Invigorating HIV and AIDS Prevention through Addressing to Poverty and Gender Inequalities among Young Women: A Case for Masvingo Urban

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Abstract

This study sought to explore the perspectives of young women in Masvingo with the aim of better informing them on HIV prevention. Focus group discussions and interviews were used to explore issues relating to HIV prevention. An inductive content analysis identified emerging themes and patterns in the participants’ conversations. The study revealed that, although young women were informed and motivated to prevent HIV, poverty and inequality were significant barriers, limiting their power to protect themselves. The research adds evidence to the current argument that failure to address the disempowering effects of poverty and gender inequality limits the effectiveness of current HIV prevention for young women. HIV prevention must now address poverty and gender vulnerabilities, promoting a protective environment, rather than focusing on influencing individual sexual behaviour.

Keywords: Women, HIV, Poverty, Gender, Sexual behaviour, Gender inequalities

1. Background

The question of whether the world is going to experience, at any given moment, zero HIV and AIDS infection rates and zero AIDS related cases is very relevant for academics in order to come up with useful strategies to stem the tide. Over 80 per cent of people living with the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome are aged between 15 and 24 years according to the United Nation Programme on HIV and AIDS (UNAIDS as cited in Mosha and Manda, 2012).

Among key issues that account for the increase in the epidemic are issues of poverty and gender inequalities. This raises the need to address to the tide for young women in the various communities and in society. It is argued that sex is taken as a norm by many young women as a means of earning a living due to poverty and unemployment. Additionally, sexual behaviour is subject to social, cultural, religious, gender and moral norms (Klouman, 2004) across communities of different types. HIV infection is transmitted mainly through heterosexual intercourse with an infected partner (Barongo as cited in Mosha and Manda, 2012); exposure to infected blood and blood products; and from an infected mother to the baby during delivery or through breast-feeding (Msuya, 2008).

Gender inequality is a driver of the HIV and AIDS epidemic (Shisana, Rice, Zungu, and Zuma, 2010). Booysen and Summerton in Shisana et al. (2010) found that poor women are less likely to be knowledgeable about HIV and AIDS and are more likely than comparatively affluent women to have engaged in risky sexual practices with a recent sexual partner. Kalichman et al in Shisana, et al, (2010) found a positive correlation between risk of HIV transmission and perceived lack of basic needs and services among township residents in South Africa. Researchers have postulated that in many disadvantaged contexts, poverty and gender inequality together create conditions where high-risk
sexual behaviours become prevalent. In contexts, where gendered inequalities influence access to needed resources, poor women can increase their access to resources through “sexual networking” with men (Shisana, Rice, Zungu, and Zuma, 2010). This raises the need to address poverty and gender inequalities among young women so as to stem the epidemic from society.

We cannot talk of eradicating HIV and AIDS without aiming to achieve Millennium Development Goals (MDGs) in our nations. The issue of addressing poverty and culture is a central strategy to the achievement of Millennium Development goals in any country. Countries made quite a number of commitments to achieve the MDGs. This study particularly centred on the need to eradicate the HIV and AIDS epidemic through addressing poverty and culture issues among young women. The following shows commitments made by nations in trying to address and combat the spread of the epidemic.

**MDG-6 HIV/AIDS – COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES**
To halt and reverse the HIV epidemic by 2015 and to build on past success in the fight against tuberculosis and malaria, we are committing to:

a) Significantly intensify prevention efforts by scaling up strategically aligned programmes, targeting the vulnerable and most at risk, that combine biomedical, behavioural and social, and structural interventions, such as empowerment of women, stigma reduction, and protection of human rights.

b) Building new strategic coalitions to strengthen and leverage the synergistic linkages between HIV and other health and development initiatives, and in this regard expediting action to integrate HIV information and services into programmes for primary health care, sexual reproductive health, and mother and child health.

c) Planning now for long-term sustainability, including addressing the inevitable increase in demand for second and third line drug regimens.

d) Sustaining the rapid progress in scaling-up of the use of insecticide treated bednets to combat malaria.

e) Renewing efforts to prevent and treat neglected tropical diseases, prevention and treatment services for malaria and tuberculosis, including by accelerating further research and development, developing innovative medicines and adopting comprehensive prevention strategies.

f) Increasing national and international funding to meet agreed commitments to ensure universal access to HIV prevention, treatment, care and support and in this regard committing full funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria, and to exploring additional innovative financing mechanisms to ensure the long-term sustainability of the response.

