Gender and HIV/AIDS in East Africa

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Introduction

Since the discovery of HIV/AIDS in 1981, more than 25 million people have died worldwide, making it one of the most destructive epidemics in history. In 2007, there were more than 33 million people living with HIV worldwide. The number of newly infected people was 2.7 million, and more than 2 million people died of HIV/AIDS. Young people aged 15–24 account for an estimated 45 percent of new HIV infections worldwide (UNAIDS and WHO 2008:2).

Sub- Saharan Africa (SSA) is more affected by HIV/AIDS than any other region in the world as it accounts for the largest percentage of world's HIV/AIDS infections and deaths. In 2007, more than 22 million people were living with HIV in SSA. About 68 percent of new HIV infections and 76 percent of all HIV related deaths in the world occurred in SSA (UNAIDS and WHO 2008). HIV infection is mainly concentrated in the most productive age group of 15-45 years. Moreover, about 90 percent of HIV infected children under the age of 15 worldwide live in SSA (UNAIDS and WHO 2008).

Although HIV affects both men and women, women are at a higher risk of infection than men (Kalipeni 2008). In SSA, women represent 57 percent of all infected people and are 30 percent more likely than men to be infected. Young females aged 15-24 years are on average 3.4 times more likely to be infected by HIV than their male counterparts (Brieger et al. 2001). Contributing factors to women's higher rate of HIV infection are: social and cultural factors such as gender norms and unequal social status of women compared to men, economic factors such as lack of ownership to productive resources and biological factors such as the vulnerability of women's reproductive tracts which make them more susceptible to infection (Amarillas et al. 2007).

This article uses the Connell (1987) theory of gender and power and Wingood and DiClemente (2000) expansion of the theory to analyze the biological, social, cultural, and economic factors that put women at a higher risk of HIV infection than men in East Africa. The article uses Tanzania as a case study. The analysis of the impact of gender on HIV/AIDS emphasizes the importance of women empowerment and integrating gender into HIV prevention programs. Data used in this article were obtained from literature and from the 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey (2007-08 THMIS). Technical assistance and funding for the survey was provided by Macro International Inc. through MEASURE Demographic and Health Surveys (DHS), a USAID-funded project that assists developing countries to collect data on fertility, family planning, maternal and child health, and HIV/AIDS. The 2007-08 THMIS is a nationally representative survey of 9,144 households selected from 475 sample points throughout

Tanzania. Individual interviews were conducted in selected households to all women and men aged 15-49. A total of 9,343 women and 6,975 men were interviewed.

HIV AIDS in Tanzania

Tanzania, the largest country in East Africa, has a population of more than 35 million. The country is among the worst affected by HIV/AIDS in Sub-Saharan Africa. The first three cases of HIV/AIDS in Tanzania were clinically diagnosed and reported in 1983 in Kagera region on the western shores of Lake Victoria bordering Uganda. However research indicated that HIV was probably in existence long before the first diagnosis (Cohen and Montgomery 1998:146). Scholars suggest that HIV/AIDS started at the border of Tanzania (Kagera) and Rakai district in Uganda where smuggling and trade across the two borders took place. Although this border was closed after Tanzania-Uganda war in 1979, illegal trade across the two borders continued to increase, a factor that may have contributed to an increase in sex workers in Kagera region especially in Bukoba town and other nearby villages (Hanson 2007:6; Lwihula et al. 1993). The confirmation of the first three cases of HIV/AIDS was followed by a rapid spread of the pandemic such that by 1986, all regions of Tanzania had reported HIV/AIDS cases. By 1990, it was estimated that between 400,000 and 800,000 people were infected. HIV/AIDS was fast becoming the major cause of death among young people and middle aged adults (Cohen and Montgomery 1998:146). Currently there are more that 2.2 million people living with HIV/AIDS in Tanzania. HIV/AIDS has also orphaned an estimated 2 million children (AMREF 2009).

Gender and HIV/AIDS in Tanzania

Women comprise a larger proportion of people living with HIV/AIDS as they represent more than 58 percent of the HIV-infected people in Tanzania (Ministry of Health Tanzania 2004). Data from the 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey indicates that six percent of adults aged 15-49 are infected with HIV. The prevalence of HIV is 7 percent for women and 5 percent for men. Most of the infected are young people. For example, four percent of women and three percent of men aged 15-24 are HIV positive. The gender gap is larger among young people than adults where one of out every five youth in Tanzania is infected with the HIV, and 70 percent of all young people living with HIV are females (Ng'ang'a and Kaahwa 2002). Contributing factors to the youth's higher rate of infection includes: sexual intercourse at early ages; poverty and its related problems; idleness and despair due to lack of employment or education and skills building opportunities; lack of timely and proper mentoring on sexual issues; immoral cultural practices; and customs that promote promiscuity (TACAIDS 2008).

