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## Marriage No More a Safe Haven : HIV infection and Married Women in sub-Saharan Africa

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# 11 Marriage No More a Safe Haven

## HIV infection and Married Women in sub-Saharan Africa

*Anniegrace Mapangisana Hlatywayo*

### Abstract

In the midst of much reverence and sanctification within the church and communities in the African context, the institution of marriage is identified as a major risk factor and a 'potential death trap' for many married women given the current scale of the HIV & AIDS pandemic. Increasing studies reflect that marriage is a major route of HIV transmission. Sexual intercourse within marriage places women at risk of HIV infection primarily from their spouses' extramarital sexual relations. Whilst this study acknowledges that both husbands and wives are at risk of contracting HIV from their spouses, a myriad of barriers at individual, relational and community level inclusive of socio-cultural, biological and gender inequalities render married women more susceptible to infection. In order to preserve the sanctity of life for women within marital unions, this chapter argues for a theological framework that offers life and dignity to all of humanity. Additionally, in order to redress the gendered nature of the HIV & AIDS pandemic, this study calls for the transformation of harmful masculinities through a bold church and community praxis as mitigation strategies. Drawing from selected works of Chitando on HIV & AIDS, firstly, the study argues for the active engagement of men in the HIV & AIDS discourse. Secondly, the study calls for solidarity between men and women as a strategy for redressing the challenge of married women's vulnerability to HIV infection.

**Keywords:** Institution of marriage, HIV & AIDS, bold church, community praxis, Chitando, married women, transformative masculinities

### Introduction

A growing body of studies reflects that marriage is a major route of HIV transmission in sub-Saharan Africa whereby a large number of newly infected people are women contracting the virus from their spouses (Gumbo 2015; Hagemann et al. 2010; Kamau 2011; Mugweni et al. 2015;

Setume 2016). This means that sexual intercourse within the context of marriage or long-term relationships exposes women to the risk of HIV infection particularly from their partners' extramarital sexual relations. While it is acknowledged that both husbands and wives are at risk of contracting HIV from their spouses, socio-economic, cultural, behavioural, structural and biological gender inequalities expose women to the vulnerability of HIV transmission from their husbands or partners (Awoleye et al. 2022; Ramjee & Daniels 2013; Shoko 2012). It has since been noted that in some countries in sub-Saharan Africa, married women (25.8%) are twice likely to be infected with HIV as compared to their never married (13.4%) female counterparts (UNAIDS 2022). Recent studies also reflect that 54% of all people living with HIV are women and girls who accounted for 49% of all new infections in 2021 (UNAIDS 2023). In 2021 in sub-Saharan Africa, women and girls accounted for 63% of all new HIV infections. These figures are alarming given the fact that sub-Saharan Africa commands only 12% of the total global population (UNAIDS 2023). Furthermore, in sub-Saharan Africa, adult women comprise 1.4 times more the number of adult men living with HIV. This reflects the disproportionate level of the pandemic in the region. A large number of new HIV infections are recorded within heterosexual marriages and/or long-term cohabiting partnerships (UNAIDS 2011b). Accordingly, sub-Saharan Africa is identified as commanding the highest prevalence of HIV amongst women of reproductive age. Drawing on these observations, the institution of marriage is identified as a major risk factor for HIV infection amongst many women. It is against this background that this chapter seeks to interrogate the many drivers that expose married women to the susceptibility of HIV infection.

In a bid to redress the gendered nature of the HIV & AIDS pandemic, the chapter draws on selected works of Ezra Chitando, an outstanding African male theologian who has been on the forefront of engaging with the pertinent subject of HIV & AIDS. As an African male theologian, Chitando's activism and publications interface with religion, gender and HIV & AIDS and have immensely contributed to the deconstruction of patriarchal notions that result in harmful masculinities. In some of his publications, Chitando has proffered strategies that can be adopted for promoting the fullness of life for women in Africa and beyond. This chapter, therefore, engages with Chitando's conception of transforming masculinities as well as lobbying for solidarity between men and women as bold church and community praxis for addressing the gendered challenge of the HIV &

AIDS pandemic. The chapter is based on secondary sources of data collected from the internet and research articles. Literature consulted includes publications from the Circle of Concerned African Women Theologians (Circle) and publications on HIV & AIDS authored by Ezra Chitando.

