Facing

the challenges of

HIV

AIDS

STDs:

a gender-based response

Understanding gender issues

Strategies to deal with HIV / AIDS

Interventions that work

Personal testimonies

Additional reading

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Contents

EXECUTIVE SUMMARY

» *This publication aims to provide policy-makers, planners and programme implementers with information and ideas on how to incorporate a gender-based response to HIV/AIDS and STDs into their policies and programmes.*

After outlining the global epidemiology of HIV infection, AIDS and STDs, it explores the concepts of gender and a gender-based response. The focus of the next section is the impact of the epidemic, elaborating on how gender-related factors affect HIV-infection risks and obstacles to prevention and care. Then gender-based responses and strategies are suggested and described.

Personal testimonies and brief descriptions of programmes and interventions personalize the text, show the impact of gender inequality on female and male risk and coping, and provide examples of effective responses.

To conclude, a checklist is provided for assessing the gender-based focus of existing or planned programmes and interventions.

Why gender and HIV/AIDS/STDs?

» *"One of the most striking features of the response to the HIV epidemic to date is how few of the policies and programmes we have developed relate to women's life situations. The daily lives of women and the complex network of relationships and structures which shape them are well known to women and well documented. Despite this, our theories, research agendas, policies and programmes have not been grounded in and informed by these experiences."*

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As the hiv/aids epidemic and sexually transmitted diseases (stds) continue to advance worldwide, we are learning ever more about how they affect individuals, households, families, communities, organizations and nations. The individual loss has been enormous, particularly in those countries and regions affected early on. aids is increasingly recognized in developing countries as a serious concern for socioeconomic development as a whole. Its impact is seen in family and community structures and relationships and in sectors as varied as education, employment, health care, social welfare, agriculture and the judiciary.

Economic consequences are already apparent. In highly affected countries, the business sector is experiencing increased absenteeism as employees fall ill, care for the sick or attend funerals. Loss of experienced and skilled workers in the formal and informal sectors may lead to lower productivity, savings and investments. In subsistence and small-scale agriculture, loss of labour may result in changes in farming patterns and food shortages.

Strategies to prevent the spread of hiv have focused on the promotion of condom use, reduction of numbers of sexual partners and treatment of stds [2]. Many of these responses, however, have failed to address social, economic and power relations between women and men, among men and among women. These relationships, together with physiological differences, determine to a great extent women's and men's risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic:

– Women are physiologically more vulnerable to hiv infection than men. Young women are especially at risk and aids death rates are highest in women in their 20s.

– Stereotypes related to hiv/aids and stds and their association with marginalized groups (e.g., sex workers) contribute to blaming women for the spread of hiv. Fear of stigmatization inhibits people from taking preventive measures and leads women and men to assess their own risks inadequately. Moreover, many ideas and expectations regarding male and female (sexual) behaviour neither encourage men to act responsibly and protect themselves and their partners from infection nor stimulate women to challenge notions of female inferiority and social structures which keep them vulnerable.

– Low social status and economic dependence prevent many women

and young people (e.g., street-children) from controlling their own risk. With little negotiating power, they are often unable to insist on safer sex; disproportionately poor, they may have little choice other than to barter sex for survival.

– As society's traditional care-givers, women carry the main psychosocial and physical burdens of aids care. Yet they have the least control over and access to the resources they need to cope effectively; few men share domestic responsibilities and family care with their partners.

Although the necessity of focusing on women's needs has been highlighted time and again, especially since 1990 when the theme of World aids Day was "Women and hiv/aids", women continue to bear the brunt of the epidemic and to be highly vulnerable to infection. Reducing their – and men's – risk of infection demands gender-based responses that focus on how the different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic. This involves analysis of gender stereotypes, redefinition of male and female relationships and roles, promotion of cultural beliefs and values supporting mutually responsible behaviour and exploration of ways to reduce inequalities between women and men. A supportive environment can be created thereby, enabling women *and* men to undertake prevention and cope better with the epidemic.

Women and men both have much to gain from increased gender sensitivity in general development policy, planning and programmes, and particularly by national aids/std programmes, aids service organizations and related services. At all levels a gender-based focus on problems and solutions is urgently needed.

This publication aims to provide policy-makers, planners and programme implementers with information and ideas to help them incorporate a gender-based approach to hiv/aids and stds into their policies and programmes. It highlights the nature and scale of the epidemic, explores the concepts of gender and a gender-based approach and the ways hiv/aids and stds affect and are affected by gender. Suggestions are made for approaches and strategies to address some of the problems.

It is hoped that the analysis, information, ideas and examples will help stimulate many more gender-sensitive initiatives to help us cope with hiv/aids and stds more successfully.

A gender-based response to HIV/AIDS and STDs focuses on how different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic.
It analyses gender stereotypes and explores ways to reduce inequalities between women and men so that a supportive environment can be created, enabling both to undertake prevention and cope better with the epidemic.

How extensive are HIV/AIDS and STDs?