According to Connell (1987) theory of gender and power, there are three major social structures that characterize the gendered relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis (the structure of social norms and effective attachment). Connell also emphasized that these three structures are rooted in society's forces that divide power between men and women and ascribe social norms on the basis of gender-based roles (Connell 1987). These three social structures are maintained within the society through various mechanisms such as unequal pay between men and women for similar work, gender discrimination, unequal social status

between men and women, and gender stereotypes. This affects women by producing gender inequities in women's economic potential, women's control of resources, and gender-based expectations of women's role in society (Wingood and DiClemente 2000). Expanding on the theory of gender and power, Wingood and DiClemente (2000) conceptualize women's higher risk of HIV infection as a function of the three structural gender inequalities that leads to differences in the exposures to HIV between men and women.

The sexual division of labor relates to allocation of men and women into various occupations, creating a division between "men's work" and "women's work" (Wingood and DiClemente 2000). In Tanzania, the division of labor is gender based. Women have the primary responsibility for production of food crops, caring for children, the elderly and the sick, and house work. Men produce cash crops and work for wages. Men's work is more valued than women's work because much of women's work is unpaid, and because they often perform low- status jobs and earns less than men. Therefore men's work gives them the ability to control family income and women end up being financially dependent on men. Additionally, Tanzania mainly operates under patriarchal system where property is owned and devolves along the male line and excludes women. Under this system, women's access to and control over productive resources is generally more limited than men's. Men have control over critical productive resources such as land and women gain access to these resources through their relationship with men especially in marriage. This inequality in economic resources between men and women "create a situation where women's experiences of poverty tend to be more severe than those of men" (Wrigley-Asante 2008). It also leads to little or no economic security for most women, and increases women's dependence on men. Women's economic dependency on men limits their ability to leave risky relationships and to negotiate for HIV protection and increases their risk of exposure to HIV infection (Wojcicki and Malala 2001; Zulu et al. 2002). Some women are threatened of physical violence or divorce if they try to negotiate for safe sex (Wingood and DiClemente 2000).

Research shows that women are poorer than men. Women account for 70 percent of all the people in the world who live on an income of less than $1 a day. Almost 66 percent of the world's uneducated people are women (Samrawit 2006). In Tanzania, women are often discriminated against in terms of access to education, employment, credit, health care, and property rights causing gender inequality in economic resources. Formal employment for women is affected by their low education, illiteracy, and gender discrimination in the labor market. For example, women are about twice as likely as men to have no education in Tanzania. Almost 75 percent of illiterate adults in Tanzania are women. The literacy rate for women is 67 percent compared to 85 percent for males (Fitzpatrick 2005). Research shows that educated women are five times more likely than illiterate women to know facts about HIV/AIDS. Illiterate women are four times more likely to believe that there is no way to prevent HIV infection (Vandermoortel and Delamonica 2000). Because of gender discrimination and women's low education, most women are more likely to be engaged in informal economy, subsistence farming and lower paid employment. More than 90 percent of all women in Tanzania are employed in agriculture. Those few who are employed in formal sector are concentrated in service sector such as nursing, teaching and other clerical jobs which may be

characterized by low pay and poor working conditions (Rwebangira 1996). In addition, many women earn 30-40 percent less than men for comparable work (Amnesty International USA 2007). Women's low or lack of education enhances their dependence on men as it reduces their abilities and opportunities to develop financial independence.

Poverty renders women powerless and exposed them to a HIV infection because it is linked to risky behaviors for survival. Some women have limited financial ability to access methods of practicing safe sex. Even when a woman has the financial ability to access safe sex methods, she may face difficulties negotiating safe sex if she is dependent on a male partner for financial security (Doyal 1995). Sometimes women face pressure from men to engage in unsafe sex for material favors such as: to get employed; keep their job; or get financial assistance. A number of studies show that young girls have sex with older men for money, gifts or status (Ankomah 1998; Calves et al. 1996; Nyanzi 2001). Because of poverty, some women may be forced to engage in prostitution or sex work for their daily survival and the survival of their families (Agadzi 1989; Hankins 1997). Some sex workers may not use HIV preventive practices for fear of losing customers and jeopardizing their financial opportunity.

