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Research Article

Gender Power Inequalities in the Context of HIV/AIDS among South African Indians in an Urban Setting in Kwazulu-Natal, South Africa

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Summary

A lot of studies on gender power dynamics in relation to HIV in South Africa focus on the high risk African Black population, and little attention has been given to the minority groups. Similar to other communities in the country the HIV/AIDS has had a devastating effect Indian communities and impoverished families. There is also evidence that male dominance among South African Indians encompasses every aspect of women's lives including family, social and religion, and influences their ability to be assertive and to negotiate safe sex which makes them more vulnerable to HIV/AIDS. It was from this point that we set out to research this largely unexplored study topic, in order to gain insight and understanding of gender-power inequalities underpinnings in the Indian community residing in urban setting in KwaZulu-Natal, South Africa. Thirty-two in-depth interviews and three focus group discussions were conducted among Indian women with local community members. Interviews were audio recorded, and transcripts were coded and analyzed using ATLAS.ti. Findings revealed that gender power relations were major social factors contributing to the growth of HIV/AIDS in this population. Gender inequalities make women more susceptible to contracting HIV, with culture playing a role in placing women in high risk situations.

Abstract

Background

In South Africa gender power inequities play a key role in the HIV epidemic through their effects on women's power which limit their sexual power to negotiate safe sex and avoid sexual violence, eroding their confidence and economic independence in sexual relationships. However, little is known about gender and power dynamics in the context of HIV among the South African Indian community. This study examined this largely unexplored study topic, in order to gain insight and understanding of gender-power inequalities underpinnings in the Indian community residing in urban setting in KwaZulu-Natal, South Africa.

Methods

Thirty-two in-depth interviews and three focus group discussions were conducted among women from 18-24 years of age. Interviews were audio recorded, and transcripts were coded and analyzed for emerging themes using ATLAS.ti.

Findings

Four major themes emerged that were linked gender power inequalities with risk of HIV/AIDS in the selected communities, and these included influence of culture and gender, violent and abusive relationships, economic dependence and sex work.

Conclusion

Findings confirm that even among minority groups such as the selected Indian community, gender power inequalities make women more susceptible to contracting HIV, with culture related social norms playing a role in placing women in high risk situations. More in-depth research is needed to develop interventions that address the role of gender power imbalance as a pathway to improved HIV-related behaviors.

Introduction

In South Africa gender power inequities play a key role in the HIV epidemic through their effects on women's power which limit their sexual power to negotiate safe sex and avoid sexual violence, eroding their confidence and economic independence in sexual relationships [1]. Anthropologists who study HIV/AIDS have long argued that the transmission of HIV in women must be considered within the context of gender roles, access to social and economic capital and cultural values [2]. Most dimensions of economic and social life are characterized by a pattern of gender inequalities that routinely value what is male over what is female influencing skewed access to and control of resources, economic opportunities, power, and political voice [3].

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Likewise differences between women and men drive the engendered underlying mechanisms of HIV/AIDS infection is influenced among others by social and economic inequalities that informs gender roles and responsibilities, access to resources, and decision-making power [4]. In South Africa as in other sub-Saharan Africa countries women are disproportionately affected by HIV [1,4-6]. This has been partly attributed to the economic vulnerability of women that makes them more likely to exchange sex for money or favors, less likely to negotiate safe sex, and less likely to leave a relationship that they perceive to be risky [5,6]. These gender inequalities imply that women lack negotiating power in sexual relationships put them more risk of HIV/AID than their male counterparts [5-8].

There is clearly a need to address the role of gender inequalities on women's susceptibility and vulnerability to HIV/AIDS in South Africa. Gender norms and sexual scripts are not static, vary across communities and have the potential to respond to changing socioeconomic landscape according to social constructions [9]. However, studies on gender power dynamics in relation to HIV in South Africa focus on the high risk African Black population [3,5,7] and less attention has been given to the minority groups. Similar to other communities in the country the HIV/AIDS has had a devastating effect Indian communities and impoverished families. There is also evidence that male dominance among South African Indians encompasses every aspect of women's lives including family, social and religion, and influences their ability to be assertive and to negotiate safe sex which makes them more vulnerable to HIV/AIDS [5,10,11].

