north of Durban, called Clayfield. Through intensive one-on-one interviews and discussions with my study

group in Clayfield, I was able to link certain aspects relating to gender, such as sex, sexuality, condom use, power relations, and masculinity, to gender inequality and vulnerabilities.

Earlier chapters focused on the numerous factors that contributed, first to the imbalances in gender relations and sexuality, and then to gender vulnerabilities, and how the interplay between these elements contributed to exacerbating the spread of HIV/AIDS (cf. **Chapters 2 and 3**). **Chapter 2** focused on the socio-economic and physiological vulnerabilities of women and how culture and condom use (or rather the lack thereof) played a part with regard to gender inequalities and vulnerabilities, which in turn increased the spread of HIV/AIDS. **Chapter 3** highlighted integral issues such as: the intersection between sexuality and masculinity; gender-based violence within patriarchal societies; fidelity versus multiple partners; access to education and healthcare services, and the increasing burden of care being placed on the shoulders of women. These issues, it was argued, were all very significant to gender imbalances and vulnerabilities that render women susceptible to HIV infection. **Chapter 4** profiled pertinent ideas emerging from my sample by accessing the views of some of my participants. I now suggest a few recommendations that could address gender inequalities and vulnerabilities, with the aim of curbing the spread of the pandemic.

## **5.1 Providing effective healthcare within resource constraints**

According to Drysdale (2002), the initial thrust of the response to the HIV epidemic focused entirely on prevention. This was not so much out of choice, as out of necessity, since there were no treatments available. Recently, however, treatments have become available that may impede the advance of the disease (triple therapy or HAART), or substantially reduce the chances of acquiring it in the first place (ARVs in pregnancy).

Furthermore, a great deal of experience and knowledge has been accumulated with reference to managing many conditions associated with early HIV infection. However, in developing countries, such as South Africa, the implementation of these treatments has been slow, or in most cases non-existent. The reasons for this are mainly economic in

nature, since many of the drugs are expensive. Other reasons include the inability of health systems to deliver the necessary treatments and services.

Drysdale (2002) also mentions that it is now an established fact that the use of ARVs during pregnancy can reduce mother-to-child, or vertical transmission of HIV. Increasingly shorter courses of ARVs are being shown to be effective and, hence, affordable. The ability of health services to deliver such an intervention is still questionable, and the jury is still out on cost-effectiveness, as the full cost of such a programme has not yet been documented. Another bone of contention is related to feeding practices. Some authorities advocate that ARVs must be combined with exclusive formula feeding to be fully effective during pregnancy, while others feel that the benefits of breast-feeding (such as the reduction in deaths resulting from pneumonia, diarrhoea and malnutrition) are better, and do not feel that the former policy can be advocated.

The AIDS Brief for Sectoral Planners and Managers (2002) also states that HIV testing facilities are not essential to enable treatment of those in the early stages of infection. However, the availability of free and efficient testing services at a local level, preferably outside the parameters of health service settings, along with the provision of information about early stage treatments, may go a long way towards the acceptance of HIV as a chronic medical condition. Partnerships with other sectors and close liaison with communities will be required to make this feasible and effective.

The obstacles barring women's access to treatment and care must be identified and overcome. Part of the answer lies in strengthening sexual and reproductive health services and improving the entry points for women's access to treatment and care services (UNAIDS, 2004).

By integrating STI treatment services with family planning activities, women's fear of censure could be reduced and their uptake of services increased. Wider efforts to reduce HIV-related stigma are also vital. Also needed are steps to ensure that girls younger than 18 are not barred from voluntary counselling, testing, and treatment

because they lack guardians' consent or proper identification. The increased participation of women in clinical trials of new drug treatments is also required (UNAIDS, 2004).

## **5.2 The interplay between gender and socio-economic inequality, and vulnerability to HIV**

Mere information and awareness regarding HIV/AIDS is not enough. If prevention efforts are to succeed in the long run, they need to address the interplay between gender and socio-economic inequality and vulnerability to HIV. Prevention activities need to take into account the unequal terms on which most women have to conduct their lives. Strategies need to address the fact that, for millions of people, sex can be one of the few methods of accessing capital (UNAIDS, 2004).

