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Gender Inequality and HIV/AIDS in Lesotho: A Human Disease Ecological Perspective

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ABSTRACT In this article we ponder gender inequality and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) in the context of Lesotho from a human disease ecological perspective. Overwhelming literature reveals a general trend in terms of inequalities relating to power relations, socialisation and culture, as well as legislation. Women remain disadvantaged. However, the reverse of the current scenario seems to have not always been the case as some literature revealed a nuanced picture of gender relations in nineteenth century in Lesotho convincingly showing that social presence of African women was at once contingent and independent, subordinate yet oddly powerful. It can be argued that addressing gender inequality in Lesotho, and in other countries as well, needs a conscious, concerted and deliberate effort, in mitigating the impact of HIV/AIDS, and at making sense of each of the interdependent elements of human ecology.

INTRODUCTION

The purpose of this article, drawing from existing literature, is to traverse gender inequality among the Basotho (a tribe in the southern African country called Lesotho) in the era of HIV/AIDS. Several studies portray gender and HIV/AIDS - which is a human disease, as having a very strong and critical relationship with human behaviour and the way people respond to health challenges (Kimaryo et al. 2004; Owusu-Ampomah et al. 2009). We draw from Meade and Earikson's (2000) human disease ecology framework. Human disease ecology approaches the geography of disease from an ecological viewpoint. Ecology is the scientific study of the relationship of organisms to each other and to their environment. Disease ecology can thus be interpreted as the study of how disease interacts with humans, animals, plants, and the environment. Meade and Earickson (2000:21) further point out that "the human ecology of disease is concerned with the ways human behaviour, in its cultural and socio-economic context, interacts with environmental conditions to produce or prevent disease among susceptible people" (p. 21).

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The framework was adapted by Curtis (2004) who states that an understanding of the social and behavioural factors can help in the understanding of ecological and other risks in order to inform public health strategies with the aim of reducing health inequalities. She (Curtis) further presented the conceptual framework for human disease ecology in the form of a triangle of interrelated groups of factors, comprising population, habitat, and behaviour. Human ecology is an emerging discipline that studies the interrelationships between humans and their environment, drawing on insights from other disciplines, including health and elements such as language, culture and society. Curtis highlights the fact that all the above are interlinked and for one to fully understand the behaviour of people for instance, it is necessary to consider all other factors like the distribution of people within a population or other social environmental factors that may contribute to people's behaviour. In an effort to provide some background to the social analysis of the HIV/AIDS epidemic in Lesotho, we will highlight the link between gender inequlities and health, with a specific focus on HIV/AIDS.

As Brown and Zavestoski (2005) indicate, Health Social Movements (HSM) are an important force concerned with health access and quality of care, as well as broader social change. They can be a collective set to challenge medical policy, public health policy and politics, and belief systems, just to mention a few and they include

an array of formal and informal organisations, supporters and networks. These movements challenge political power, professional authority and personal and collective identity, and they address access to, or provision of health care services; disease, illness, disability and contested illness; as well as health inequality and inequity based on race, ethnicity, gender, class and or sexuality. In the case of Basotho, these movements have also been realised and have evolved over the years, with a specific focus and dominance on the HIV/AIDS front. They evolve from the communities, through the districts, to the national level and beyond, with most of them focusing on the three key areas as outlined by Brown and Zavestoski above, though the level of their interaction is somewhat limited compared to other movements in the southern African region. The article proceeds to briefly contextualise Lesotho, engages issues relating to legislation, power relations, socialisation and culture, and discusses how these impact on gender inequality and HIV/AIDS in Lesotho.