However, little is known about gender and power dynamics in the context of HIV in the South African Indian community. This study examined this largely unexplored study topic, in order to gain insight and understanding of gender-power inequalities underpinnings linked to HIV vulnerability among Indian women in an urban setting in KwaZulu-Natal, South Africa.

Methodology

Study Site and Setting

The study was conducted in a predominantly South African Indian township, situated fifteen kilometres south of Durban the third largest city in South Africa. The population is characterized by new generation South-Africans Indians who use English as their first language although Indian languages such as Hindi, Tamil, Telugu, Gujarati and Urdu are spoken at home by most inhabitants. The major religions practiced amongst the Indian community of Chatsworth are Hinduism, Islam, Christianity and Buddhism. Present day Chatsworth consists mainly of poor (lower income group) and working class people. The rise in poverty, unemployment, homelessness, welfare dependency, crime and prostitution has been accompanied by an increase in the prevalence of HIV/AIDS in this urban Indian community [9,11].

Study Procedure

Purposeful sampling was used to recruit participants though community based organizations targeting both males and females. Potential respondents were informed about the purpose, methods and possible risks associated with the study. Confidentiality and anonymity were ensured through the use of pseudonyms. Consenting participants provided verbal or written informed consent the interview. The study was approved by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and Biomedical Research Ethics Committee (BREC) at the University of KwaZulu-Natal in South Africa.

In-depth qualitative methodology was used to elicit the subjective experiences and allow participants to express their views about the roles of men and women in their community and how these influenced their perceptions, attitudes and behaviors in relation to HIV/ADIS. In-depth interviews (IDIs) and focus group discussion (GDGs) were conducted with respondents to reveal their reflections, self-perceptions, personal opinions and emotions to unveil meanings associated on pre-determined themes "inequities and gender" and how these are informative of internalized cultural and social in relation to HIV and AIDS" in their community.

Analysis

Interview and FGD data were audio- recorded. The first author read all IDIs and FGD transcripts, and developed an initial coding scheme. ATLAS.ti® version 7 software was used for line-by-line coding. The codes were further grouped into families and retrieved as emerging themes and sub themes.

Findings

The study sample of comprised of total of 60 participants, 27 males and 38 females aged from the ages of 18 to 50 years. A total of 32 IDs and 38 FGD were completed. Three FGDs were conducted for females 8-24 years old (n=10), 25-35 years old (n=10) and those 35 years and older (n=8).

Results and Discussion

The terrain of gender roles in South Africa is both complex and diverse, and gender inequalities persist at many levels in the economy, social institutions, households, and sexual partnerships. The current study identified four major themes and this included culture and gender, violent and abusive relationships, economic dependence, and sex work.

Culture, Gender and the Spread of HIV/AIDS

The definition of culture emphasizes knowledge and behavior patterns that are unique in the society. It is in these unique practices within the community in an urban setting in KwaZulu- Natal, South Africa that we still find imbalances and inequalities between men and women.

One participant (female, 36 years old) elaborates *"I grew up in a very traditional home, where I was thought to always obey my husband; I was thought never to disrespect him and always be a good wife that cares for my family. My parents always told me that a husband is god and a good wife never questions a husband's word"*. Another participant (female, 35 years old) reiterates

"We grew up learning that women should always respect men especially their husbands. Even my mother told me that a wife should always obey and respect her husband no matter what. A wife is there to care for the family and a man provides for his family and as a provider he must be respected. As a man I do believe I am superior and my wife should obey me."