A great deal of sexual risk-taking by girls and young women is marked by unequal gender relations, and unequal access to resources, assets, income opportunities, and social power. Far more must be done to ensure sustainable livelihoods for women and girls, particularly those living in female-headed households, if they are to be able to protect themselves against HIV infection and deal with its impact. Boosting women's economic opportunities and social power should be seen as part and parcel of potentially successful and sustainable AIDS strategies (UNAIDS, 2004).

## **5.3 HIV and violence against women**

If HIV-prevention activities are to succeed, they need to occur in conjunction with other efforts that address and reduce violence against women and girls. Violence against women and girls is not a private matter, but rather a violation of basic human rights, which has significant economic and social consequences for families, communities, and even entire nations. Laws against such violence must be formulated and adopted, and law enforcement structures need to be adapted and officials trained to ensure that these laws are effectively implemented (UNAIDS, 2004).

In South Africa, there is still a critical need for shelters or safe havens where abused women and girls can access legal services and healthcare. The South African government, working in partnership with NGOs and women's groups, has established over 90 "one-stop" facilities for survivors of domestic violence and sexual assault, but more are needed (UNAIDS/The Global Coalition on Women and AIDS, 2004).

An encouraging development is the growing number of men who are also joining the struggle against sexual violence. The South African organisation Men for Change (MFC) has carried out training sessions, not only within South Africa, but also in Namibia and Zimbabwe, which encourage men to become directly involved in ending gender-based violence (UNAIDS/The Global Coalition on Women and AIDS, 2004). The reduction of the incidence of sexual violence requires the joint efforts of both men and women.

#### **5.4 Education and HIV awareness**

Equal access to education, for girls and boys, must be implemented. The abolition of school fees would eliminate at least one barrier to universal education, and schemes to enable girls to complete secondary school are particularly crucial. Evidence shows that secondary school education can significantly reduce girls' vulnerability to HIV, since those years of schooling boost the skills and opportunities they need to achieve greater economic independence (UNAIDS, 2004).

Evidence from many countries (South Africa included) confirms that school subsidies increase girls' access to education and offer other benefits to girls and their families. They are also easier to monitor than other forms of direct subsidies. Steps must be taken to ensure that schools provide a safe and nurturing environment for girls in particular. Finally, concerted efforts are needed to improve and mainstream life skills classes, as well as sexual and reproductive health education in primary and secondary school curricula, and to upgrade teacher training so that these topics can be taught effectively (UNAIDS, 2004).

## **5.5 The increasing burden of care placed upon women**

Additional financial costs associated with AIDS do not just burden women and their households, but also the economy at large, and these burdens have to be relieved. AIDS home-care programmes need to be extended beyond medical and nursing care, to include counselling, food assistance, welfare support, schooling subsidies, and income opportunities that benefit households.

What is also needed is social protection and economic support for older people and those caring for orphans, as well as smoother and more efficient administrative procedures for accessing pensions and child support grants, which often sustain entire families (UNAIDS, 2004).

It was evident from this study that the women from my sample group felt that family planning and pregnancy were matters that were left to them, and that their husbands and partners really did not feel a need to be actively involved in decision-making around contraception. The women felt vulnerable because they lacked support from their partners and husbands on a matter that they considered to be crucial to the financial stability of their families. The sentiments expressed were, that if men could not be concerned with contraception as it relates to family planning, then they were not concerned with contraception as a factor essential to preventing the contraction and transmission of HIV/AIDS.

## **5.6 Women's inheritance and property rights**

Women and girls risk possible destitution after the death of their partners or parents, because they lack enforceable rights to own or inherit land and property. All the while poverty and economic dependence exposes them to increased sexual exploitation and violence (UNAIDS, 2004). Even though legal protection exists, the reality is that most women are left without recourse. Disinterested officials, women's lack of awareness of their rights, and fear of violence, along with the social stigma attached to pursuing a claim means that many give up and allow themselves to be stripped of all rights (Human



Rights Watch, 2003).

Legal systems must be adapted in order to establish and uphold women's property and inheritance rights. Also, legal precedents need to be established through test cases. This could help cushion the economic impact of AIDS in households. Additionally, by boosting women's economic independence it is possible to reduce their vulnerability to intimate partner violence, intergenerational and transactional sex, as well as other HIV-related risk factors (UNAIDS, 2004).