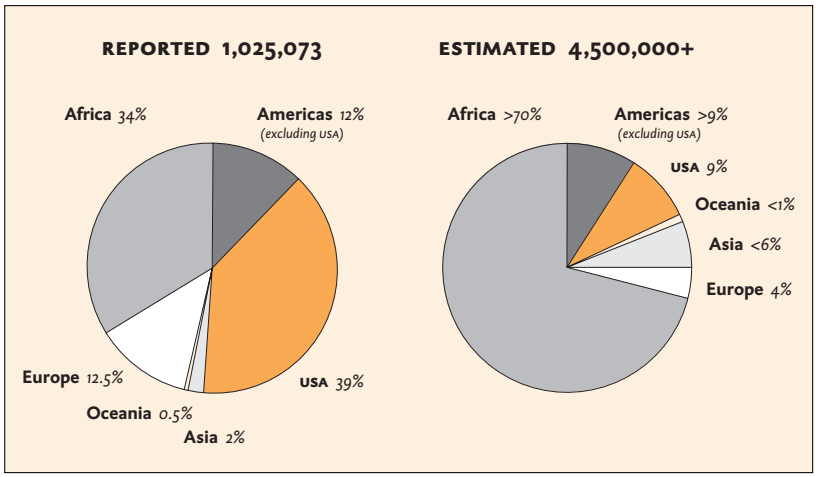
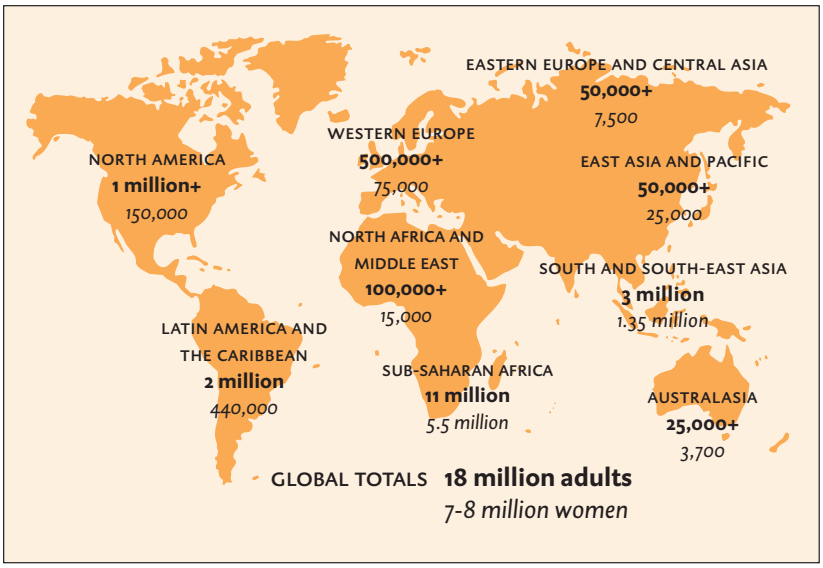


Figure 1 *Total numbers of reported and estimated AIDS cases (adults and children) from the late 1970s/early 1980s until late 1994 (Source: WHO/GPA)*

At the end of 1994, a cumulative total of 1,025,073 aids cases (adults and children) worldwide had been reported to who. The actual number of aids cases is unknown because of under-diagnosis, incomplete reporting and reporting delays. However, an estimated 4.5 million aids cases have occurred in adults and children since the beginning of the epidemic (Fig. 1).

An estimated 18 million adults (13-15 million alive) and 1.5 million children have been infected with hiv. Of the adults, 7-8 million are women (most of childbearing age, Fig. 2). who forecasts that, by the year 2000, 30-40 million hiv infections will have occurred, 90% in developing countries. Moreover, an estimated 5 million children under 10 years of age will be orphaned, losing one or both parents.

Figure 2 *Estimated distribution by region of total HIV infections in adults (**bold**) and women (italics) from the late 1970s/early 1980s until late 1994 (Source: WHO/GPA)*



The proportion of women with hiv and aids has increased dramatically. By 1994, women represented 40% of all new aids cases; up to 50% of all new hiv infections were in women, mainly those aged 15-24 years.[1] Female vulnerability has become increasingly clear in Africa and Asia. By the year 2000, an estimated 14 million women will have been infected with hiv and about 4 million will have died of aids.

hiv is transmitted predominantly through sexual intercourse (70-80% of infections). Mother-to-child transmission and needle-sharing by drug users each account for 5-10% of all hiv infections, while needle-stick accidents among health workers account for less than 0.01% of reported cases.

Higher proportions of young women than young men acquire hiv infection through sex. Their exposure to the virus at an earlier age, coupled with physiological factors, increases their risk (see page 10). In countries with high hiv prevalence, the greatest numbers of reported aids cases occur among women aged 15-34 years and men aged 25-44 years (Fig. 3).

hiv infection due to blood transfusion is more common in women than men. Women more often have blood transfusions because of anaemia and complications during pregnancy and childbirth. Perinatal transmission occurs during pregnancy, delivery or breast-feeding. The chance that a child of a seropositive woman will also be infected with hiv-1 is 33% overall, with transmission reported to be as high as 48% in some developing countries [3].

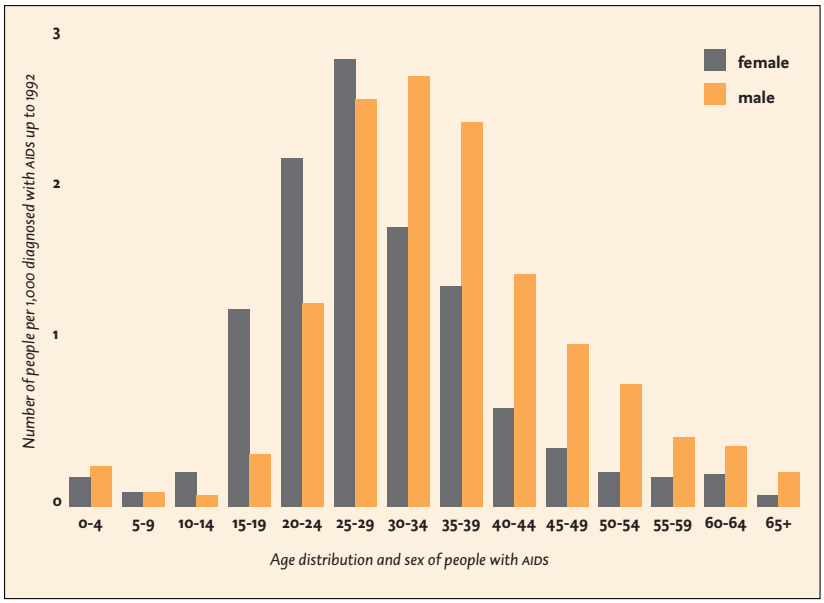


Figure 3 *Age and sex distribution of cumulative totals of people reported to have AIDS (Source: "Young people first!", AIDS Action, 1994, 25, p. 2)*