According to Govender [10], South African Indian culture is generally male-dominated, with women accorded a lower status than men. Men are socialized to believe that women are inferior and should be under their control. On the other hand women are socialized to over-respect men and act submissively towards them. The resulting unequal power relation between the sexes is problematic particularly when negotiating sexual encounters, and breeds animosity in relationships. As one participant (female, 38 years old) recounts, "*My husband was a dog, he slept around with many women, I knew this but how do I tell him to use a condom when sleeping with me, it was so difficult to do so. As a woman, you are brought up not to talk about all these things and to just be passive when it comes to sexual relation."*

These gendered behaviors entrenched in both men and women play a vital role in the spread of HIV/AIDS within the South African Indian community. Women are supposed to take orders from men in a way that they cannot refuse, such as engaging in unprotected sex even if they do not want. Many female participants cannot challenge a man on sexual issues and cannot talk about a condom since they feel that the man would be curious to know as to where she learnt 180 about it.

One participant (female, 36 years old) reflects on this dilemma, *"I know my husband is sleeping with other women, but I do not dare ask him to wear a condom when we have sex. I am afraid of what he would do to me and growing up in a traditional home I was brought up to never question a man, he is my husband so I just keep quiet."* Another participant (femal, 42 years old) explains further, *"How can I ask my husband to use a condom, he is my husband, even though I now he is sleeping around I cannot insist on him using a condom. He would think I am sleeping around and would ask me how I know about condoms."*

Women often find themselves in these predicaments where their husbands are promiscuous, leaving them exposed to the virus. Women reported that they often know that their husbands have been unfaithful, but feel incapable of taking the appropriate measures to protect themselves by demanding their husbands use protection while with them. Their husbands will question why they want to use protection, offended, as found, by their suspicions that they have been unfaithful [7]. One participant (female, 28 years old) explains, "*My husband gave me the disease, I knew he was sleeping around with other girls but I didn't say anything. I was too afraid of confronting him about him sleeping around and even more afraid of asking him to use a condom when he slept with me, how can a wife ask her husband to use a condom?"*

Evidence from the current study suggests that most women are expected to be faithful, while accepting the unfaithfulness of men with an inability to protect themselves against sexually- transmitted infections by demanding safe sex. A participant (female, 45 years old) elucidates "*I am HIV positive, I was a faithful wife. I knew my husband had other women, but what could I do? As an Indian woman you are brought up to not question a man and always obey your husband and be faithful. Look at me now I am HIV positive because I was too scared to confront my husband about his other women and to insist on safe sex."*

Most of the female participants were afraid of asking their partners to use a condom. Women'sinferior status means that they often have little or no power to negotiate for safer sex. As one participant (female, 38 years old) explains, "*My husband is the man of the house, I cannot question him. It was the way I was brought up. As a husband I am to respect his wishes, even if he has other women I could not have asked him to use a condom. It was through this that I am HIV positive today."* This way woman appear to have little power in relationships and perceive themselves not to be in a position to negotiate safe sex practices with their partners.

Violent and Abusive Relationships

Many women in the study indicated that they face the threat of physical violence (both domestic violence and sexual abuse) if they are not sufficiently responsive to a partner's desires. Under these circumstances, many of the women will prefer to risk unsafe sex in the face of more immediate threats to their well-being.

A participant (female, 33 years old) explains, *"My husband used to be very physically violent towards me, I stuck in the marriage as I was too afraid to leave him. If I refused to have sex with him he would get very angry and punch me around and force himself on me, so I use to just give him sex when he wanted."* Another one (female participant, 35 years old) goes on to say, *"I face abuse from my husband nearly every day, he comes home from work and takes all his stress out on me. What can I do this is my life I have learnt to accept it, even in the bedroom if I do not want to have sex, he forces himself on me. I am his wife I have to go along with what he wants even if I don't want it."*

