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GENDER INEQUALITIES AS KEY DRIVER OF HIV/AIDS IN JAINTIA HILLS, MEGHALAYA

INTRODUCTION

India is the second most populous country in the world. It accounts for 17% of the world's population and is home to 21.17 lakhs of People Living with HIV/AIDS, which is second to Sub-Saharan Africa and Nigeria. Women are the worst affected and the most marginalized groups when it comes to HIV. They constitute more than half of all People Living with HIV/AIDS. AIDS-related illnesses remain the leading cause of death for women aged 30-49 and the third leading cause of death for women aged 15-29 (World Health Organisation, 2017). It is well known that the disease affects women differently and disproportionately compared to men. Gender inequality is the singular most important reason for this unequal and unjust impact of HIV on women. This disparity manifests itself in myriad ways at all levels. Women are pushed to the periphery when it comes to education, ownership of economic resources and health care facilities. The traditional society considers them as the weaker sex. They have been exploited, degraded and accorded a subordinate position to men both at homes and outside world. This peculiar type of bigotry against women is prevalent everywhere in the world and more so in Indian society. They are often less able to negotiate safe sex, suffer greater social stigma from being HIV positive, and as the principal family carers, may have added burdens if there is AIDS within the household. The factors fuelling the HIV infection among women are early marriage, reproductive age, unsafe sexual practices, forced sex, violence against women and girls, gender inequality, other sexual transmitted diseases etc. (WHO, 2017; UNAIDS 2015, 2014; Jewkes et al., 2006). "This epidemic unfortunately remains an epidemic of women" (UNAIDS, 2013). Marriage does not always protect a woman from becoming infected with HIV. Many new infections occur within marriage or long term relationships as a result of unfaithful partners. They typically have more frequent access to healthcare than men due to antenatal care. This means they often know that their HIV status before their partners. However, the imbalanced power in the household, and lack of education, can lead to men assuming their partner was infected first; this may cause friction that may lead to violence. (Global Network of People living with HIV, 2010) Gender bias between men and women is closely related to notions of legitimacy and

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correctness. In family behavior, inequalities between men and women (and between boys and girls) are often accepted as natural or appropriate (Sen, 1985). In India, the root cause of gender bias is its patriarchal system. But in a matrilineal community of the Jaintia people in Jaintia Hills, Meghalaya, gender disparities take a strong hold which makes the women of the community vulnerable to HIV. A slow creeping patriarchy in this matrilineal community of Meghalaya is being mirrored. However, according to the Jaintia women, this secret can never be revealed. The situation is ironic considering this community as one of the oldest practitioners of matriliny under which family lineage comes from the mother and family and social control flows from the same source. Matriliny has, however, become akin to an ad for Meghalaya but is not its reality no matter what outsiders think. In the current study, women are the custodians of family wealth but not owners. The uncle is the one who actually takes decision. In 2015, HIV prevalence in Meghalaya has shown an increase from 0.16% to 0.73%. (HIV Sentinel Surveillance, 2017) In view of high prevalence of HIV infection and unavailability of information on HIV and gender issues prevailing in Jaintia Hills, Meghalaya, the current study was carried out with an aim to determine the problems faced by women due to gender disparities, physical, sexual and emotional violence which opens the door for HIV/AIDS infection.

MATERIALS AND METHODS:

A cross- sectional study was conducted among 320 Jaintia tribe women belonging to the age group 15-35 years in East and West Jaintia Hills, Meghalaya. There are five blocks in both the districts namely Thadlaskein, Laskein, Amlarem, Khliehriat and Saipung. Young women and adolescent girls aged 15-24 years are particularly affected in HIV infection. Globally, in 2015 there were an estimated 2.3 million adolescent girls and young women living with HIV, that constitute 60 per cent of all young people infected with HIV (15-24 years) (WHO, 2017). Several studies on HIV infection among the women between age group 15-49 years was conducted and among the youth population between age group 15-24 years globally (for both men and women). Few studies were conducted among the youth population in general (aged 15-35 years) and no information was available particularly on women between this age group. As per the National Youth Policy of India (2003), the youth population belongs to the age group of 15-35 year. In view of high prevalence of HIV infection among the women in reproductive and sexual active group and availability of limited information on HIV particularly among the youth population, especially in women, the present study focused on the young women belonging to the age group 15-35 years.