REGIONAL PATTERNS

In regions where initially more men than women were infected, there is now a marked increase in infections transmitted through heterosexual intercourse. In Europe, 15.4% of new infections in adults in 1993 were due to heterosexual transmission. In France, heterosexual transmission increased from 19% in 1991 to almost 25% in 1993. In 1993 in the usa, aids cases in women were almost 10% higher than in 1992; in nine major cities aids has become the leading cause of death among women of childbearing age.

In sub-Saharan Africa, hiv has been transmitted predominantly through heterosexual intercourse since the beginning of the epidemic. More than half of newly infected adults are female (11-12 women for every 10 men). The annual number of infections is still increasing. In Francistown, Botswana, for example, hiv prevalence in pregnant women rose from 8% in 1991 to about 35% by 1993. In some countries, e.g., Côte d'Ivoire, Zaire and Uganda, aids has become the leading cause of adult death [4].

[1] *All figures are based on who reports unless otherwise indicated.*

Seroprevalence rates in North Africa and the Middle East appear relatively low but are increasing. In Djibouti, for example, hiv prevalence has reached 14% among men attending std clinics and 4% among women seeking antenatal care.

In Latin America and the Caribbean region, a shift from transmission through primarily homosexual intercourse to bisexual and heterosexual transmission as well as injecting drug use has taken place since the early 1980s. In Brazil, one woman was infected with hiv for 100 men in 1984; by 1994 this was one woman for four men.

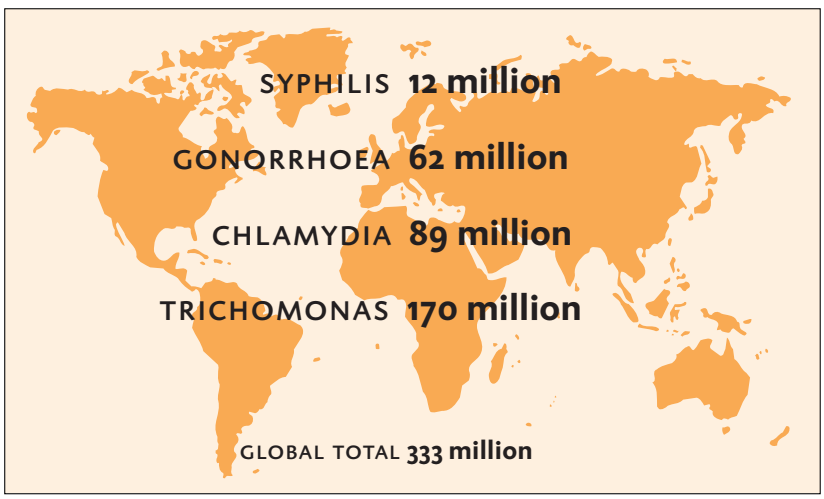
Half of the newly infected adults in Asia are women. In a border town in Shan State, Myanmar, 6-10% of women registered at public maternal and child health centres were already seropositive in early 1995 [5].

Figure 4 (above) *New cases/year of curable STDs in the world (Source: WHO/GPA)*

Figure 5 (below) *Estimated new cases/year of treatable syphilis, gonorrhoea, chlamydia and trichomonas (Source: WHO/GPA)*

SEXUALLY TRANSMITTED DISEASES

std rates remain high in much of the world. Each year about 330 million new cases of stds occur, of which more than 90% are in developing countries (Figs 4-5). Overall infection rates for stds are higher in women than men. Ulcerative stds, including syphilis and chancroid, and stds causing inflammation, such as gonorrhoea and chlamydial infection, facilitate transmission of hiv in both women and men. Women, however, are disproportionately affected. As with hiv, women often acquire stds at an earlier age than men. Gonorrhoea and syphilis are asymptomatic in 50-80% of women against less than 10% of men. In women, they often go untreated, especially in countries with inadequate std programmes. The secondary health consequences of stds are more serious for women as they may contribute to infertility, ectopic pregnancy, cervical cancer, premature delivery, stillbirth, low birth weight and neonatal infections. Ectopic pregnancy, cervical cancer and sepsis following pelvic inflammatory disease can be fatal.



What does a gender-based response involve?

What changes are needed to create an environment enabling women and men to protect themselves and each other? How can they collaborate equally in providing adequate care and support for those directly affected by the epidemic? Gender-based approaches can help us answer these questions in a way which orients programmes towards promoting social changes supportive of hiv/aids and std prevention and care.

Gender refers to widely shared ideas and expectations (norms) about women and men: ideas about "typically" feminine and masculine *characteristics* and *abilities* and expectations about how women and men should *behave* in various situations. These ideas and expectations are learned from families, friends, opinion leaders, religious and cultural institutions, schools, the workplace and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.

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Status and power affect the individual's risk of infection and communities' abilities to cope with the epidemic. The low status and power of women and young people lead to their subordination and restrict their possibilities of taking control of their lives in relation to hiv/aids and stds. Societal pressures also make it difficult for men to change their behaviours in this regard. Their sexual behaviour may be influenced by their relations with other men and women (e.g., fathers, sons, mothers, sisters, peers) [6].