Public awareness of these issues also needs to be increased substantially. Women's land and housing rights, and tenure security, should be documented, particularly in areas with a high HIV prevalence. It is crucial that traditional authorities and leaders become partners in these efforts because they have the power to interpret and adapt customary laws in ways that favour women's rights (UNAIDS, 2004).

## **5.7 A holistic approach to dealing with HIV/AIDS**

New strategies are needed to address the structural dynamics of the AIDS epidemic, particularly the wide-ranging gender inequalities that advance the spread of HIV. One of the first steps required is to understand the problem better. National programmes should ensure that data on the epidemic is disaggregated according to biological sex and age. This will enable a clearer analysis of how gender relations affect the demands that AIDS places on women, girls, men, and boys – knowledge that is crucial for more effective HIV/AIDS programming (UNAIDS, 2004).

It is equally important that women are more closely involved in designing and guiding programmes that are meant to serve them. This applies specifically to women living with HIV, who can contribute in unique ways to strengthening responses to the epidemic. In addition to this, the nurturing of strong civil society organisations, particularly women's and youth groups can improve the reach, accountability, and effectiveness of HIV/AIDS programmes. Men and boys must play a greater role in all these efforts. Men currently shape much of the world in which women live, and, as

such, they must be partners in social change (UNAIDS, 2004). Programmes targeting women must also learn to embrace men as partners in order to help nurture social structures that are more supportive of women. Men's participation in home-based care and other support programmes would be one way of fulfilling their responsibilities for the health and welfare of their communities and societies. Men and boys are often in the best position to challenge and invalidate harmful stereotypes of masculinity, to confront the scourge of violence against women, and to assume their share of responsibility for HIV prevention and protection, especially within intimate relationships (UNAIDS, 2004).

Implementing these strategies will be a mammoth challenge. In the interim, crisis-driven efforts alone might achieve temporary relief, but they will prove inadequate over the long term, if the conditions that promote HIV/AIDS are not addressed sufficiently. This does not mean that the pandemic can only be vanquished once gender equality is achieved, but progress on that front will certainly help reduce the scale, severity, and duration of the global AIDS pandemic (UNAIDS, 2004).

The next generation of HIV/AIDS researchers and programmers who will tackle the pandemic in the new millennium, face a number of challenges (DAW/WHO/UNAIDS, 2000). One such challenge is improving our understanding of how gender influences men's knowledge, attitudes, and sexual behaviour. This is necessary in order to design prevention programmes that address gender-related factors that influence personal and societal vulnerability to HIV more effectively (UNAIDS, 2000). Another challenge is to advocate for and provide more resources for gender-sensitive care and support, which should incorporate issues of gender mainstreaming and programmes that allow women to become more economically independent. According to UNAIDS (2000), a third challenge is to develop indicators that will enable interventions to measure the reduction in gender inequalities, as they relate to vulnerability to HIV/AIDS.

## **5.8 Conclusion**

The interface between HIV/AIDS and gender equality is characterised by dual challenges that confront the Southern African region. There are tangible ways in which

development partners can work to expand women and girl's opportunities and choices and, thereby, reduce their vulnerability to the disease (UNAIDS/ The Global Coalition on Women and AIDS, 2004).

The acknowledgement of how deeply gender permeates the enormous scope of HIV/AIDS suggests that the pandemic is more than just a "health matter" (WHO, 2003). From this study it is evident that gender inequality has far-reaching social and economic implications. For this reason, the incorporation of a comprehensive gender framework in which to address HIV/AIDS issues goes far beyond the standard or traditional set of HIV/AIDS interventions, and should include a wide range of social and economic interventions. The realities of gender inequalities within the social and economic context of any given country or community can prevent or negate even the best HIV/AIDS interventions. The recognition that HIV/AIDS is more than a health matter is a critical step forward in addressing the pandemic. As a result, these contextual factors cannot be ignored (WHO, 2003).

Ultimately, to address economic and social gender inequities that lie at the root of the pandemic, we require a multisectoral response that must increase women's and girls' access to productive resources such as education, employment, land and finances, and end the culture of silence and shame that surrounds sexuality. Lastly, it is imperative to protect girls and boys from the corrosive effects of gender stereotyping (WHO, 2003).