It is not important just to put things in writing. Lip-service without practical follow-up of issues does not help remove and uproot social problems in society. There is still sustained prevalence regardless of the presence of this MGD of eradicating HIV and AIDS. This study takes the dimension of poverty and culture in a bid to contribute towards meeting the aim of combating the HIV and AIDS pandemic from society.

Feldman, Manchester and Maposhere (2002) argue that poverty makes households less able to deal with the effects of HIV as it undermines their capacity to provide for nutrition, health and other needs related to HIV and AIDS. HIV and AIDS disproportionately affects young women (MoH and ORC Macro, 2006). Socio-cultural norms reinforce gender inequalities, leaving young women more vulnerable to HIV
than their male peers, and this is often compounded by poverty (Chao et al., 2005). At present HIV and AIDS poses an enormous threat to Sub-Saharan Africa. The HIV and AIDS pandemic is considered to be one of the most severe crises confronting societies, especially in developing countries. In Zimbabwe, the city of Masvingo has the greatest impact of the epidemic due to its geographical location. It is the city which links the Harare- Beit Bridge route, where all traffic passes through to the South African border post. HIV and AIDS pose a big threat to all of society and particularly Sub-Saharan Africa. Responding adequately is a major challenge to communities and governments. Looking specifically at this region it is important to realise that Sub-Saharan Africa has just over 10 per cent of the world’s population but is home to more than 67 per cent of all people living with HIV and AIDS (Zeelen, Wijbenga, Vintges and de Jong, 2010, p. 383).

At school level a sizable minority of teachers lack adequate knowledge of the disease, or feel uncomfortable talking about such an issue. Poverty in HIV and AIDS-affected families is directly associated with quality of learning and educational outcomes (Robsona and Kanyanta, 2007). Consequently, it will be almost impossible to educate the students about HIV and AIDS especially when there is lack of support from the community and parents (Ahmed et al., 2006). Even in situations where there is some focus on sex education in the classroom, the messages are mostly too repetitive and lack depth (Paxton, 2002). It seems that it is still a taboo on talking about HIV and AIDS, especially when one draws a relation between the disease and sexuality (Conen and Swierstra, 2003).

Poverty and gender inequality interact to hinder protective behaviour and therefore propagate the spread of HIV and AIDS (Nicholas, 2010). The pressures of poverty can lead to parental neglect and parents facing difficult decisions including forced early marriage, and young women are frequently forced to take risks with their health in order to meet the costs of their basic needs. The resulting transactional sex or early marriage is strongly associated with increased HIV risk (Cote et al., 2004). Gender inequality, seen in both power relations and income inequality, exacerbates these issues, rendering young women unable to protect themselves from HIV and AIDS.

As Mabala argues, all three components of the ABC (Abstinence, Be Faithful, use Condoms) formula for HIV prevention are largely male-dominated strategies which “fail to offer African young women real options” (Mabala, 2006):

A: “Abstinence is unrealistic...when sexual activity is coerced, or women and young women have to resort to sex as a matter of personal survival” (Mabala, 2006, p. 421).
B: “Being faithful only works if partners play by the same rules” (Mabala, 2006).
C: “Condom use is almost invariably a male decision” (Mabala, 2006).

Although education can be empowering for young women, poverty exacerbated by gender inequality limits the options available for young women (UNFPA, 2005). Therefore, this study explores the issues surrounding HIV and AIDS prevention from the perspectives of young women living in poverty, with the aim of better informing interventions to address their needs more effectively.