Below, three examples show how gender is related to norms affecting hiv/aids and std prevention and care. The examples are simplified. In-depth gender analysis would also consider other differences that interact with gender to create situations of dominance and subordination, such as age, class, ethnicity and religion [7].

NORMS CONCERNING PARENTHOOD

In most societies, women's primary role in life is to bear and nurture children. Although responsible fatherhood may be promoted,

men's main duty is seen to be earning a living and dealing with the broader society on behalf of the family.

Such norms have two broad implications in relation to hiv/aids and stds. First, a false division is made between "reproductive" (women's) and "productive" (men's) roles [8]. The expectation that women must care for the children is extended to all household members needing support, e.g., the elderly, those who are ill with hiv/aids and/or orphaned children. Men are not usually expected to undertake care roles.

This supposed division does not correspond entirely to reality, however. Almost universally, women have always undertaken productive as well as reproductive work; it has simply been unpaid, unrewarded materially and unrecognized. In many African countries, for example, well over half of the agricultural work is undertaken by women (68% in Central African Republic and the Congo, 70% in Gambia). Yet women do not gain equal access to educational opportunities or the paid labour market, both of which may contribute to social and economic independence and more self-assurance.

A second consequence is that childless women are not viewed as "fully adult" or may be considered deviant. Their social status is often low. If their childlessness is due to infertility, they may not know this or refuse to accept the diagnosis and try repeatedly (even with a variety of partners) to become pregnant. This of course implies that they have unprotected sex, thereby increasing their risk of exposure to hiv/stds.

Moreover, when childless women express their opinions about community measures needed for hiv/std prevention and care, their suggestions may not be fully respected or accepted by other community members. The voices of women who are mothers may also be given less credibility, because they are expected to confine themselves to household matters.

Sample statements reflecting the idea that women lure men into sex:

» *"Women should wear purdah [head-to-toe covering] to ensure that innocent men do not get unnecessarily excited by women's bodies and are not unconsciously forced into becoming rapists. If women do not want to fall prey to such men, they should take the necessary precautions instead of forever blaming men" (comment by a member of Malaysia's parliament during debates on the reform of rape laws [9]).*

» *"The child was sexually aggressive" (reason given by a Canadian judge for suspending the sentence of a man who had sexually assaulted a 3-year-old girl [9]).*

» *"The female condom will increase immorality among women and single mothers. It is worse than the male condom, giving women the opportunity to do what they want. We are going to preach against these condoms - the church cannot condone their use" (parish priest in Kenya [10]).*

NORMS CONCERNING SEXUALITY

Among the numerous norms related to sex, many societies share ideas that women seduce men into having sex and that because male sexual needs are so strong, men cannot resist this. Such notions make men appear to be governed by their instincts, unable to control their behaviour and victims of female power. As a result, men are not expected to behave responsibly, while women's sexuality and behavior are controlled. For example, in many countries, girls who become pregnant must leave school, while boys who father children can continue their education with no requirement to contribute to child care. To protect men from themselves, social rules may also deprive women of the freedom to move about freely and lead to situations in which women, instead of their attackers, are blamed for sexual abuse.

These ideas form an obstacle to hiv/std prevention because they absolve men from taking responsibility

for their sexual behaviour. They may also prevent women from taking measures to protect themselves. For example, women may be reluctant to buy and carry condoms because they will be accused of wanting to "entice" men into having sex. Women may be reluctant to report abuse because they fear this will affect their position in society: if it becomes known that a young girl has been sexually abused (the result of a trial), in some countries she will have difficulty marrying because both women and men see her as "spoiled".

> » *"Right now I'm pregnant. It was an accident, I was planning to go to the clinic but my husband took away my card. He wanted more children so I became pregnant" (woman in* ***Kenya*** *[11]).*
>
> » *"I told my husband that it was better to use condoms, the doctor said so. The doctor had also given me some to use at home. My husband became very angry and asked who gave me permission to bring those condoms home" (woman in* ***Kenya*** *[12]).*

NORMS CONCERNING POWER IN RELATIONSHIPS

In many societies, men are expected to control women in all aspects of relationships. This involves decision-making on when and whom a girl/woman will marry, when and how she will have sexual relations, when and how many children she will have, household expenditures, etc.

This type of male power is supported by tradition and social norms. Women learn, for example, that their first loyalty must be to their kin and families, causing them to act in ways that reinforce rather than challenge female subordination. Often, female family members enforce community norms saying, for instance, male relatives must assume authority over widows. In addition, men may impose their will on women, even resorting to violence to do so. Coupled with economic dependence on men, ideas and expectations concerning so-called "proper" male and female roles make it difficult or impossible for women to demand that men share responsibility for preventing sexual and perinatal transmission of hiv/stds.

Gender analysis and gender-based programmes can help women and men redefine their relationships in a mutually beneficial way. As women move into traditionally "male domains", men can be encouraged to begin sharing responsibilities in the "female domain". Some women already exert considerable power, if often in subtle ways. Their existing strengths should be recognized and their self-confidence and social skills expanded. Men can be helped to see how their privileged position and social roles orient them more towards relationships involving authority and competition (and, perhaps, conflict) than collaboration. As the dynamics of male-female relationships change, communities will be able to benefit from the potential of all their members to minimize the impact of hiv/aids and stds.

Men as well as women are trapped by the social and cultural conventions that require women to be subservient. They both need to be freed from the constraints of their social conditioning and helped towards a fairer – and less dangerous – relationship with one another (Photo: G. Diez, WHO)

Why do HIV/AIDS/STDs affect women more?