The sexual division of power plays an important role in sexual behavior among men and women. Because of gender division of labor, men have more power and control in their relationships than women. The sexual division of power may increase women's risk to HIV infection through physical and sexual violence. Violence against women is one of the most visible consequences of inequalities that exist between men and women. Research has shown that many women are forced or coerced to have sex (WHO 2000). Sexual violence against women makes them vulnerable to HIV infection because during an act of rape or forced sexual intercourse, abrasions and cuts are more likely to occur and condom use in such a situation is less likely to occur (WHO 2000). Additionally, many young girls are vulnerable to sexual abuse and rape due to an increased number of homeless girls and orphans of AIDS living on the streets in Tanzania (Samrawit 2006). Sometimes women are scared to protect themselves by refusing to have sex or requesting the use of protection for fear of violence (Blanc et al. 1996).

Polygamy is widely practiced in Tanzania as a symbol of men's wealth, virility, and need for sexual satisfaction. Some men end up having more than one wife because of widow inheritance which is a common practice among several ethnic groups. If a brother dies, one of the surviving brothers would take over the family of the deceased brother including his wife. Data from the 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey shows that 23 percent of women had co-wives and 12 percent of men have more than one wife. Polygamy brings more people into the marriage group. If one member of the group is infected with HIV, more people are exposed to infection within the marriage group. Moreover, data from the 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey shows that men are more likely to have multiple sexual partners than women. The mean number of lifetime sexual partners is higher among men than women who ever had sex. Men reported a mean of 7 while women reported a mean of 2.4 lifetime sexual partners. For the past 12 months prior to the survey, 18 percent of men reported having had sex

with more than one partner in the 12 months preceding the survey compared to only 3 percent of women. For married people, 29 percent of men and 12 percent of women reported having sex in the 12 months before the survey with someone who was not a husband/wife or cohabiting partner. Over 22 percent of men who said they had two or more partners in the past 12 months, said they used a condom the last time they had sex. Studies show that having unprotected sex with more than one partner increases the risk of acquiring or transmitting HIV to other partners.

The structure of social norms and effective attachments refers to social and cultural norms that dictate gender-based sexual behaviors that influence women's risk to HIV infection. This structure affects people's attitudes towards men and women's sexual behaviors. Traditionally, men in Tanzania are supposed to be the major decision makers about sex and women are expected to follow. They have a 'cultural right' to demand sex even if it is unprotected at any time they want and women are expected to be passive and obedient (Wight et al. 2006). This makes it hard for women to refuse to have unprotected sex with their HIV infected partners or insist on using condoms for fear that men may be violent or decide to find another woman (Lugalla et al. 1999).

Cultural practices such as Female Genital Mutilation (FGM) is another factor that contributes to women's higher risk of HIV infection. Momoh (2005:6) defines Female Genital Mutilation (FGM) as all procedures that involve the partial or total removal of the external female genitalia or other injury to female genitals whether for cultural, religious, or non-therapeutic reasons. FGM is practiced by approximately 20 of the 120 main ethnic groups in Tanzania (Boyle 2002:31).Although the prevalence of FGM varies by regions, it affects about 18 percent of the female population in Tanzania.

FGM is illegal in Tanzania but the practice is regarded by some ethnic groups as a rite of passage into womanhood, a prerequisite for marriage, bearing children and acceptance into the community (Boyle 2002:30). FGM is also regarded as a symbol of respect and purity by some communities such that a bride groom pays a higher bride price to the bride's family if the bride has undergone FGM (The Arusha Times Newspaper 2007). Most of FGM is done to young girls when they become adolescent or before they get married (Boyle 2002:30). FGM increases the risk of HIV infection among women because some of the FGM ceremonies are conducted in unhygienic conditions. For example in some cases unsterilized tools such as knives and razor blades are used. Sometimes the same tool is used to mutilate several girls at the same time, some of which could already be HIV-positive. A study conducted on 7350 young girls less than 16 years old in Dar-es-Salaam, Tanzania revealed that 97 percent of the time, the same equipment could be used to mutilate 15-20 girls (Mutenbei and Mwesiga 1998). Thus, the transmission of HIV through FGM is enhanced through shared instruments and blood products during genital cutting and the damage of the vaginal epithelium associated with the trauma, inflammation and other complications. Women who have undergone FGM are at a higher risk of getting cuts and bruises during sexual intercourse. This increases the risk of HIV transmission if their sexual partner is infected.