2. Conceptualisation of poverty

Ogwumikeas cited in Raimi, Bello and Mobolaji, (2010) posits that there is no agreed universal definition of poverty. Poverty is complex and multidimensional and has various perceptions. It is experienced differently by men and by women and can differ according to geographical area, social group and political or economic context. Therefore, it is safe to agree that the poor are not a homogenous group. According to CBN as cited in Raimi, Bello and Mobolaji, 2010), poverty is a plague afflicting people all over the world. It is considered as one of the symptoms or manifestations of underdevelopment. On the other hand, Onibokun and Kumuyias cited in Raimi, Bello and Mobolaji, 2010) argued that poverty is
linked to a shortage of vital resources and the endurance of “harsh and inhospitable environments”, including the breakdown of economic, demographic, ecological, cultural and social systems, and “bad governance”, which they claim sustains systemic poverty in developing countries. Besides, Gass and Adetumbias cited in Raimi, Bello and Mobolaji, 2010) posit that in real terms, poverty denies its victims the most basic needs for survival, which are fundamental human rights, such as water, food, clothing and shelter. Therefore poverty manifests itself not only in economic deprivation but also in terms of an individual’s inability to access basic social amenities.

The most common and preferred definition of poverty is derived from the economists’ concept of “income poverty”, which assesses the poor as people living in “absolute” or “relative” poverty. A person is in a state of “absolute” poverty when his or her level of income is insufficient to provide the basic necessities for life. Someone is considered to be in “relative” poverty when he or she appears to have more than someone who is in absolute poverty (Aliyu, 2003).

3. Research Methodology

This study was based in the qualitative paradigm. Qualitative research is a system of inquiry which seeks to build a holistic, largely narrative, description to inform the researcher’s understanding of a social or cultural phenomenon. Qualitative research takes place in natural settings employing a combination of observations, interviews, and document reviews (Strauss and Corbin, 1990). Using qualitative methods for primary data collection, including focus group discussions (FGDs) and in-depth interviews (IDIs), the aim was to enable young women to express their opinions in their own words (Berg, 2007).

Population and Sample
In total, 10 young women aged 15-24 years participated in the study.

Sampling procedure
Participants were recruited through personal contacts with the help of two friends who acted as “gatekeepers” to the community.

4. Results

Respondents felt that the behaviour of young women is likely to be affected by poverty among other many reasons. The following sentiments shed light:

Poverty leads to early indulgence in sexual activities

If young women have already indulged into sexual activities in the early years in order to get money to survive, they would not benefit much from lessons which call for abstinence.

Poverty usually involves a judgement of basic human needs and is measured in terms of resources required to maintain health and physical efficiency. The following reasons are advanced for studying the problem of poverty:

- it is important to study the profound damage poverty inflicts on the individual that suffer from it;
- hungry children cannot learn properly and malnourished adults cannot work productively; and
- the presence of poverty in many societies is often an indication of a deeper structural problem.

Poverty in HIV and AIDS-affected families is directly associated with quality of learning and educational outcomes (Robsona and Kanyanta, 2007). Feldman, Manchester and Maposhere (2002) argue that
poverty makes households less able to deal with the effects of HIV as it undermines their capacity to provide for nutrition, health and other needs related to HIV and AIDS.

**Our answer to poverty is prostitution**

Respondents felt that there is nothing they can do in situations of poverty. They actually indulge in prostitution. They had this to say:

_In times of poverty, there is no way out except to indulge in prostitution. We just take it to be a normal activity. We just feel AIDS is a baby we carry at the back when faced with difficult poverty situations. That one would suffer from AIDS would come second after indulging in unprotected sex which the payers demand._

Poverty often raises the amount of prostitution in a state, as individuals (mainly women) are forced into commercial sex work as a means of survival (Stockemer and Lamontagne, 2007). Additionally, poverty may provoke population shifts within a country (often rural to urban migration for employment), which fragments familial structures and social networks, leading to fewer economic opportunities and higher HIV vulnerability. Scholars have found a positive correlation between HIV and poverty. It is argued that globally, ‘extreme poverty is associated with higher prevalence rates’. Others scholars have asserted that while low wealth is neither necessary nor sufficient for an individual to contract HIV, it may be necessary for an epidemic as severe as that in parts of Africa (Stockemer and Lamontagne, 2007).