Women's vulnerability to hiv/aids and stds is partly determined by physiological factors. It further reflects their wider social, sexual and economic vulnerability. The central issue is inequality. Economic need, lack of job opportunities, poor access to education and training and cultural expectations of female submissiveness and male dominance combine to prevent women from actively making choices and decisions about their lives, particularly with regard to limiting sexual risks and protecting their and their families' health. For the same reasons, men are led to deny risk and avoid responsibility, not only for their partners but for themselves. For both sexes this situation needs to change.

PHYSIOLOGICAL VULNERABILITY

Women and men

Researchers estimate that women's risk of hiv infection from unprotected sex is at least twice that of men. Semen, which has high concentrations of virus, remains in the vaginal canal a relatively long time. Women are more exposed through the extensive surface area of mucous membrane in the vagina and on the cervix through which the virus may pass. In men, the equivalent area is smaller, mainly the entrance to the urethra in a circumcised man plus, in an uncircumcised man, the delicate skin under the foreskin. Circumcision in males (not in females!) appears to have some protective value against stds, including hiv. Men and women's risk of hiv escalates manyfold if stds are present [13].

Young women

Young women are at even greater risk than mature women (except for menopausal women in whom thinning of the vaginal mucosa increases susceptibility to infection). A teenager's vagina is not as well lined with protective cells as that of a mature woman. Her cervix may be more easily eroded, potentially enhancing risk of hiv infection. She also faces potential bleeding at first intercourse through tearing of the hymen. In cultures where sex with very young girls is condoned, sexual intercourse is especially likely to cause trauma. In some countries, girls as young as 12 may be married to men three times their age. In addition, girls aged 17 years or younger who have unprotected sex are at increased risk of developing cervical cancer. Sexually active young women may easily

contract herpes simplex and human papillomavirus infections.

All these factors make young women especially vulnerable at a time when their negotiating and economic power is least, making them easier targets for sexual coercion and exploitation. This situation is worsened when more men, especially in high hiv-prevalence areas, seek out ever younger female partners in the belief that they are least likely to be infected. This is the most risky pattern of sexual partnership, as a group more likely to have hiv already (older men) transmits the virus to a group with low levels of infection (young girls).

Sexually transmitted diseases

who estimates that about 330 million cases of treatable stds exist worldwide at any time. Yet women may have these infections without realizing it; some 50-80% of stds in women are asymptomatic or go unnoticed because they are internal. Women are much less likely than men to seek timely treatment for stds for this reason. Stigma attached to stds, especially for women, inaccessibility of clinics, lack of money and too many other responsibilities further prevent them from getting treatment. Negative attitudes of health workers towards women presenting with stds may be another major deterrent to their seeking treatment or even contraceptive advice. This is true of teenage girls in South Africa, for example [14].

Cultural practices

Certain cultural practices may exacerbate women's physiological risk of hiv infection, especially when hiv is widespread in the population. Many women actively support these practices because they enhance their social status and security with their partners. Examples:

– In some parts of the world, women use herbal and other agents in the vagina to cause dryness, heat and tightness. This practice is carried out because people believe men prefer "dry sex" (in which women feel like virgins) and because they think that female secretions are unclean. The substances used can cause inflammation and erosion of the vaginal mucosa, making it easier for hiv to enter.

– Excessive rubbing of the genitals during foreplay and intercourse, or "rough sex", can lead to sores in the mucous membrane.

– Anal intercourse carries higher risks of hiv transmission because of frequent lesions. Although it is often associated with homosexual contacts, heterosexual couples practise it to preserve virginity, to protect against pregnancy, for (usually male) sexual pleasure and in a search for sexual variety.

– Female genital mutilation (circumcision) is practised in various countries. Infibulation (in which the labia minora and majora are cut away and the vulva is sewn shut leaving a pinhole opening for urination and menstruation) leads to extensive tearing and bleeding when sexual intercourse is attempted. It may also cause couples to practise riskier anal sex instead. The procedure itself could be risky if unsterilized instruments are used for several patients in succession. Less extreme circumcision, like removal of the clitoris hood, carries little risk during sex, but the procedure itself is potentially risky. Bleeding after circumcision may lead to the need for blood transfusions with unscreened, possibly contaminated, blood.

» *Shyamala, **India**: "From one end of the room, partitioned by a curtain, a voice, loud and haranguing, came through the silence. It was unmistakably the doctor's. 'Spread your legs!… Tell me, where is it paining? Now tell me properly! Is it or isn't it paining? How are we supposed to understand anything if you won't talk? OK. Now you can go'… Suddenly the nurse's voice boomed: 'Everybody go and pass urine and come back!' I quickly followed three other women towards the single toilet… Back in the waiting room, some men had appeared. Two seemed to have come with their wives and two others… were hospital orderlies. I noticed their eyes stray towards the gap in the curtain" [15].*

GENDER-RELATED VULNERABILITY AND OBSTACLES TO PREVENTION AND COPING

Male sexual priority

Commonly, though not universally, male sexual needs are acknowledged to a greater extent than female needs. This may be reflected in the very terminology describing male sexual desire, genitals and partnerships compared with female equivalents. Many cultures use words to describe male sexuality in a positive way and female sexuality in a more negative and judgemental way. Many women and men define sex largely according to what they believe gives men pleasure, particularly penetration. Often women do not explore, let alone assert, their own preferences, because this is considered inappropriate.

"Everything is centred around the pleasure of the man," says a Zimbabwean woman at a market. She sells herbs which, when put in the vagina, cause dryness and tightness. "So if these substances are harmful or even if discomfort is caused, it doesn't matter to the woman. She's doing what she thinks he wants. This is how we have been conditioned" [16].