## **Women and the Institution of Marriage from an African Worldview**

In many African societies, marriage is regarded as the focal point of human existence (Mbiti 1989). It forms the rhythm of life. All members of society are expected to participate in the institution of marriage at an appropriate time. Through the institution of marriage, “all the dimensions of time meet, the whole drama of history is repeated, renewed and revitalized” (Mbiti 1989:130). Failure to partake in this revered institution is believed to be a curse and those who fail to fulfil this traditional expectation are regarded as sub-human. When one fails to get married under normal circumstances, then that person has rejected society, and therefore, society responds by rejecting them (Mbiti 1989). When persons die without being married and in the absence of an offspring, they are deemed to be totally disconnected from society, hence, it is perceived as forfeiting their connectivity to human life.

Drawing from African traditional culture, a woman is only considered to be fully human through marriage which suggests that a woman needs a husband to ‘complete’ her (Masenya 2003). Furthermore, traditional beliefs stipulate that a woman has no honour outside of marriage (Oduyoye 1995a). Marriage is, therefore, regarded as the basis for women to attain honour and dignity within their communities. Accordingly, African marriages are instituted mostly for procreation and are validated through the evidential fruits of that union. Marriage is therefore the avenue for humanity to procreate (Baloyi 2022). Given this understanding, much reverence is assigned to marriage because it is regarded as “...the sovereign social regulation of sexuality and a union of persons of the opposite sexes for the purpose of the procreation and rearing of the human species” (Beya 1995:155). Culturally, it is believed that a husband and wife are reproduced through their offspring hence conserving the continuity of life (Mbiti 1995). It therefore becomes the social responsibility of every mar-

ried couple to procreate and contribute to the continued existence of society through their offspring. Marriage serves as the “vital mechanism in maintaining the consistency of all societies on earth” (Baloyi 2022:1).

Whilst it is believed that the conjugal life of a marriage union is for fertility and pleasure of the couple, in most African societies, the wife is not expected to seek sexual gratification (Kamau 2011). Cultural beliefs that promote the notion of masculinity encourage men to adopt patriarchal attitudes which regard their wives as possessions thereby leading men to demand conjugal rights without rejection (Kamau 2011; Kemboi 2011; UNAIDS 2012). The wife is always expected to assume a passive role within the marital union. Drawing on the same perception, Oduyoye (1995a) and Ayanga (2008) observe that this situation positions women such that their sole purpose within a marital union is to procreate to the advantage of their marital relations. Oduyoye further argues that within the African context of marriage, no due attention is paid to women’s “...personal or psychological needs to the locus of life” (1995a:134). The only imperative for women is to get married, “be fertile, and bear children as a matter of absolute priority” (Ayanga 2008:34). Failure to fulfil these expectations would render a woman a societal misfit.

The vulnerability of married women to HIV infection is worsened by the fact that a married woman does not have any right over her own body, and she cannot have any say in matters of sex and sexuality whilst the husband’s sexuality can be shared with other women outside marriage (Masenya 2003; Setume 2016). Women also stay married even though they know of their husband’s infidelity because they do not have dignity outside marriage. In this regard, unmarried women are considered as ‘loose’ (denoting promiscuous) and unmannered and they often become vulnerable to sexual abuse (Masenya 2003). In the event of the death of a husband, a wife is inherited by a surviving brother or another member of the immediate family and her expectations of being a wife and mother continue, hence, a married woman’s societal value is her sexuality and reproductive capacity (Mbuwayesango 2007). These values are owned by all the men in the husband’s family. Similarly, Phiri points out that the “African marriage is at the centre of the African community yet it is also the centre of patriarchy, which constructs the subordinate position of African women” (2003:10). Such a situation is detrimental to the well-being of women in societies especially in the current context of HIV & AIDS where statistics reflect new and increased infections amongst married women (Mugweni 2015; Ramjee & Daniels 2013). Additionally, even

though married women or those in long term and stable relationships express their fears over being infected by their spouses, research shows women believe they have no right to withhold sex from their spouses as well as to negotiate for safer sex (Mugweni et al 2015; Shoko 2012). Women are socialized into believing their role in sexual relations is to please their husbands as opposed to expecting “mutual sexual satisfaction” (Marshall and Taylor 2006:366). Resultantly, many married women consider their marital status as a major risk factor for HIV infection as they are powerless to protect themselves (Awoleye et al. 2022).

