HIV/AIDS and Gender Issues

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Introduction

In 1997, women represented 41% of all adults infected with HIV; in 2001, they made up 50%.

In sub-Saharan Africa, 58% of HIV-positive people are female as are 67% of infected young people.

An estimated 60-80% of HIV-positive African women have had sexual intercourse solely with their husbands.

To understand these statistics, we must first appreciate the significant impact that gender has on the HIV/AIDS epidemic in every region in the world. Gender refers to socially defined and learned behaviour that shapes the opportunities that one is offered in life, the roles one may play and the kinds of relationships that one has. It is distinct from sexuality, which is a biologically determined and fixed set of characteristics for men and women.

Gender affects:

- Masculinity and femininity
- Roles, status, norms and values
- Responsibilities, needs and expectations
- Sexual behaviour
- The division of labour, power and responsibilities
- The distribution of resources and rewards

Gender roles and responsibilities leave women especially vulnerable to the pandemic. Systemic discrimination against women is widespread and this discrimination damages women's ability to educate themselves about HIV/AIDS, both to prevent their own infection and to manage the consequences of illness for themselves and their dependents. Understanding the role of gender in HIV/AIDS can help us better grasp the differing experiences of infected and affected women and men. And it can help us understand a whole series of risk and vulnerability factors that influence the spread and management of the disease.

The increased risk to women can be explained in part by physiological factors such as the higher concentration of HIV in semen than in vaginal fluids, and the larger surface area exposed to the virus in women. But the power imbalance between the sexes also increases risk and can result in domestic violence, rape and sexual abuse, problems that are not only violations of human rights but also opportunities for HIV transmission. The financial dependence of women on men can leave them with little choice but to remain in relationships that they might otherwise choose to leave. It may be that the alarming prevalence of HIV among married women in many parts of the world is caused by the fear of violence, a fear that makes it more difficult for women to negotiate condom use or otherwise refuse unsafe sex.

In the early stage of an HIV epidemic, those who are HIV-positive are predominantly adult males. This shifts over time to a preponderance of women and children. Overall, females become infected earlier, as studies show. For example, a not-atypical 1997 WHO study in Kenya demonstrated that boys in the 15-19 year old age group were four percent HIV-positive while girls of that age were 22% HIV-positive. Because their bodies are not mature and vaginal tearing is more common, HIV passes even more easily to young women that to adult women. Young girls are particularly at risk and are also hurt by a mistaken but widely held belief that having sex with a virgin will protect men against HIV. Young women find it difficult to refuse the sexual advances of older men who assume that they are disease-free because of their youth. In many resource-poor countries, it's increasingly common for girls and young women to seek out the favours of a "sugar daddy" who provides cash for school fees, or even family support, in exchange for sexual favours.

Negotiating safer sex is best effected between two equal and consenting adults. The legal, social and economic realities of men and women in resource-poor settings are mostly unequal and not an optimal environment for safe sex negotiation.

Enlisting Men in HIV/AIDS Prevention

Analyzing the role that men play in the epidemic is crucial. Because men commonly have more sexual partners and more control over decisions regarding sex than women do, it is their behaviour that largely determines how quickly and to whom the virus is transmitted. Consequently, prevention efforts targeting men and boys are crucial, not only to promote their own health, but also the health of women and girls.

Underlying the sexual behaviour of men and women are powerful and unstated assumptions about male and female sexuality and entitlement. Men are often encouraged to equate a range of behaviours - the use of violence, alcohol and substance abuse, the pursuit of multiple sexual partners, the domination of women - with being manly, while viewing health-seeking behaviour as a sign of weakness. This renders both the men and their partners vulnerable to HIV transmission. To turn the epidemic around, men will need to take responsibility for their actions - and change begins with the ways that boys are raised. Certain cultural attitudes and beliefs encourage risk-taking and discrimination against women.

At the International Conference on Population and Development (ICPD) in Cairo, 179 countries reached the following consensus on what needs to be done:

> The ICPD calls upon parents and schools to ensure that attitudes that respect "women and girls as equals are instilled in boys from the earliest possible age" and that programs reach boys before they become sexually active. Boys who lack positive male role models and who observe their fathers and other men mistreating women, may believe that this is "normal" male behaviour. Studies find that when boys interact with adults and peers who reinforce alternative gender roles they are much more likely to be flexible in their ideas about men's and women's roles.