The dominance of male needs and denial of female needs impedes open discussion between the sexes and limits people's chances of achieving mutually satisfying, respectful and safe forms of sexual behaviour. To curb hiv transmission, both partners should be able to express their worries about infection and use protective measures such as condoms out of respect and affection rather than as a sign of mistrust.

Sex within marriage, in particular, needs to be a source of mutual pleasure and bonding, rather than only a duty and a condition for procreation. However, it is within marriage or with regular partners that women may have most difficulty negotiating safer sex, such as condom use, as this implies lack of trust and infidelity. But it is essential that they be able to do so, as most hiv-infected women have been infected by their husband/regular partner.

Men living separately from their families for months at a time often have unprotected sexual relations with several partners, increasing their risk of infecting themselves and, subsequently, their wives or girlfriends (Photo: G. Diez, WHO)

Economic vulnerability and sexual services

For women and men struggling with daily survival, concern about a disease that may kill 10 years hence is a luxury they can ill afford. Women's economic dependence makes them vulnerable and, for many, training and employment opportunities are few. If selling sex enables them to survive today, long-term concerns remain out of focus. A Ghanaian woman engaged in sex work in Abidjan, Côte d'Ivoire, commented, "I need to feed and clothe my children now. How can I worry about something that may not affect me for many years?" [17].

A ready market for sexual services exists almost worldwide and is a significant factor promoting the hiv epidemic. In some countries, it is reportedly the norm for young men's first sexual experiences to be with sex workers. Demand for sexual services is fuelled by cultural attitudes condoning or even encouraging male sexual freedom while repressing female sexuality. Migration, with its associated disruption of family life, partly promotes the demand for and supply of sexual services. Members of the armed forces away from home, displaced populations and affluent sex tourists from Europe, Japan, the Middle East, North America and the Pacific region further contribute to demand.

At the same time, the boundaries of sex work are often blurred: payment and intimacy may range from a brief anonymous sex act for a specified fee through a gradation of casual and commercial interactions. In many societies, not only those with marked gender inequality, men entertain women or provide them with desired goods in return for sexual access on a one-off, short- or long-term basis. Sex may be demanded or bartered in the workplace to gain a job, promotion or trade permit. This is not usually considered sex work but is nonetheless related to economic need. Unfortunately, sex in these situations is often unsafe.

Control over sexual relations within and outside marriage

Marriage may be viewed as a social and economic commitment between individuals and families. Sexual access, procreation, child-rearing and other services are universal to social expectations of marriage; romantic love and affection are not. Because of this, as well as lower social status and economic dependence, married women may be unable to challenge their husbands' extra-marital affairs or insist on condom use for themselves even when they know they are at risk. One philosophy professor used the Bible to justify this, arguing that women vowed to follow their husbands "in sickness and in health". In his view, this absolved husbands of the need to protect their wives; it did not apply the other way round.

Double standards – different sets of sexual rules for women and men – also may hold for other informal long- and short-term relationships. Various societal institutions may promote fidelity, on the one hand, yet also transmit the message that women should not question male unfaithfulness. Thus, heavy peer pressure may make it difficult for

VULNERABILITY TO SEXUAL EXPLOITATION

» *Nhlungwane, **South Africa**: "A woman may go to look for employment all day and fail. On her way back home she might meet a man who wants to have sex with her. She will accept any amount of money in exchange for sex in order to purchase meals for herself and her children. She could get AIDS from that person" [18].*

» *In **Asia**, daughters may be sold by the family to the sex industry because they need the income.*

» *In **Fiji**, 8 out of 10 domestic workers reported that they are sexually abused by their employers. Female industrial workers are paid a pittance; some are also sexually abused by supervisors and employers. Because of these problems and increasing poverty, more of the women (often deserted wives) are engaging in sex work. As one sex worker said: "Why put up with your boss demanding sex and receiving $30 a week when you can get more a day by selling your body?" [19].*

» *Havinei, **Zimbabwe**: "[My husband] told me he'd been going with all sorts of women. He said that he couldn't see a woman passing by without falling in love with her… He always told me that I was lucky to be his wife. He said the ladies that he'd fallen in love with could fit into four or five buses, but he never took any of them as his wife. He told me to pray to God to say thanks for the husband that I'd been given" [20].*

» *Richard, **Uganda**: "After dropping out of school at age 17, I made friends with four boys who were prominent. We had quite a lot in common, only they engaged themselves in business and sexual life. We used to have evening walks from place to place, especially where there was entertainment and drinking. At such places, these boys could meet more than one sexual partner. They tried their best to persuade me to do what they were doing, by sending me different girls so that we could exchange a word or two relating to sexual activity. I usually had fears and shyness. I didn't know how to start: what could she think of me and what could she say afterwards? How would I engage in actual physical intercourse?*

After all their pressures, the group was not happy with me at all. They felt that I didn't belong and started to tease me with a lot of embarrassing questions and statements like: 'You will suffer from backache because of not releasing the semen. Richard, you seem to be impotent – were you castrated?' To sum it up, they deserted me on those grounds" [21].