Another factor for women's higher rate of HIV infection in Tanzania is early initiation of sexual activity among girls. One of the reasons is early marriage for girls. According to the Marriage Act of 1971 in Tanzania, the minimum legal age at first marriage is 18 for males and 15 for females (United Republic of Tanzania 1971). Data from HIV/AIDS and Malaria Indicator Survey shows that women start having sex at earlier age compared to men. About 14 percent of women and 8 percent of men aged 20-49 had first sexual intercourse before they were 15 years. Only 8 percent of men reported to have sex before 15 years old. Additionally, about 59 percent of women and 41 percent of men reported to have first sexual intercourse before they reached 18 years. More than 11 percent of young women and 10 percent of young men age 15-24 in Tanzania had sex before they were 15 years. Over half of women and 43 percent of men age 18-24 reported having sex before reaching age 18 years. Rural women are more likely than urban women to have had sex by age 15 (12 and 8 percent, respectively). For men, these figures are 11 and 7 percent, respectively. Some girls are dropping out of school to become an older man's second or third wife. Many families especially in rural discriminate their female children in terms of education. They often give them to marriage because they receive bride price from the groom. Data from the 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey indicated that 40 percent of women age 20-49 got married before reaching 18 years while only 5 percent of men got married before age 18 and 14 percent before age 20.Women who got married before age 20 were 62 percent. This increases their risk of abuse and HIV infection because many of these young girls are married by much older men who may have had more sexual exposure. Adolescent brides are also more likely to marry into polygamous unions. Clark (2004) research on early marriage found that married adolescent girls have higher rates of HIV infection than do sexually active unmarried girls. Also "early marriage increases coital frequency, decreases condom use, and virtually eliminates girls' ability to abstain from sex" (Clark 2004).

Wingood and DiClemente (2000) extension to the theory of gender and power described biological factors that contribute to women's risk to HIV infection. Research shows that HIV is transmitted 2-8 times more efficiently from men to women than from women to men (Cummins and Dezzutti 2000). Biologically, women have higher risk of HIV infection through unprotected heterosexual intercourse than men. This is because: female genital tract has larger areas of sensitive skin and tissue exposed during an intercourse than male genital tract; there is larger amount of fluid exchange from male to female; and men's sexual fluids has higher viral content than female's (Quinn and Overbaugh 2005). Younger females when coerced or forced to have sex, are more biologically vulnerable to HIV infection because they have less mature tissue.

Conclusion

Without proper interventions, many women will continue to die of HIV infection. It is important to use gender sensitive poverty eradication programs, education programs, job and skill training and policies that will protect women's rights at home, in the community and at work place, and challenge customs that causes women's low status and discriminate against them. One of the most powerful tools for women's empowerment and fight against HIV/ AIDS is enhancing women's status and protecting their rights. This

is includes the rights to productive assets such as land and credit. Lack of access to these assets is a core dimension of poverty. Poverty limits women's ability to negotiate for safe sex and forces some women to engage in unsafe sex for survival. Stronger community-based poverty reduction and income generating programs for women will help women. Both men and women must be involved in gender sensitization and awareness programs as an important step to address patriarchal attitudes and gender inequalities that makes women poorer than men.

Education is the key to women empowerment and very important dimension in the fight against HIV/AIDS. Education increases women's economic opportunities, reduces their dependency on men and their vulnerability to gender discrimination. In addition to increasing school enrollment for girls, the government deed to provide more support to poor families such as scholarships for girls to continue with education. It is also important for the government to increase the level of support to HIV/AIDS orphans. Many HIV/AIDS orphans are left with no proper care, many drop out of school and end up in the streets. The government should increase the level of help to HIV-affected by waiving all school fees for HIV/AIDS orphans, and helping those who come out of school to secure a job or establish their own income generating activities. Education delays marriage and sexual activities and helps women to be more informed on how to protect themselves from HIV infection. It also gives women more confidence to negotiate for safe sex. The government can also promote a more gender-sensitive education curriculum that will instill non-discriminating aspects of culture, and empower young people both men and women to overcome gender stereotypes that exist.

Tanzania has ratified both the United Nations (UN) Convention on the Rights of the Child and the UN Convention on the Elimination of All Forms of Discrimination against Women, and it signed the African Charter on the Rights and Welfare of the Child on 23 October 1998. However, the violation of women rights and Female Genital Mutilation (FGM) continue to take place. The government needs to strongly enforce its anti-FGM laws and ban FGM and all forms of violence against women. The government can use the media, non- governmental organization, customary and religion institutions, and school curriculum to spread anti-FGM message and create an awareness of the dangers of FGM. Women also need to take charge and challenge social norms and traditions that violate their rights. Feminist activism is critical in changing the male dominance and transform patriarchal systems. For women to achieve this, they need support from members of society, both men and women, from the government, local and international institutions and non-governmental organizations.

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