Sexuality is one of the most common areas in which men exert power over women through violence. Women may be beaten for refusing a sexual advance, wanting to end a relationship, or having or being suspected of having other partners [12]. One participant (female, 27 years old) explains, "*When I found out that my husband had been sleeping around I refused to have sex with him. He then stated to beat me up saying I have other men that is why I do not want to have sex with him. He would then force himself on me."* Another participant (female, 22 years old) goes on to say, "*I did try to leave my boyfriend once. He got really angry and assaulted me so bad that I landed up in hospital. He said if I ever left him he would kill me. I had no choice but to stay with him. Now looking at it now, I should have walked out a long time ago, he gave me AIDS. I should have walked out back then and had him kill me instead of now living with this disease."*

According to most of female participants, many men still do not want to use condoms, and some become violent in order to force

women to have unprotected sex. Women may not even raise the issue of safer sex for fear of a violent response. One participant (female, 22 years old) explains, *"My boyfriend was a very violent person. I would not dare ask him to use a condom in fear of him hitting me. I was too afraid to leave him and now I got this disease from him."* Young South African Indian women in the study viewed sexual violence or sex that is obtained through force, fear or intimidation as normal, reflecting perverse gender norms in their community. A participant (female, 19 years old) elaborates, *"For me this is normal, it is a way of life for most of the women here in Chatsworth. My boyfriend hits me and sometimes forces himself on me. I grew up with my father hitting my mother all the time, so this is normal to me in my relationship. I just have to deal with it."* Another participant (female, 52 years old) further states, *"Because of the abusive environment, with my husband abusing me all the time, my daughter was exposed to all this. Now she is in the same situation. Her boyfriend hits her all the time. When I asked her why she is still with him, she told me it's one of those things, men are like that, look at daddy, he hits you all the time, men are like that, and we just have to put up with it."*

Gender-based violence both reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. Many forms of violence are reported to be widespread among the South African Indian community in general, and this was clearly reflected in interviews for this current study.

Economic Dependence

Many South African Indian women in the study are economically dependent on men; this dependence renders them unable to take decisions on divorcing their husbands. One participant (female, 52 years old) recounts, "*I wanted to leave my husband many times, but how would I support my children? I am not working. I have never worked before, my husband didn't allow me to work; he wanted me at home to take care of the family. He provided me with what I needed. If I had left him and gone to my parents, how would I have supported my children, as my parents are pensioners? I was forced to stay with him for that reason.*"

Another participant (female, 33 years old) explains, "*I could not leave my husband, who would care for me and my children if I had left him?"* This dependence is a product of the patriarchal culture that exists in many communities such as that of the South African Indian community. With this dependence on men, the women have little say in decisions about practicing safe. Since their husbands are bringing home the money, women do not have leverage to deny sex to their husbands. One participant (female, 27 years old) recounts another scenario, *"My husband was the only one that worked in the family, I knew he had other women, but since he was bringing inthe money in the house, how could I have asked him for safe sex, when he was my only means of support."*

Many of the female participants feared that if they spoke out, their husbands, as financial supporter, might leave them with nothing. One participant (female, 42 years old) reflected this general view, "*I was too scared of leaving my husband, my parents are poor. If I leave him and go back to my parents, who would take care of me and my children? It is for that reason I stayed with him, knowing all too well he had other women. I had no choice.*"

Sex Work

The situation of economic dependency has led some women and girls in the community to resort to sex work as a survival option. For many divorced, widowed or abandoned women who live in an urban setting in KwaZulu-Natal with soaring unemployment rates and low levels of education for girls, the chances of finding a secure job and therefore gaining financial independence are slim.