LESOTHO IN CONTEXT

Lesotho, also known as the 'Kingdom in the Sky' has, from the dawn of its creation cultivated a strong culture and heritage to overcome the most daunting challenges with a true sense of pride and a will to survive (Kimaryo et al. 2004). Lesotho is a constitutional monarchy, with a population of 1.8 million inhabitants whose external relations are dominated by its economic and geographic dependence on its neighbour, the Republic of South Africa, which completely surrounds Lesotho. Kimaryo et al.(2004) further indicate that it has been estimated that over 250 000 Basotho (nationals of Lesotho) are normally resident in South Africa, with their numbers constantly growing with the increasing job opportunities in South Africa which create further opportunities for Basotho to support the ever important extended families in Lesotho's rugged terrain.

Basotho have always stood together in times of crises to find solace and solutions in order to celebrate their heritage, peace and unity. This is also highlighted by the strong identification of Basotho's origin and strength from the vision of Moshoeshoe I, who is the founder of the Basotho nation. Moshoeshoe built the nation on the principles of leadership, family, diplomacy, and when necessary, war. Since gaining its independence from Britain in 1966, Lesotho has endured a number of trials in civil unrest in the political arena alternating between political unrest, protest, and democracy. Lesotho is a highly patriarchal society, as the man is still considered to be the head of the family and the key decision maker, based on the customary and common laws enshrined the in Constitution. It should, however, be noted that due to strong advocacy in the areas of gender equity and equality, as well as through the ratification of international treaties and protocols, the Sexual Offences Act was enacted in 2003 to protect women from the injustices that had been socialised into society. The Sexual Offences Act of 2003 was further complemented by the Legal Capacity of Married Persons Act of 2006, which also aims to protect women within the different forms of union, whether married, co-habitating and single women and men in various relationships.

Kimaryo et al. (2004) also indicate that Basotho have in the past triumphed against diverse challenges to their survival, though the current challenge of HIV/AIDS is bigger than any other challenge Basotho have ever faced. The authors are, however, of the opinion that such grave challenges may bring out the best in people, as with the same fortitude, resilience and will that have seen Basotho through past challenges, Lesotho can overcome the challenge of HIV/AIDS and related challenges. Lesotho's generalised epidemic impacts every sector of Basotho society and has led some to posit that, according to CARE Lesotho (2004), there are two types of people in Lesotho; those infected and those affected by HIV/AIDS. Following the first diagnosed case of HIV/AIDS in 1986, the number of individuals living with the virus increased rapidly.

GENDER AND HIV/AIDS IN LESOTHO

Gender inequality is regarded as one of the major drivers offir the spread of HIV/AIDS (Braun and Dreiling 2010; Hatcher et al. 2010; Natrass 2004; Poku 2002). While initially AIDS was seen as a disease for 'middle-aged gay men' in Western industrialised societies and for the elite in both Brazil and some sub-Saharan African societies in the 1980's, it has become a gendered epidemic in the twenty-first century (Bolin and Whelehan 2009). Lesotho has made

some considerable strides in an effort to attain gender equity and equality though there are still some glaring challenges facing the country in terms of its gender dynamics, as well as in terms of its policy and legal frameworks. Similar to other countries, the 1990's saw considerable advances for women in terms of political representation, as women's organisations and female members of political parties have vigorously lobbied for the increase of women's representation in decision- making bodies – notably through quotas – though there are still some structural challenges that need to be addressed. While many countries including South Africa (and Lesotho) identify and consider themselves as democracies, and have established institutions of representative government, the degree to which democracy has been consolidated and institutionalised is highly variable (Razavi 2002).