> *Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour . . . Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women.*
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> *ICPD Program of Action, paragraph 4.27*

Gender Considerations in HIV/AIDS Programming

Gender-based norms are not easy to change. The fear of losing potent cultural values creates huge obstacles to HIV and gender programming. Some of these obstacles are discussed below:

Barriers to women's participation. Women's limited participation in both public and domestic decision-making continues to influence the progress of the epidemic. One of the greatest gender-based challenges in instituting HIV programming is overcoming the barriers that deny women meaningful participation in social institutions. Halting the disease is left to government agencies, medical practitioners and even pharmaceutical companies. And yet, to paraphrase Stephen Lewis, the UN Special Envoy on HIV/AIDS in Africa, the face of the pandemic is female: women represent not only the majority of the infected people but they also carry virtually the entire burden of nursing, care-taking and additional labour.

Poverty. The socio-economic status of women is often dependent on that of a male parent, sibling or spouse. When a man becomes debilitated or dies from HIV/AIDS, his wife is likely to lose her main source of economic and social support. In societies where women are not allowed to own property, the death of a spouse often means that a woman will loses her home and land. With relatively limited access to resources and work opportunities, widows become more likely to exchange sex for money, food or shelter.

Increased risks in sex work. Women who choose sex work in order to meet economic obligations face particular risk. For example, a client who refuses to wear a condom might simply negotiate condom-free intercourse with another worker (unless a collective position is taken as with Thailand's 100% condom programme); the worker is thus encouraged to take the risk. Where sex work is criminalized, the workers, most often women, are even more unlikely to seek recourse from the institutions that protect them from violence, and which also provide education, prevention and care. As well, where the threat of police arrest looms, sex workers may not be inclined to carry condoms or take the time to negotiate safer sex.

Controlled access to information. In most societies, adults control sexual and health information for young people. Yet many adults are uninformed about HIV/AIDS, and many others mistakenly believe that giving youth access to information about sex will lead to early sexual initiation. In societies where virginity among girls is highly valued, young women are inhibited from seeking out the reproductive health services and information they need. If they do seek them out, they may be perceived as being sexually active and face expulsion from home or other severe consequences. Yet without such services and information, they may begin to adopt unsafe sexual practices.

Difficulty accessing health care. A number of factors may make it more difficult for women than for men to access information about HIV and get appropriate treatment. Because of their domestic responsibilities, women can be less mobile and the distance to clinics and other resources may be more of a constraint; they may also have fewer funds to pay for medications and professional services. And if their family role is to be caretaker, women may be less well cared for themselves, should they fall sick. In places where women do have access to public health institutions, their health is rarely addressed specifically. It was not until more than a decade into the epidemic that the Center for Disease Control in the United States conceded that women experience gender-specific medical problems associated with HIV. Men, on the other hand, may believe that visiting a doctor reflects badly on their

masculinity; yet not going could endanger their own sexual health and that of their partners.

Expectations of women's sexual passivity. Females are often conditioned to be willingly submissive. Although this is being redressed in the west, in many cultures women are expected to be sexually inexperienced and passive, and to give priority to male sexual pleasure. Female genital mutilation may be practiced to ensure sexual pleasure is the sole domain of men. Drying agents are sometimes placed in vaginas in the belief that increased friction during penetration will please men, despite the increased likelihood of vaginal tearing and the consequent increased risk of HIV infection. Some cultures teach that pain and suffering in relation to sex, including forced sex, are to be tolerated.

Discussing sex is taboo. Sex, including heterosexual sex, is still often considered a private matter not fit for public discussion. Women are expected to remain ignorant about it, while men are expected to be already well informed. Gender conditioning can make it difficult for men to admit their lack of knowledge and for women to better theirs.

Lack of government action. Governments have often passed down the responsibility for dealing with AIDS to the community level, but neglected to devolve the necessary resources for communities to do the job adequately. Families are thus forced to subsidize the public sector, commonly by women picking up the burden of care-taking at home and the men providing additional financial support. Children may be pulled out of school to take care of sick parents or to bring in additional income.

Political repression. Governments in many countries have used laws that discriminate against sexual minorities and sex workers to silence work around HIV/AIDS. Existing laws that offer a measure of protection are sometimes used arbitrarily. For example, in societies where women are denied the right to inheritance, customary law often ensured that a widow and her children would be provided for; today those women may be abandoned if they are HIV-positive.

Displacement and conflict. Violent conflict can severely reduce infrastructure, thereby preventing access to education, prevention and treatment. In the Congo, for example, estimates are that over 50% of military personnel are HIV-positive. Violent conflict is also strongly associated with rape, which may carry the additional violation of HIV infection. The presence of troops, even in post-conflict peacekeeping situations, may encourage sex work as women try to find means of survival in a war-torn economy. The limited infrastructures of refugee camps are also a public health challenge and may reduce access to education, prevention and treatment.