**Culture affects us in many ways**

Respondents had the following to say:

Due to cultural dictates, we lack proper communication with people who can assist us. We feel uncomfortable talking about matters related to sex with elders and to engaging in sexually related debates.

Culture is an umbrella concept embracing all the accepted traditional customs, moral attributes and behaviours practised by a particular group (Van den Aardweg and Van den Aardweg, 1988, p. 56). These findings seem to concur with what Mapolisa and Stevens observed. They argue that in many societies, there are cultural dictates for women to play a passive role in sexual interactions and strong social pressures for women and girls to remain ignorant about sexual matters. Social norms requiring that women be virgins when they marry mean that girls may be especially afraid to ask for information about sexual matters as the impression created could be that they are sexually active (Mapolisa and Stevens, 2004, p. 18).

**We lack information due to cultural dictates**

Respondents highlighted that they lack information on how to combat HIV and AIDS due to some cultural dictates. They had this to say:

Information sharing with parents, community leaders and even with school teachers is highly limited. Culture plays a significant role in discussing issues about sexuality among young people. Sexual behaviour is rarely discussed in public in African countries (Amuyunzu-Nyamongo, 1999). Parental care may be lacking and parents are not invariably good role models themselves (Mmbaga et al., 2007). Some cultures disapprove of sexual intercourse before marriage, which militates against young people seeking information about sex and HIV and AIDS. It is a taboo for mothers and sons or fathers and daughters to discuss issues relating to sex (Manda, 2006). In addition there is fear that providing information about sex
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or sex-related topics will encourage premarital sex (Moahi and Lekau, 2005). Poor channels of information also limit the use of HIV and AIDS information.

**Contraceptives are rarely used to meet the demands of sugar dadies**

Respondents were of the opinion that contraceptives are rarely used due to poverty. They had this to say: The sugar dadies might demand for dry sex and because you want money you have to comply. That is why some of us get pregnant. Due to poverty, we carry the burden of care for our families, engaging in risky sexual behaviour including unprotected sex, possibly with HIV-infected men and this might be the only route available to them.

HIV is most frequently transmitted through sexual intercourse, which accounts for 75–85% of the nearly 40 million infections with the human immunodeficiency virus (HIV) that have occurred so far. In many African countries where women engage in sexual practices such as ‘dry sex’, which dramatically increases their own risk of infection, primary prevention strategies such as the use of contraceptives remain the mainstay for control of the HIV epidemic. The tendency of teenage girls to have relations with older men increases the likelihood of adolescent girls becoming pregnant and of contracting HIV (Stockemer and LaMontagne, 2007). It is argued that in sub-Saharan Africa, one factor working against the realisation of gender equality and the empowerment of women is illness and demise, particularly among poor women as a result of HIV and AIDS (Moletsane, 2005).

**Unemployment is a major cause**

Respondents highlighted that lack of employment causes indulgence in prostitution and hence in unprotected sex. They had this to say:

We have problems of unemployment and how do you think we can survive. During the evening, we dress attractively and visit night clubs in order to get takers. This is our source of income and means of living. Initially we drink beer to remove shyness. When drunk, you can take any guy. The problem only comes when you get sick. There is no money to go to hospital. Even minor illness is not attended. There comes trouble because business will be out of reach on those days.

This is pointing to a deeply rooted problem in society, that is, unemployment. It shows that most young women engage in sexual activities in order to make ends meet. Poverty makes them indulge in certain behaviours that result in HIV transmission. Lack of money causes them fail to attend to minor health problems that will result in weakening of antibodies.

5. **Conclusions and Recommendations**

It is evident that poverty strikes young women in the urban areas and they end up indulging in sexual activities without protective measures. There is need to educate the young women on safe sex and to engage them in projects that can sustain their living. Workshops have to be run by the Ministry of Health and Non-Governmental Organisations (NGOs) on strategies to an HIV and AIDS free life particularly to help young women earn a smart life.

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