Marriage in Lesotho occurs relatively early on in life and one in five girls between the ages of 15-19 have been married. Traditionally, women have been dependent upon male family members for economic support and representation. Unable to own or inherit property, women were legally considered minors until the Government passed the Legal Capacity of Married People's Act in 2006. Owusu-Ampomah et al. (2009) indicate that the high HIV prevalence and mortality among women of reproductive age has serious implications for the health and well-being of other vulnerable populations. Women are the primary care providers of children and the sick, and when women die, coping mechanisms are stressed and vulnerable populations become increasingly susceptible to livelihood failure and infection. According to Partners In Health Lesotho (2009), the total number of children orphaned by AIDS, including dual, paternal and maternal orphans, is estimated at 108,700 – implying that about 5.8% of Lesotho's population has had one or both parents die from an AIDS-related disease. Certain segments of the population are disproportionately infected and affected by HIV/AIDS, with women carrying the burden of disease and at greater risk of infection as among those infected nationally, 56% are women and 44% are men. Within the 15-24 age groups, 71% of those infected are females. It is critical for decision makers and communities in general to understand the relationship between human sexuality (biology), psychology and culture. This stems from the authors' observation of the Basotho and the way they disconnect or dissociate issues of culture and those of psychology and sexuality. This is explicitly outlined by Bolin and Whelehan (2009) as they state that psychology emphasises the importance of the individual's relationship to their cultural context, and from a biological perspective, each individual has a unique genetic heritage (with the exception of identical twins). They further allude to the fact that sexual behaviour is culturally patterned; it is not accidental or random but interconnected to varying degrees within the broader context of culture. There are a number of underlying factors to the current gender dynamics (legislation, socialisation and culture, power relations) in Lesotho, and these will be further explored next.

Legislation Egislation

Though Lesotho has enacted both the Sexual Offences Act (2003) and Legal Capacity of Married Persons Act (2006), there are some legislative issues which further perpetuate the challenges faced by women and girls in Lesotho. The United Nations Development Programme (UNDP 2005) indicates that in terms of food security and survival, the distribution of land for agriculture is biased towards males. The current law on land matters (the Land Act of 1979 – currently under review) is gender neutral in its provisions, something that the researcher has still identified with the version under revision. However, the common practice (especially in the rural areas) is to allocate land to married men based on customary practice. This further strengthens the views expressed by Owusu-Ampomah et al. (2009) and Drimie (2003) earlier as they re-affirm that according to these attitudes, a family is headed by a man, and he has control over family property, including land, which must be in his name. This implies that women's access to land is mainly through men. Wahlstrom (1990) also noted that women in Lesotho are the *de facto* heads of household. This means that they are seen as not having any true decision-making power, despite the reality that men are away from home for longer periods of time. Decisions are usually deferred until men return (Everett 1997; Gordon 1981).

This arrangement is in direct conflict with the Southern African Development Community (SADC) Protocol on Gender and Development of 2008, which Lesotho is signatory to. Article

2, 1 (a) of the Protocol states that, " States Parties shall harmonise national legislation, policies, strategies and programmes with relevant regional and international instruments related to the empowerment of women and girls for the purpose of ensuring gender equality and equity." It should also be noted that Lesotho still uses the dual system of Law, being the Roam Dutch Law and the Customary Law. As Mosetse (2006) points out, in terms of marriage for instance, two forms of marriage are recognised in Lesotho, being the customary marriage and the civil marriage under the Common Law. It, therefore, becomes apparent that there are instances of inconsistency as the two laws are not in total synch with each other with regard to the considerations. This clearly leads to some challenges and repercussions for Basotho women in terms of them realising their rights.

Socialisation and Culture

Epstein et al. (2004) and Drimie (2003) posit that the incidence of HIV/AIDS cannot be separated from social relationships and therefore the different forms of manifestations of social relationships are bound to have different impacts. Bolin and Whelehan (2009) further affirm that humans acquire their culture through the process of socialisation, as the capacity to learn and to adapt to one's environment is part of humans' unique bio-cultural and psychological evolution. With a variety of definitions available for culture, they define culture as," the information, skills, attitudes, beliefs, value – capable of affecting an individual's behaviour, which they acquire from others by teaching, imitation, and other forms of social learning". Parental and relationship forms are based on cultural patterns of gender role behaviours and expectations, which are learned, patterned and symbolic.