### **Drivers of Increasing HIV Infections among Married Women in sub-Saharan Africa**

The common belief that marriage is a safe haven establishes a ‘false sense of protection’ against HIV infection since most married couples do not utilize any form of protection against sexually transmitted infections (STIs) (Awoyele et al. 2022). Additionally, lifetime fidelity is not enough to protect married women from the risk of HIV infection (Hagemann 2010). This suggests that in most cases, husbands may have been infected prior to entering into marriage and/or they fail to be faithful within the marriage (Hagemann 2010). A myriad of factors expose women to the vulnerability of HIV infection. These are inclusive of socio-cultural, biological, behavioural, economic, and structural risks. Mugweni et al. (2015) make reference to individual, relational and community level barriers as drivers of HIV infection among married or cohabiting women.

### **Economic Drivers**

Many married women’s economic dependence on their spouses within rural and urban African communities in sub-Saharan Africa is a result of skewed gender relations and high levels of unemployment and poverty (Kemboi et al. 2011; Mugweni et al. 2015; Ullah et al. 2021). Many women stay in risky sexual relations as a result of their social subordination and economic dependency on men (Kemboi et al. 2011; Ullah et al. 2021). Likewise, the unfavourable economic position of women denies them the right to determine whether, where and how sexual relations should take place as well as the ability to challenge their husband’s extra marital sexual

relations (Shoko 2012). Ramjee & Daniels (2013) posit that a lower economic status is linked with lower condom use because women do not have financial agency to negotiate safe sex, exposing them to the vulnerability of HIV infection.

Increasing levels of poverty resulting from the high unemployment rate is also reported to have an effect on the male psyche. The inability to provide for the family impacts negatively on masculine identities. Men therefore seek to redeem their bruised image through "...sexual prowess with multiple, concurrent partners" (Marshall and Taylor 2006:366) rendering many married women vulnerable to HIV infection. In addition, the affirmative action that is practiced by some countries within sub-Saharan Africa accords priority to women within the employment sector as well as the political arena (Slater 2014). Affirmative action has resulted in qualified women commanding higher positions of employment as compared to their husbands. This affects the male psyche and impacts their socially expected status as head of the family. This situation is further compounded by incessant calls for gender equality. As a result, men who are faced with such challenges tend to be violent towards their wives through asserting sexual dominance within the marital union.

Migration which results in husbands leaving their rural homes in search of work mostly in urban areas renders married women vulnerable to HIV infection. This is because, in many cases, their husbands would engage in extramarital relations to ease their loneliness as well as to assert their male psyche amongst peers. According to Gumbo (2015), migration, which might be in the form of internal (rural to urban), circular (predominantly within the region) and international, alter couple's living arrangements which may result in the engagement of risky sexual behaviour and consequently HIV infection. Recently, in the context of Zimbabwe, we see the mass exodus to the United Kingdom for greener pastures. Whilst it is commendable for partners to seek economic relief in the current context of economic depression, this practice separates couples for prolonged periods of time, often resulting in illicit sexual affairs. It has also been reported that sexual favours are exchanged for passage to the United Kingdom. Fake marriages are part of the arrangement for safe passage. Such an arrangement often results in sexual intercourse in exchange for financial assistance. This practice also fuels the spread of HIV infection as married people are also taking part in this financial arrangement.

## **Socio-cultural and Religious Drivers**

Cultural practices such as dry sex, female circumcision, widow cleansing and inheritance expose married women to the risk of HIV infection (Kamau 2011). Dry sex and female circumcision are mostly undertaken to ensure the sexual gratification of husbands within the marriage union. The payment of *lobola/ bogadi/* bride-price, which is considered as the transfer of a woman's sexual rights from her father to her spouse is another cultural practice that exposes married women to the risk of HIV infection (Mugweni et al. 2015; Setume 2016). The new bride, after the payment of *lobola/ bogadi/* bride-price, is expected to be submissive to her husband. The vulnerability of married women to HIV infection is also intensified by higher coital frequency within marital unions (Tolan 2005). Sexual intercourse within marital relationships is regarded as part and parcel of the marriage deal and the wife is therefore expected to avail herself whenever the husband has a sexual urge.