A Gender-Based Response to the Epidemic

An effective response to the epidemic needs to be built on an understanding of how gender influences the HIV/AIDS epidemic. Both men and women need to be involved in developing effective responses to the pandemic at the national and community levels. Here are some directions to move in:

Promote women's participation at all levels. Participation means not only women's physical presence, but also their actual decision-making power - at home, in the community, and at national and global levels. Promote their physical presence by providing transport for women to attend meetings of communal importance. In areas acutely struck by AIDS, women often have caretaking responsibilities as well. Thus, childcare should be available, or activities should embrace the presence of children.

Make gender a public issue. Advocate that governments examine all policies to see how they might impact women and men differently. Encourage a legal framework where gender-based grievances can be heard fairly. Advocate for more balanced or appropriate resource allocation between men and women. Support an active civil society where issues of gender can be debated. Take gender-based violence out of the closet and name it as part of the societal inequality between men and women.

Be sensitive and confident discussing gender-sensitive issues. Address how education, prevention and treatment affect the sexes differently. For gender-sensitive material, groups may initially need space for each sex to talk separately, facilitated by a person of their own sex, age and cultural background.

Provide skills training in sexual communication. Sexual behaviour is only partly driven by rational decision-making; such other factors as social taboos and the emotional need for intimacy also affect people's choices. Programs need to find ways to encourage frank discussion around sexual choices. Subjects for discussion might include alternatives to penetrative sex, perhaps, or the various aspects of condom use: purchasing and determining quality, negotiating use and learning the proper method of use.

Support the development and use of female-controlled methods of prevention. Given the challenges that women face in protecting themselves from HIV, it is astonishing that feasible prevention strategies are still unavailable to the millions of women for whom abstinence, mutual monogamy and male condom use are simply not possible. The female condom has proved to be at least as effective as the male condom and consequently should be supported as a reliable and effective prevention method - and made widely available. It has the obvious advantage that it can be initiated by women and inserted well before intercourse. The development of microbicides (gels or creams, etc., that are applied topically in

the vagina and that have the ability to prevent the sexual transmission of HIV) is another potential alternative. Microbicides are not available at present, except through clinical trials. However with sufficient investment, at least one of the products could be available as early as 2007. (See ICAD fact sheet *HIV/AIDS and Prevention Options for Women* for more information.)

Be aware of the stigma associated with HIV/AIDS. In all societies, the experience of living with HIV/AIDS is accompanied by discrimination. The fear of ostracism and isolation - of losing a job or a house or being denied treatment - prevents many women from confiding their status and seeking the support they need. Furthermore, where HIV is seen as a sign of sexual promiscuity, the stigma is much more burdensome for women than for men: women are frequently thrown out of the home by husbands who may have been the source of their infection. Innovative and creative programs that address stigma and discrimination are invaluable.

Disempowering language. Counter tendencies to view certain populations as "causes" of AIDS rather than persons affected by it. Also be wary of treating people solely as "victims," rather than as leaders in the struggle to protect their dignity and rights.

Hold governments accountable. Use international obligations, covenants and statutes to advocate for action. The commitments adopted in June 2001 at the UN General Assembly Special Session (UNGASS) on HIV/AIDS are particularly invaluable.

Conclusion

AIDS feeds on systems of injustice that existed long before HIV had considerable impact on human society. Ending the epidemic both exposes these systems and presents an historic opportunity for real change. It will involve a revolution in long-held cultural beliefs and intensely held personal norms for both men and women.

Men will need to work hard to face their vital part in the pandemic. They will need to learn about and dismantle the parts of their gender conditioning that have resulted in the development of inappropriate power over women and the assumption of rights that belong, not just to them, but to all humans. While this work is theirs and cannot be done for them, men's efforts will bear most fruit in a climate of encouragement and understanding.

Women need to be encouraged and empowered to 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 where that is the case. At the same time it must be remembered that women are powerful and not helpless victims of male oppression. They are full proactive participants in the fight to halt the HIV/AIDS epidemic.

Web Sites

Atlantic Center of Excellence for Women's Health
www.medicine.dal.ca/acewh

Eldis
www.eldis.org/gender

Femmes Africa Solidarité
www.fasngo.org

Gender-AIDS Forum
www.archives.healthdev.net/gender-aids/

HIV Net
www.hivnet.ch

Information and Support Network by, for and about Women
www.womenhiv.org

Institute of Development Studies
www.ids.ac.uk/ids/

International Centre for Research on Women
www.icrw.org

Joint United Nations Program on HIV/AIDS
www.unaids.org/gender

The Population Council
www.popcouncil.org

Unicef
www.unicef.org

United Nations Development Fund for Women
www.genderandaids.org

The World Bank Group
www.worldbank.org/gender

World Health Organisation
www.who.int/gender/hiv_aids

ICAD's aim is to lessen the impact of HIV/AIDS in resource-poor communities and countries. We are a coalition of Canadian international development organizations, AIDS service organizations and other interested organizations and individuals.
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