In brief association with a project under Indian Council of Medical Research, various written permissions were sought prior to the initiation of the study:

- Permission was sought for working in the districts from the Social Welfare Department, Government of Meghalaya through Ministry of Tribal Affairs, Government of India.
- Accordingly written permission was sought from the Deputy Commissioner of West and East Jaintia Hills to conduct the fieldwork in the area.
- The District Vector Borne Disease Officer of West Jaintia Hills granted written permission to conduct the field study.
- The permission was also sought from the Village Headman "*Rangbaishno*" (local name) before conducting the fieldwork in that particular village.
- The local NGO (Mihmyntdu Community Social Welfare) in Jowai village under Thadlaskein Block was surveyed. In order to collect data from the NGO**,** permission was granted by Dr. J.N. Shullai, Project Director of the NGO. The vision of this NGO was to enable the creation of a just and equitable social order, with the goal to enable individuals to live a life of dignity and respect.

The sample size of 308 was calculated using online sample size calculator http://www.surveysystem.com/sscalc.htm, giving prevalence estimates with 95% confidence level and within 5% confidence interval for a total number of people living with HIV (PLHIV) in Meghalaya, which is 1, 541. (Meghalaya AIDS Control Society, 2014). Structured interview schedules, participant observation and in-depth interviews were used to understand the stress, abuses and gender issues related to HIV infection. The interview schedules were prepared focusing on factors like decision making and violence against women. Various anthropological approaches were used to collect qualitative data like case studies and by conducting focused group discussion (FGD) targeting married females. Data was collected by interacting with the women and building rapport by developing mutual trust with them. This was supplemented with living in the community, participating in their activities and constantly observing what the women actually do in specific situations.

FINDINGS:

The present study revealed that all the women belonged to the age group 15-35 years of age and belonged to the Pnar, Biate, War Khasi and Garo tribes. The religions followed by these women are Christianity, Hinduism and Niamtre. Niamtre is an indigenous religion of the Jaintia tribes. It is the original tribal religion of this community. They believe that their religion is God-given (not founded by man) and comes to this world by God's decree. The three cardinal principles dictated by God are *kamai yei hok*, *tipbru tipblai* and *tipkur tipkha*. They signify right living and practice based on right livelihood;

fulfillment of duties toward fellow men to reach God; and showing respect to the members of one's father's and mother's clans. Therefore, Niamtre stresses equal weight to be given to fellow humans to attain God realisation. It is found that majority of the women in the study population were literate (primary education-36% and middle school education- 26%) and the rest were illiterate. The occupational status of the women shows that most of the women of Jaintia Hills, Meghalaya are engaged in agriculture for a living (66%). While the rest of them work as vendors (20%), health workers (5%), sex workers (7%) and some are housewives (2%). In both social and medical perspectives, age at menarche is considered as the central event of female puberty, as it signals the possibility of fertility. Most of the Jaintia women under study were married (51%). 23% of the women were unmarried, 17% of them were divorced and 9% were widowed. This shows the existence of early marriage, divorce leading to multiple sex partners and early death of the husbands in the study population. Hence, these factors make women more vulnerable to HIV/AIDS in Jaintia Hills, Meghalaya. (Table 1)

Table 1

The Frequency Distribution of general and household information

Parameters	N	%
Community		
Pnar	195	61
Biate	60	19
Wars	45	14
Garo	20	6
Religion		
Christian	156	49
Niamtre	113	35
Hindu	51	16
Age		
15-20 years	50	16
20-25 years	70	22
25-30 years	80	25
30-35 years	120	37
Women's Education		
Illiterate	120	38
Primary	115	36
Middle	85	26
Occupation		
Labourer/ family farm	210	66
Vendor	65	20

Homemaker	22	7
Sex worker	7	2
Health worker	16	5
Age at menarche		
12 years	158	49
13 years	112	35
14 years	26	9
15 years	24	7
Marriage		
Married women	162	51
Unmarried women	73	23
Divorced women	55	17
Widowed women	30	9

Among the Jaintias, in most of the families the women take decisions consulting the elder one in the family (elder brother). But there are variations in decision making. The factors like use of condom, sex and divorce are decided by men in most of the families. This marks the presence of gender disparities in the study area. The decision making power of the family regarding what to eat everyday varies in different families. In the present study, it is observed that in majority of the families the women decides what to be cooked and which school their children should go. However, the decision regarding having sex (74%) and use of condom (74%) in most of the cases is taken by the male partners. The percentage of women having power over household chores is 61% and men is 39%. Though the population under study is a matrilineal society but gender issues exist in the study area. In matrilineal societies, a person's descent is traced through the mother or maternal ancestors. For instance, property such as land is handed down from the mother to the daughter (youngest). The decision of divorce depends on both women and men. But the percentage of men deciding on divorce is more compared to that of women i.e. 60% (men) and 40% (women). The study revealed various reasons of divorce like refusing sex, unfaithfulness, HIV infection, failure to support family, physical, sexual and emotional violence. (Table 2)