Women's minority status, religious and cultural beliefs and adverse economic conditions negatively impact the health status of most Basotho women. This, therefore, makes it difficult for women to negotiate safer or protected sex within their relationships. As a consequence, women face increased chances of contracting sexually transmitted infections (STIs), HIV/AIDS and having undesired pregnancies. Gender- based violence and gender inequality are increasingly cited as important determinants of women's HIV risk. Women's vulnerability to HIV is further increased by cultural perceptions of women's sexual and reproductive obligations. Payment of a bride price ***(****bohali)* gives men the impression that they 'own' their wives. Furthermore, the fear of violence or abandonment by partners is one other factor that contributes to the spread of the disease. Women have the inherent fear of being 'left' by their partners if they demand safe sex in marriage, even if they know that their husbands do engage in risky sexual behaviour outside of marriage (UNDP 2005; Mosetse 2006). Mosetse (2006) further posits that gender appears to be a cultural construct rather than a biological construct and therefore gender inequalities appear also as a result of cultural activities. This leads to the realisation that when gender roles and stereotypes become very deeply embedded, the phenomenon then becomes part of a group's worldview and cultural values.

Power Relations

People's action and inaction are influenced by power dynamics in our everyday environment. Power relations exist between men and women, and within families and communities. Power relations affect the way we interact and respond to HIV/AIDS. It can, therefore, be argued that when people understand power relations that they are able to be proactive in recognizing and minimizing the negative impact of power relations and therefore enable people to better prevent HIV/AIDS and lessen its impact. A power relation is a concept defined in terms of relational fields rather than of personal or role attributes, of power as ruler and the ruled. Power refers to those aspects of relating that translate influence that make a difference, that have an effect. The actions of one affects the thoughts or actions of another. The poles of a power relation could be characterized by such descriptions as dominant-submissive, controlling - rebellious, have - want, strong - weak. So within the field of power relations, what one person does affect a second, which affects a third, and so on. Such effects ripple onwards and outwards from human interactions in patterns that are indeterminate; yet even so the patterns are sometimes decipherable and probabilistically predictable, for the fields that affect the patterns are stable and translatable.

For example, in all cultures there are families, groups of people genetically related whose

patterns of interaction are relatively stable, whose ways of behaving towards one another are consistently patterned; the parent influences the child, the parent's demands produce action, the power vector is from parent to child. Yet even so the child's behaviour must influence the parent's behaviour, if only to maintain the parent's controlling function. In this sense power relations involve mutual influence, even though normally asymmetric and translated into action involve dynamic events (Wilson 1998). Rath (1997) provide a working definition of power relations being the one that distinguishes them from causation without losing their similarities and goes on to provide an analytical exposition highlighting the following:

- *Power relations are what enable who to do what to whom* - rather than "who does what to whom."
- *Power relations are the matrix of possible actors and their possible interactions*
- *(what) enables (who) to (do what to) (whom)*, for example, *(wealth)* enables *(the west)* to *(exploit) (the rest)* - *(labour)* enables *(the rest)* to *(sell to) (the west)*

He goes on to offer a derivative of the starting (who-gets-to-do-what-to-whom) definition being that *power relations are the bounded portion of power that gives agents the ability to act and to interact in a particular way.* They are *the domain of latent power that makes it possible for entities to interact in a way that temporally manifests that power among them*, and can be referred to as *ever-shifting threats and promises.* In the context of unequal power relations such as gender relations, Moletsane et al. (2009) argue that collaborative and collective feature of participatory video-making is essential for effecting social change. The collective nature of such an intervention also addresses possible threats of intimidation and violence against women, especially in patriarchal contexts where it is taboo for women and girls to speak out against important issues that affect their lives.Sustained changes in behaviour that are large enough to affect the course of the HIV epidemic are difficult to achieve. In part, this is because social, economic, political and environmental factors affect HIV risk and vulnerability, including poverty, gender inequality and social exclusion. The importance of such structural factors in the dynamics of the global HIV pandemic is increasingly recognized and favours longer-term development approaches to HIV prevention, which address the social processes that shape and constrain individuals' behaviours and their possibilities to protect themselves (Waldo, Coates 2000; Gupta et al. 2008; Sidibe et al. 2010; de Wit et al. 2011).