## **Biological Risk Drivers**

Women do possess an elevated physiological risk of contracting HIV from their male partners due to their "greater mucosal surface area that is exposed to pathogens and infectious fluids for longer periods during sexual intercourse" (Ramjee & Daniels 2013:2). They are also reportedly more prone to increased tissue injury during sexual intercourse (Ramjee & Daniels 2013). Abaasa et al. (2013) reports that 60% of adults living with HIV in sub-Saharan Africa are women, and between 30-40% of the infections is a result of heterosexual transmission through the female genital tract (FGT) (Kaushic et al. 2010). It is also reported that several characteristics of the FGT inclusive of changes in the FGT as a result of infection by bacteria are known to expose women to heightened susceptibility to HIV infection (Machado et al. 2014). Abbai et al (2016) posit that damage to the mucosal lining of the vagina increases women's susceptibility to HIV infection. Other biological factors that increase the risk of HIV infection for women include the presence of sexually transmitted infections (STIs), genital warts/sores/ulcers, reproductive tract infections, abnormal vaginal discharge and the disruption of the vaginal epithelium (Abbai et al. 2016). A healthy vaginal epithelium (which is the inner lining of the vagina) prevents intrusive infections hence its disruption increases a woman's susceptibility to STIs and HIV infection.

## **Individual, Relational and Community-level Drivers**

Individual barriers result from the lack of sexual decision-making power, economic dependence, and low self-efficacy. According to Mugweni et al (2015), individual barriers emanate from women's lack of autonomy. Individual barriers disempower women thereby rendering them voiceless and unable to negotiate safer sex. Individual barriers also result in the fear of definite or the predictable penalties of negotiating for safer sex (Mugweni et al. 2015). In most cases, negotiating for safer sex within the context of marriage often results in intimate partner violence.

Relational barriers centre on trust and the ability to self-disclose within a relationship (Mugweni et al. 2015). Community level barriers are also termed structural barriers and are inclusive of social, economic, cultural or organizational dynamics that restrain individuals from negotiating for safer sex. They are further driven by extended family members and religious leaders who implicitly discourage women from negotiating safer sex (Mugweni et al. 2015).

## **Gender-Insensitive HIV Prevention Strategies**

The vulnerability of married women and those in long-term sexual relations is further compounded by gender-insensitive HIV prevention strategies which lack a focus on married women. The common and widely used strategy for HIV prevention has been the traditional Abstain, Be faithful and Condom method, henceforth, the ABC method which has been considered a key strategy in comprehensive HIV prevention programmes (Kurian 2006). This simple and catchy acronym has been credited with considerable success in reducing HIV infection particularly in Uganda (Larki et al. 2022). However, the 2004 Joint United Nations programme on HIV & AIDS report published during the period of Uganda's success story of HIV prevention based on the ABC model revealed a new face to the pandemic (Dworkin & Ehrhardt 2007). The report indicated that about fifty per cent of the total number of infected people worldwide were women with an estimated thirty-five per cent increase from previous years (Dworkin & Ehrhardt 2007). In addition, the report detailed that fifty per cent of new HIV infections were reported between spouses with women identified as those at most risk of acquiring HIV from their principal partners (Dworkin & Ehrhardt 2007:13). This report reflected the

gendered nature of HIV & AIDS, and it brought the credibility of the ABC model under scrutiny.

Evidence emerged that the ABC model fails to address the important issues of gender and masculinities in HIV prevention initiatives (Larki et al 2022; Tumwebaze et al 2023). This popular model does not take into account the powerlessness of many women who are denied the right to negotiate safer sex in their relationships (Tumwebaze et al. 2023). Furthermore, it fails to pay attention to gender inequalities and socio-cultural issues inclusive of poverty and harmful traditional practices that fuel the spread of HIV infection (Larki et al. 2022). Economic contexts that reflect a ‘critical intersection’ between poverty and women’s vulnerability to HIV infection are overlooked (Larki et al. 2022; Mugweni et al. 2015). The powerlessness of many women who are denied the right to negotiate safer sex in their relationships is not taken into consideration. Neither is their subordinate position resulting from their lack of property rights; differential access to literacy and education; lower wages; and lack of assets which in turn determine the risk context for many women is not accounted for (Gupta cited in Dworkin & Ehrhardt 2007).