Table 2

The Frequency Distribution on decisions taken by the male and female members of the Jaintia Community

	Parameters	Female		Male	
		N	%	N	%
1.	Decision on cooking	197	61	123	38
2.	Decision on children's schooling	212	66	108	34
3.	Decision of having sex	84	26	236	74
4.	Decision of the use of condom	84	26	236	74
5.	Decision on household chores	194	61	126	39
6.	Inheritance of property	320	100	0	0
7.	Decision on divorce	127	40	193	60

In the current study there exist power inequalities within relationships. These gender roles can confine women to positions where they lack the power to protect themselves from HIV infection. Women who are victims of sexual violence are at higher risk of being exposed to HIV due to lack of condom use. The study revealed that women who were beaten or dominated by their partners were much more likely to become infected with HIV than women who were not. HIV transmission was much greater in abusive relationships. The forced nature of a violent sexual intercourse results in wounds and deep abrasions that put them at a higher risk of contracting HIV. This coupled with the absence of condom use under such circumstances exacerbate the vulnerability of the woman to HIV. Apart from sexual violence, what enhances the risk for women is the culture of silence surrounding everything related to sex and sexuality. Inexperience and lack of information in this regard is looked upon as a mark of being a "cultured" woman in Jaintia Hills, Meghalaya. It is one area where being uninformed is prized as opposed to being armed with correct knowledge. Not only is the right of women for correct information nullified under the garb of tradition, they are also disempowered by the lack of control about their own sexual and reproductive decisions.

According to the World Health Organization (WHO), violence against women (VAW) is a "global health problem of epidemic proportions." Violence against women refers to acts of violence directed toward women simply because they are women. These acts can include forms of physical, emotional, and sexual harm. Often, women do not consider these harmful acts as violence, either because the acts are considered to be normal in their society, or because they occur so often that they seem normal. The percentage of Jaintia women who faced domestic violence and sexual violence is 43% and 49% respectively. 8% of Jaintia women have faced emotional violence. The ones who faced emotional abuse had low self esteem, were depressed, anxious and some were even suicidal. (Table 3)

Table 3

The Frequency Distribution of Violence against Women

Parameters	N	%
Physical violence	138	43
Sexual violence	155	49
Emotional violence	27	8

DISCUSSION:

The observation made under the present study clearly indicates that women continue to be disproportionately affected by HIV/AIDS due to their unequal cultural, social and economic status in society. Gender inequality, intimate partner violence, unequal power dynamics between men and women limits women's choices, opportunities and access to information, health and social services, education and employment. The present findings show gender based differences in HIV risk behaviour – women tend towards lower risk behaviour than men, however they also tend towards lower condom use (Chamar, 2015). Only 26 % of the women under study take the decision regarding having sex and the use of condom. In addition, men report significantly lesser belief in the right of women to regulate sexual relations within marriage.

Men evidence aggressive and self serving attitudes and behaviours (Boonzaier, 2005) –beliefs that women are subordinate to men, less belief that HIV is a real threat to their safety. These patters give men a sense of power that is likely to be acted on. This in turn makes women more vulnerable to sexually aggressive men. In the study area, 43 % of women face physical violence, 48% of women face sexual violence and 8% of women face emotional violence.

Women evidence less sexual self protection. It is also important to note that women do not believe in the right of women to regulate sex with their husbands. Women thus become a gendered paradigm – denying the right of women to protect themselves and not exercising safer sex practices to protect themselves.

CONCLUSION:

AIDS feeds on systems of injustice that existed long before HIV had considerable impact on human society. The present study exposes the systems and presents an opportunity for real change. It involves a revolution in long-held cultural beliefs and intensely held personal norms for both men and women. Men will need to work hard, learn about and dismantle the parts of their gender conditioning that have resulted in the development of inappropriate power over women. Both sexes should recognize that men's efforts will bear most fruit in a climate of encouragement and understanding. Women need to

be encouraged to continue to empower and protect themselves, as well as to speak and live their truths as autonomous sexual beings. They deserve help and support in standing up to male domination. At the same time, it must be remembered that women are powerful and not helpless victims of male oppression. They are proactive participants and full partners in the fight to halt HIV/AIDS.

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