DISCUSSION

HIV/AIDS is one of the largest challenges facing policy makers in countries affected by the pandemic (Drimie 2003). Gender inequalities clearly fuel the pandemic, leaving women particularly vulnerable to infection (Epstein et al. 2004; Mitchell et al. 2010). The policy states that the major facts that have been identified as the drivers of the epidemic comprise the following:

- Migrant labour to South African mines that have mainly provided job opportunities for males in Lesotho has contributed to high transmission of HIV as most of the workers were accommodated in males' only hostels. This increases chances of transmission and further spread to their spouses on return.
- Gender inequality and gender-based violence promoted by the low socio-economic and legal positions of women
- Intergenerational sex especially between older males and younger women due to the socio-economic vulnerability of young people particularly girls.

It is also worth noting that there needs to be more comprehensive policies and legislative framework to effectively guide the response to HIV/AIDS to be identified, highlighting the following key issues to be addressed by the enhanced policy framework: Recognition of the need to strengthen gender equality for women and girls, and other vulnerable groups to have equal access to prevention, treatment, care and support, and impact mitigation services including legal support; Recognition of the need to enhance the promotion and protection of human rights of all people to eliminate the vulnerability to HIV infection and reduce the impact of HIV/AIDS on individuals, communities and the general population the researcher feels there is a need for a more gender-sensitive response to the HIV/AIDS epidemic in Lesotho as most of the key drivers of the epidemic as outlined in the Policy have a direct relationship and impact on women more than on men. For instance, it has been identified as early as 2006 when the policy was for-

mulated that these key drivers included gender inequality, gender based violence, transactional sex, and multiple and concurrent partnerships as factors directly relating to women, but there is no evident shift in terms of programmes and strategies in the national response to HIV/AIDS following the formulation of the policy. Gender mainstreaming has mostly been seen as the responsibility of the Ministry of Gender, Youth, Sports and Recreation, without all the sectors ensuring that gender is mainstreamed in both their programming and the sectoral HIV/AIDS response.

CONCLUSION

The authors are of the opinion that the current HIV/AIDS response and coordination structures in Lesotho do not necessarily respond to the key drivers of the epidemic. For instance, there does not seem to be an obvious link and mandate of women's organisations in the national response, albeit evidence strongly suggests that women are the most affected by the epidemic. UNAIDS (2005) advocate prevention of the spread of HIV, ensuring that HIV/AIDS is a manageable disease for those infected with HIV, and successfully averting and mitigating the multiple impacts of HIV/AIDS can only be done successfully if gender issues are effectively integrated into HIV/AIDS programmes. It further goes on to indicate that reducing gender inequality in all its facets and manifestations and transforming gender stereotypes and gender relations is possibly the most effective strategy in reducing vulnerability to HIV infection. Addressing gender issues is not a matter of occasionally or haphazardly including a focus on women (and/or girls) in HIV/AIDS programming, but rather, what is at stake is the equal protection and realisation of human rights of men and women, regardless of age, ethnicity, religion, class or any other factor, so that they can realise their full human potential. The UN Assembly is reported to have noted, perhaps with regret, that the action on women's issues is already overdue (African Health Bulletin 2009). Surprisingly, a nuanced picture of gender relations in nineteenth century Lesotho convincingly show that social presence of African women was at once contingent and independent, subordinate yet oddly powerful (Eprecht 2000). It can be concluded that addressing gender inequality in Lesotho, and in other countries as well, needs a conscious, concerted and deliberate effort, in mitigating the impact of HIV/AIDS, as well as at making sense of each of the interdependent elements of human ecology.

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