» *Young girls who may be raped by a male relative or who are married off as children are especially vulnerable to HIV/STD infection. At a maternity hospital in Lima, **Peru**, 90% of the young mothers aged 12-16 years had been raped by their (step)fathers or another close family member. In **Jamaica**, 40% of pregnant girls between 11 and 15 years of age reported that their first intercourse was "forced". Meanwhile, in **India**, nearly 16% of 133 middle- and upper-class postgraduate students said they had been sexually abused before the age of 12 years [2].*

» *In **Papua New Guinea**, various factors in tribal life combine to place women in situations of HIV/STD infection risk. Customs encourage strong male bonding mechanisms that are played out during frequent group sex events. Many men participate in having sex with one woman and several other men. Even though this is often against the woman's will, it is not considered rape in the legal sense or condemned [24].*

boys to resist experimenting with multiple pre-marital partners, while girls are expected to remain virgins until marriage or at least to remain faithful to one partner.

A further potential source of risk is polygamy, usually meaning multiple wives rather than multiple husbands. If no partner has sex outside the group, this can be a safe system but if any one is infected, all may be at risk.

To curb the epidemic, marriage should be squarely acknowledged as a major risk factor for women in many societies. The simplistic message of lifelong monogamy is a poor one if one partner already has hiv infection and will not use condoms. It has been observed that some men who learn or fear they have hiv infection marry to ensure someone will care for them when they become sick [22].

Violence against women

Violence against women, especially rape, is a risk factor that is inadequately recognized or addressed. In South Africa, an estimated 370,000 women are raped every year; in the United States, the Department of Justice reports that a woman is raped every six minutes [23]. Ironically, marital violence is more tolerated by society than violence outside marriage, to the extent that rape within marriage is not a recognized offence in many parts of the world. The woman's word is usually given less credit than that of the rapist. It is also traumatic and difficult for women to report rape and secure a conviction; the extreme is reached in some Islamic countries where a male witness to the rape is required.

Violence against women is sometimes socially condoned. Many would argue that widely distributed films and television portrayals of women as sex objects and victims of abuse reinforce the acceptability of violence against them. In some countries ritualized violence, including rape, is condoned in certain circumstances.

In the worst situations, physical and sexual violence against women are commonplace. Wars and armed conflicts, generally accompanied by widespread rape, now have the added risk of

spreading hiv and std s. The physical trauma of violent sex, often multiple rape, makes transmission particularly likely. Indeed, any coerced sex increases the likelihood of micro-lesions in the vaginal mucosae which may then be entry points for hiv.

Blame and rejection

Despite the realities of infection patterns, gender stereotypes allow women to be blamed for spreading hiv/std s.Men are often reported to be infected by sex workers or casual girlfriends, who may be castigated by men and women alike, while less blame tends to fall on men than women who have multiple partners. Indeed, in some African and Asian cultures, it is believed that men must regularly release semen to avoid ill health.

Although for both sexes alcohol consumption reduces a sense of responsibility and leads to risk taking, women are more likely to be criticized for this. Male drunkenness is widely tolerated, men being excused for giving way to "natural urges".

Men in some societies may boast about std s because these show they are "real men" who have sexual relations. For a boy growing up this may be part of his initiation into manhood. But for a woman the story is different; she is more likely to be looked down on as loose or unclean. In much of southern Africa, for example, std s are derogatorily termed "women's disease" and men blame women for their infections. A doctor's wife in Australia with pelvic inflammatory disease was told by her health worker that she should be ashamed of herself: "someone in your position coming in with a problem like this"[26].

If hiv infection is discovered first in a wife, perhaps because she is the first tested when a baby falls sick, she is readily blamed. Her husband may refuse to be tested or, if found positive, accuse her of infidelity to cover his own behaviour. She may equally be blamed by other relatives, regardless of whose infection was discovered first.

At the same time, the denial of women's sexuality and the social assumption that they must be "pure" make it hard for women to acknowledge any other sexual experiences they may have had even before marriage. To do so is to court divorce or blame, even from female relatives. This blocks women from assessing their own risk and discussing risk behaviours and situations with their partners. Women living with hiv (perhaps more so than men) are even expected to become sexually inactive.

» *Married women in Palembang, **Indonesia**, who knew little about AIDS, associated it with "loose women" rather than believing themselves to be at risk. They believed that AIDS was contracted through "sexual contact with the lower class of commercial sex workers" and that the high class had usually been protected from STDs. They also said that AIDS comes from "promiscuous women and multiple partners"* [25].

BLAME AND REJECTION

» *Sylvia, **The Netherlands**: "I only dared tell my two sisters after a year. One thought I might be imagining it because I still looked healthy, didn't I? My other sister felt it was my fault. If I had lived well, with a complete family [including a husband], it wouldn't have happened to me… My ex-partner told others, too… Because people gossiped about me, the vice police started following me; they had heard I was whoring around and infecting everyone. Of course, they couldn't prove that"* [27].

» *Reina, **The Netherlands**: "When a person is infected with HIV, that does not mean that sex disappears from her or his life, even though some people think those living with HIV/AIDS should never have sex again. Of course, none us of living with the virus wants to pass it on to others… We want to have sex for the same reasons you do: because we like it, to express love, to gain consolation or security. In that, we are like everyone else"* [28].

Blame can also lead to institutionalized human rights violations, e.g., the compulsory screening of sex workers. Women carrying condoms may be charged by police as sex workers; thus even when they act to safeguard themselves, this may backfire.

Lack of information

Many women have poor understanding of their own bodies, mechanisms of hiv/std transmission and their level of risk in unprotected sex. Many men also lack adequate information about their own bodies and tend to have even less information about women's bodies and needs.

Addressing these gaps in information and understanding is difficult because many poor men, and even more women, have low levels of education and literacy and have little access to printed information on hiv/aids and stds. Men are more often able to gain information from radio and television. Consequently, women hear about hiv/stds later and not infrequently have little or incomplete information about transmission. This may prevent them from assessing adequately their own risks. A female merchant in Senegal commented: "I don't need condoms because I am not a prostitute. I have a husband and children. It is rare that during my travels I fall to the advances of a man. When I do, it is with someone I trust. I only choose to have sexual relations with men who are clean and visibly healthy, polite, and capable of respecting me. These men know me, trust me and know that they don't need to use condoms with me"[29].