The ABC model is lacking in that it implies that any person can prevent HIV infection by choosing any one of the options from the ABC short menu (Larki et al. 2022). However, abstinence is not an option for married women. The second component of faithfulness only becomes valid when both spouses are aware of their HIV status before committing to marriage and to the practice of serial monogamy. Being faithful entails engaging in sexual relations with a single partner in a long term or life-long relationship such as a marriage union (Kamau 2011). Accordingly, advocating for faithfulness is a futile initiative especially for millions of women who cannot protect themselves against their spouses’ infidelity (Chireshe & Chireshe 2011). Within the African context, faithfulness is believed to apply only to married women. The being faithful code is silent when it comes to married men who are culturally sanctioned to have extramarital sexual relations.

The last component of the ABC model advocates for condom use. Sadly, in many parts of African communities within sub-Saharan Africa, condom use is associated with those who would have failed to abstain and/or to be faithful in their relationships (Larki et al. 2022). This notion gives rise to the stigmatization of condom use as it is associated with promiscuity. Additionally, the condom is negatively perceived within the context

of marriage and or stable unions (Setume 2016). Within the African culture, the condom is mostly unacceptable within marital unions as it is associated with 'loose [promiscuous] and unmarried women' (Ramjee and Daniels 2013). This means that the condom is seldom used within the marriage bed but for extramarital sexual relations (Muhwava 2004). It is further observed that condom use amongst married couples is between 2-6%, a situation that creates an environment for HIV infection in cases where there is partner infidelity (Muhwava 2004). Given this perception, discussions about condom use within marital unions would evoke feelings of mistrust. Furthermore, married women, even if they are knowledgeable about condom use, must feign ignorance or they might be suspected of infidelity. In addition, a husband would be "...surprised and enraged if a wife suggested the use of a condom...condoms are seen as things to be used with prostitutes only" (Muhwava 2004:119). Therefore, Collins and Coates rightly point out that if HIV prevention only encompasses the ABCs, the social reality of the majority of women, especially those in marital union and long-term to permanent relationships in the African context are unable to choose A or C (Collins & Coates 2008). B offers very minimal protection or even greater risk (Collins & Coates 2008). In a nutshell, it is clear that the ABC method is inadequate and shallow and fails to recognise that HIV can also be transmitted in non-sexual ways. Furthermore, it does not pay attention to the importance of treatment in the HIV & AIDS discourse but focuses on individuals. Moreover, it does not consider the importance of the family, the community and government institutions in responding to the devastating pandemic (Tearfund 2015).

### **Towards a Bold Church Praxis in Reducing HIV Infection Amongst Married Women in sub-Saharan Africa**

Faith communities also contribute to the vulnerability of married women to HIV infection. This is enabled through their endorsement of patriarchal values whereby they uphold the notion that men are superior and dominant especially in marital relations hence they are not chastised even if they have extramarital sexual relations (Chitando 2011). In this regard, Chitando (2011) points to the ambivalent position of religion, on one part it is the problem, on the other part, it is the solution. Therefore, in order to curb the increasing rate of HIV infection and to promote the sanctity

of life for many married women who are facing death from AIDS related illness, the church is called to be equally proactive. As such, the church is called to adopt a bold praxis towards mitigating the challenge of HIV & AIDS. In many cases, men are the drivers of the pandemic, a situation necessitated by masculine beliefs that postulate them as sexual predators (Chitando 2007a). Therefore, in order to mitigate the increasing levels of HIV infection amongst married women in sub-Saharan Africa, there is need to lobby for the transformation of hegemonic masculinities. Hegemonic masculinity is considered a multidimensional concept that perpetuates patriarchy and dominance over women (Morrell et al. 2012; Morrell et al. 2013). It is associated with extreme violence, oppression, the use of force and risk taking which includes sexual risk taking (Morrell et al. 2013). In this regard, male dominance and sexual risk-taking increases women's susceptibility to HIV infection. The transformation of hegemonic masculinities would create a safe space for men to forfeit harmful practices dictated by societal norms that are detrimental to their wellbeing as well as that of their spouses. The transformation of hegemonic masculinities can be enabled through embracing the concept of solidarity, and engaging men in the HIV & AIDS discourse.