One participant (female, 18 years old) explains, *"When my father died, we lost everything. My mother could not find a job. We had no food to eat. I had to leave school to try and find a job but I couldn't get anything, so I decided to sell my body so that I could support my family. I had no choice, what could I have done? I could not find a job and my family was starving. This was an easy way to make money to feed my family."* Another participant (female, 21 years old) further states, *"I have a two year old child, my husband left us for another woman. I was not working. When he left us I went out looking for a job but was unable to find anything. I needed a way to feed my child. That is why I have sex with men for money. The only thing I had that could get me money was my body."*

For the women and girls like who exchange sex for financial security they are, for the most part, poor with low education and have no other means of ensuring that money will be available to feed and house themselves and their children. One participant (female, 22 years old) explains *"I sell myself not because I enjoy it I do this so my family can have food and the rent is paid. My father abandoned us a few years ago. My mother could not find a job. I had to leave school but could not find any work. I was sitting in the park on day when a guy came up to me and offered me fifty rand if I gave him a blowjob; I was desperate so I did it. And from there I realized I can make money in this way to feed my family."* These desperate situations of poverty that many of the female participants that are sex workers find themselves in make them extremely vulnerable to HIV. Even if they do want to use a condom, they might again find themselves in an unfavorable economic situation. A participant (female, 18 years old) further explains, *"I would love to use a condom with every client I have, but sometimes you get a few that are willing to pay more to do it without a condom. If I refuse I lose out on that money and he will go to someone else."* Another participant (female, 21 years old) states, *"If I force the guy to use a condom, I would lose most of my clients. There is lots of competition here with the girls."*

Limitations

Although the results presented here do address an important and understudied research topic in the South African Indian community. The research employed a qualitative design and cannot be generalized beyond the selected study community. Despite these limitations, the study findings contribute to the understanding of the role of gender power inequities in driving engendered HIV epidemic.

Discussion

The findings indicate that unequal power relations between Indian men and women, particularly when negotiating sexual relations, would increase women's vulnerability to HIV. The distinct roles and behaviours of men and women are dictated by that culture's gender norms and values that give rise to gender differences, which empower one group to the detriment of the other, and women and girls bear the brunt these gender inequalities [13]. South African culture is generally male-dominated, with women accorded a lower status than men.

This male-dominated culture socializes, men to feel that they are superior to women and women to relate to men in a submissive manner [11]. Women's inferior status means that they often have little or no power to negotiate for safer sex. For many of the female participants, their subordinate positions made it difficult if not impossible for them to protect themselves from HIV. They often cannot insist on fidelity, demand condom use, or refuse sex to their partner, especially when they are married and even when they suspect or know that their partner is HIV infected. In addition they often lack the economic power to remove themselves from relationships that carry major risks of HIV infection. In agreement with the current findings in other communities gender inequalities have also been associated with unprotected sex and increased risk for HIV infection among women [14,15].

For many South African Indian women in the study the threat of violence that permeates their everyday lives exacerbates their vulnerability to HIV, as explained by many of the female participants. According to the women participants' fear of violence prevented them from accessing HIV/AIDS information, being tested, disclosing their HIV status, accessing services for the prevention of HIV transmission to infants, and receiving treatment and counseling, even when they knew they had been infected. Gender inequalities have been linked to diminished educational and economic opportunities for women, and intimate partner violence [16].

Findings also revealed that commercial sex work, a coping mechanism for some women and girls struggling against poverty and lack of economic opportunities, is also a vehicle for HIV transmission. Similar to current finding evidence shows that women's lack of financial security and independence contribute to higher HIV risk through mechanisms such as the exchange of sexual favors for goods or financial resources or the inability to negotiate safe sex behaviors because of financial dependency [17].

Conclusion

Vulnerability of the study community to HIV has social roots, and gender inequalities dictated by that culture's gender norms and values are deeply entrenched and pervasive. In a context of pervasive poverty, employment and inequality there is a need to address these societal beliefs, norms, customs and practices even in minority communities if we are to win the battle against HIV/AIDS in South Africa. However, more in-depth research is needed to elucidate the underpinnings of gender power inequalities in order to inform both gender-focused and couple based interventions addressing gender equitable norms, women empowerment and shared power relations as a pathway to improved HIV-related behaviors [18].

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