South Africa's 1996 Constitution has an entrenched Bill of Rights that ensures the promotion and protection of gender equality. This legal enforcement of gender equality contributed significantly towards loosening the tight grip that patriarchy had over communities and households. Men found themselves having to 'surrender' some of their power and authority over women. However, some men continue to exert sexual violence and power over women to control them. It is evident in the community of Clayfield that, despite what our country's Constitution articulates about gender equality, dominant male behaviour, such as sexual and physical violence, will continue to prevail. In the context of my overall study, the real challenge remains to target men for behavioural change, underpinned and reinforced by the unlearning of socially

constructed gendered roles that promote power imbalances between men and women. Explicit in this argument about gendered sexual vulnerabilities in relation to some members of the community of Clayfield (Phoenix) is the idea that behaviour modification in the context of HIV/AIDS is integrally linked to the necessity for change in received notions about culture and sex that negatively impact on women and girl children.

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# APPENDICES: ANNEX 1

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## ETHICAL CLEARANCE

I, \_\_\_\_\_(full name) do hereby accept and agree to be a part of the research being undertaken by Ms P. Chetty towards the completion of her LLM (Public Health Law) studies at the University of KwaZulu-Natal.

I acknowledge that I am a resident of the Clayfield community in Phoenix.

I agree to be a part of the study group for the afore-mentioned research that is undertaken.

I agree to answer the questionnaire(s) truthfully and to the best of my knowledge and ability. I also agree to be requestioned if necessary.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 2006.

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Signature

## **APPENDICES: ANNEX 2**

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### **Gender and Sexual Vulnerabilities in the Spread of HIV/AIDS: Clayfield (Phoenix) as Case Study**

#### **HIV/AIDS QUESTIONNAIRE**

There are many reasons why gender plays a role in the spread of HIV/AIDS.

Physical Reasons: a woman is more likely to contract HIV since the vagina has a larger surface area for HIV to enter. HIV is transmitted more easily from male to female than female to male.

Social and Economic Reasons: a woman is more likely to be financially dependent on her partner and thus is less likely to demand that her partner use a condom in fear that her partner will leave her with no financial support.

Male sexual behaviour: men have more opportunities to contract and transmit HIV because they have more sexual partners than women; men also determine the circumstances of intercourse and refuse to use protection. There is also a societal norm that older men should have sex with younger women, which infects women at a much younger age. Rape is also highly prevalent and mostly committed by men against women. Rape has become so widespread that it contributes to the HIV epidemic.

Women societal expectations: there is a societal belief by men that women should not be permitted to make their own decisions about sex. Thus, women believe that they do not have the right to demand that their sexual partner have safe sex. Furthermore, women do not believe they have the right to refuse to have sex, especially with their husbands. Women are also considered to be the caregiver and thus are expected to care for the ill and be more prone to infection.

Women can transmit HIV to their children further spreading the disease.

Male behaviour generally: males are more likely to take risks and are less likely to seek medical help when sick.

Misinformation of how to 'cure' HIV is sometimes based on gender (ie. having sex with a virgin). Women, because they are unequal to men in all aspects of society including education and health care access, are less likely to be able to get medical help and accurate information regarding HIV.

Male on male sex is incredibly risky because of the slight tearing that occurs in the anus.

1. Do you think that women and men are treated equally? If not, how are men and women treated differently?

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2. Who is responsible for making sure that sex is safe?

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3. What are some physical aspects of women, which make it easier for women to get HIV and to spread HIV?

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4. What are some physical aspects of men that make it easier to spread HIV?

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5. What is the typical male image and how do you think that image leads to the transmission of HIV?

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6. Can women refuse to have sex with men?

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7. What would be some reasons that a woman might feel that she cannot refuse sex? How does this lead to the transmission of HIV?

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8. Do women and men both have equal access to education? If not, why would this help to spread HIV?

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9. Do women and men have equal access to healthcare? If not, why would this help to spread HIV?

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10. Are men amenable to using a condom before engaging in sexual intercourse? If not, why?

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11. Is domestic violence high in this area? How do you think that this could contribute to the spread of HIV/AIDS?

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12. Are boys and girls raised equally in this community? How do you think that this could contribute to the spread of the disease?

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13. What are the silences in your community around HIV/AIDS? What are people afraid of speaking about with regard to the disease?

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14. What would you say is the major cause of the spread of HIV/AIDS in your community?

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