### **Solidarity between Men and Women**

Solidarity is a concept borrowed from the liberation struggle whereby freedom fighters had to unite to win the fight against apartheid and colonialism (Chitando 2008:56). In the current context of the devastating HIV & AIDS pandemic, the concept of solidarity, which Chitando (2008:56) argues is a liberationist paradigm, is crucial in addressing the challenges posed by the pandemic. Chitando defines solidarity as "...standing for and standing with 'the Other'" (2008:56). In addition, solidarity "transcends sympathy and represents an existential transformation on the part of the one who commits himself or herself to stand with the suffering and the marginalized" (Chitando 2008:56). Therefore, solidarity is a concept that emerges from 'empathetic interpolation' which is described as a situation in which an individual assumes the world view of another in order to understand his/her experiences which are different from one's own (Chitando 2008). A common interpretation of this situation would be likened to putting oneself into another person's shoes/situation in order to understand their pain and suffering. Empathetic interpolation would entail that

men forfeit their hegemonic masculinities and consequently, identify themselves with the experiences of women who are culturally and religiously oppressed (Chitando 2008).

Chitando (2008) identifies solidarity as a process that invites men to be self-emptying of their constructed masculine identities. Furthermore, solidarity involves men reconsidering their positions of power to enable them to identify with the oppressive situation endured by women (Chitando 2008). It also demands that women be given the opportunity to assume a leading role in their struggle for liberation. The role of men is to act in solidarity with women who will be championing their own struggles (Chitando 2010).

Within the context of African communities, the principle of solidarity could be adopted as an extension of the concept of *ubuntu*. The philosophy of *ubuntu* informs the locus of life within the African worldview. However, Chitando (2008) observes that even though African communities give reverence to the concept of *ubuntu*, the embrace of this principle has not paid due attention to the oppressive masculinities that continually marginalize and disadvantage women. In this regard, the transformation of masculinities therefore, calls for the recognition of women as fellow human beings who form part of the locus of life within the African worldview.

## Engaging Men in the HIV & AIDS Discourse

The transformation of masculinities as a response to mitigating the increasing levels of HIV infection amongst married women calls for the church to reconceptualise its mission towards men. Chitando observes that men spend time in places that are labelled as ‘worldly’ by religious and faith institutions therefore, the need to “...sacralise such places and reach men” (2007a:49). In its endeavour to reach out to men in the context of the HIV & AIDS pandemic, the church needs creative evangelism, and this can be enabled through the reconceptualization of mission inclusive of the need to desist from demonizing places of leisure frequented by men during their spare time (Chitando 2007a). This should include reaching out to men in professions that increase their vulnerability to HIV infection i.e., those in military, migrant labourers, and truck drivers (Chitando 2007a). Accordingly, Chitando (2007b) also argues against theological rigidity in the fight against the HIV & AIDS pandemic. Instead, he calls for

a fresh understanding of religious truths and castigates traditional theology where God rewards the good and punishes evil. This gives rise to the doctrine of retribution and reward in responding to the pandemic since HIV & AIDS is associated with punishment for the promiscuous and rebellious, thereby overlooking the various drivers of the pandemic as well as innocent people being unknowingly infected with HIV (Chitando 2007b). Furthermore, Chitando (2007b) rightly contends that theological rigidity overlooks structural sin that drives the pandemic and also obstructs the church's response to the pandemic that brought about death and destruction in Africa. Structural sin, sometimes interchanged with social sin, refers to societal oppressive structures that violate human dignity and gives rise to inequality (Kelly 2019; Shadle 2015). Structural sin also includes the subordination of women (Shadle 2015) hence exposing them to the vulnerability to HIV infection.

Engaging men in the HIV & AIDS discourse calls for faith communities to engage in a bold community praxis through working with men's organisations in addressing the challenge posed by the pandemic. Faith communities are encouraged to partner with organisations that focus on men (Chitando 2007a). In addition, faith communities are mandated to seek collaboration with organisations that pay special attention to male reproductive health, violence against women as well as organisations that speak against gender injustices (Chitando 2007a). Such a call is a worthwhile endeavour to address the challenge of harmful masculinities that expose women to HIV infection.

Engaging men in the HIV & AIDS discourse includes advocating for men's accountability for their actions in the current context of the pandemic. In essence, I contend that African men, including church men, have not been socialized to be accountable to anyone, least of all to women. Therefore, the church is advised to encourage the formation of men's movements that will aim at challenging men "... to be accountable to their families, the church and society at large in all areas of their life including sexual, socioeconomic and political justice" (Moyo 2005:194). And so, Chitando justly contends that responding to the increasing levels of HIV infection among married women includes appropriating the pulpit "... in the struggle to transform masculinities ... sermons that challenge men to embrace gender justice must be preached with clarity and compassion" (2007a:49). He further points out that it is the duty of the church to always "remind men that true discipleship entails questioning

traditional (both Christian and indigenous) attitudes towards masculinity” (Chitando 2007a:49). Such a call as proposed by Chitando also calls for reconstruction theology. In one of his publications, Chitando (2009) presents reconstruction theology as one that embraces various filaments of African theology such as inculturation, black theology and African women’s theology. Inculturation theology centres on reconstructing African ethos, black theology focuses on reformulating Christianity to enable it to be life-giving especially to black African people, and African women’s theology strives to overcome patriarchy and to reconstruct gender relations (Chitando 2009).

### **Holistic and Multi-faceted Gender-sensitive HIV Prevention Strategies**

In order to effectively respond to the gendered nature of the HIV & AIDS pandemic, there is need for a bold church praxis that incorporates holistic and multi-faceted gender-sensitive HIV prevention methods. The SAVE approach is a model that was developed by the African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS (ANERELA+) (Kurian 2006). This model was developed as a holistic, comprehensive, and multi-faceted approach designed to respond to the challenge of the HIV & AIDS pandemic. The SAVE approach comprises of four key principal elements to HIV prevention and care which are safer practices (prevention of mother to child transmission (PMTCT); post exposure prophylaxis (PEP); mutual fidelity within permanent relationships; vaginal microbicides, which are chemicals that reduce the transmission of sexually transmitted diseases and are suitable for use by women who are unable to negotiate safer sex; condom use which can also be used in marital relations where one partner may be HIV positive); available medical interventions (inclusive of anti-retroviral therapy (ART); Nevirapine for pregnant mothers; treatment of opportunistic infections); voluntary counselling and testing (all persons must be aware of their HIV status; churches must mobilize for HIV counselling and testing); and empowerment through education and advocacy (Kurian 2006).

## **Conclusion**

The focus of this chapter was to pay attention to the increasing levels of HIV infection amongst married women in sub-Saharan Africa. The paper gave a critical analysis of the drivers giving rise to the increasing levels of HIV infection amongst married women in sub-Saharan Africa. The chapter focused on the interface between marital unions and/or permanent sexual relations and HIV & AIDS. The common understanding is that the marital bed is sanctified, and the marital union based on love, trust and faithfulness hence positioned as a sanctuary and a safe haven against HIV infection. However, of late, scholarship indicates increasing levels of HIV infection among married women and those cohabiting or in long-term sexual relationships. As a result, marriage is no more a safe haven but a major risk for HIV infection and a potential death trap especially for married women who are restrained from negotiating for safer sex due to religio-cultural as well as other drivers that render them powerless. I discussed the common drivers of HIV infection among married women. Some of the identified drivers include economic, socio-cultural, religious, biological, individual, relational and community level drivers. The chapter also discussed gender insensitive HIV prevention models as contributing to the spread of HIV infection. In a bid to find ways to redress the challenge of the increasing levels of HIV infection among married women, the chapter drew upon Chitando's publications, one of the outstanding black African male theologians who has comprehensively engaged with gender and HIV & AIDS. Chitando's work on the transformation of harmful notions of masculinities for addressing the challenge of the gendered nature of HIV & AIDS is profound. The chapter focused on Chitando's notion of solidarity between men and women and the importance of engaging men in the HIV & AIDS discourse as mitigation measures to curb the increasing levels of HIV infection among married women.

## **Author's Contribution**

The chapter draws on the author's Masters dissertation titled 'From the marriage bed to the graveyard: Towards a bold community praxis in reducing HIV infection amongst married women in sub-Saharan Africa. The author acknowledges the mentorship and supervision of the Masters' dissertation by Professor Beverly Gail Haddad who also kindled the flame to research on the interface of gender and HIV & AIDS.

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