COMMUNICATING CAN BE HARD

» *Somchai, **Thailand**: "I want someone to talk to, but it is very difficult to open up. I cannot talk to my wife about this. She does not have much to say about it and rarely exchanges conversation with me. I don't really know how she feels or what she really thinks. She is a very good wife but we cannot be friends"*
[30].

» *Woman, **South Pacific**: "I was aware my husband was having casual sex when not with me, but I was too ashamed to ask him to take precautions. I kept telling myself, next time. My advice to young mothers is, 'Don't ever wait for next time.' Now I have big regrets. I'm so lucky that I didn't have any more children after I was infected"*

Communication

Poor communication between parents and children and between partners about relationships, male and female sexual needs and responsibilities exacerbates risk. Youth as well as adults can be taught to discuss sex-related issues (health, needs, relationships); ideally, this should become an accepted norm.

Family stress

Women's traditional family roles are arduous. Rural women in many parts of the world are primarily responsible for subsistence agriculture and, in rural

» *In an **African country**, when Janet's husband learned that she had HIV infection, he threw her out with their two small children. Janet's father had died of AIDS and her mother was sick but trying to look after Janet's seven younger siblings. The logical outcome was for Janet to return to her parents' home and help. Her mother has since died, leaving Janet to care for all nine children. None are in school, all are malnourished. They live in one room, a corner of which is partitioned off and rented out to provide a small income. This, and what the older girls can earn from selling sex, keeps the family alive. No help has been forthcoming from Janet's husband nor from other relatives on either side.*

and urban areas, informal sector activities. Women usually undertake most household tasks, go through pregnancy, childbirth and lactation, and rear children. Large numbers of women are in fact household heads but lack sufficient authority, money and material resources, family and formal support to provide adequately for their children and themselves. aids-related stigmatization and the extra care burdens brought on by the disease worsen existing gender inequalities, increasing women's vulnerability and exploitation.

The impact of aids on the family may be devastating, with both parents and sometimes one or more children becoming ill and dying. Girls may be withdrawn from school to look after their families, thus increasing their economic and social vulnerability when they grow up. The elderly also take up an increasing care burden when they themselves may be frail.

» *A nurse: "In many countries in* ***Africa*** *families admit they have had to disrupt the schooling of the girl children; first, because they need another pair of hands to help them in caring for the sick, and second, because the family resources are reduced and the little funds available go into meeting the basic survival needs of the family… They seem to see this as one big disadvantage of the home-care programme activities" [3 2].*

Young girls are kept from school to help with care, e.g., to get food and medicines (Photo: Roel Burgler)

Elderly grandparents may face the responsibility of raising their grandchildren (Photo: Roel Burgler)

aids makes decision-making about child-bearing, abortion and breast-feeding much more difficult. Available services may or may not provide helpful advice or be sensitive to the stress women face around these and other sexual health issues. In fact, women and couples may face humiliation and misinformation in the very centres and at the hands of the so-called professionals supposed to help them.

» *Pung, **Thailand**: "It all happened with my first pregnancy when I had a blood test. The nurse asked me some questions and finally told me I was infected with the HIV virus… I brought my husband in for testing and he tested HIV-positive… I remember crying when both of us sat in front of the nurse.*
She asked us what we wanted to do with our unborn child. She suggested aborting the child and added that it would be free of charge. If I agreed to do so, I was also required to have a hysterectomy.

I talked to my husband and we both agreed to have an ultrasound to see if our child was healthy. The technician said the child was healthy and strong. Then she looked at my HIV status and suddenly replied: 'No, no you cannot keep the child'; her voice was so threatening. 'You must abort the child', she insisted.

My husband said it is probably better to abort the child, letting go now was better than losing it when the child grew and became as lovely as our dreams. I was not sure myself but was in a state of shock. I asked the nurse if I could have a sterilization that was reversible. She looked at me with surprise and asked if I still had hope for a cure. On the form there was only a hysterectomy so she wrote that I wished not to have a permanent sterilization operation.

I had my child aborted, with a special deal: abortion with sterilization – free of charge. But I still don't know what kind of sterilization I got. I am not sure if it is a reversible or permanent sterilization. I have no way of knowing what has been done to my own body"

Home care

In areas where the epidemic is already severe, particularly sub-Saharan Africa, hospitals cannot cope and much patient nursing is done at home. Numerous home-care programmes have been developed by church and community groups or as hospital outreach programmes. aids service organizations provide counselling, material and practical help, spiritual support, nursing care and advice. Excellent work is performed by dedicated staff, yet coverage remains low, often under 10%. Visits from support teams may be on a fixed and infrequent schedule, and cost-effectiveness and sustainability remain serious concerns. The extra burden inevitably falls on the family, in particular on women.

In other regions, such as Latin America, the Middle East and Asia, some hospitals, clinics and social services do not provide care because staff are still afraid to accept people with hiv/aids. Stigmatization and discrimination may also prevent families and community members from providing support.

The growing orientation towards home care may, in fact, worsen women's situation, particularly as men are often the first to become sick. The wife may have to nurse her husband while her own health deteriorates, but the main expenditures are for his care. There may be no appropriate care-givers to nurse her through her sickness. Rather than an excessive focus on home care, developing a continuum of care between hospital, clinic, local hospice and other community care is preferable, a strategy supported by who. This enables health workers at the local clinics, community health workers and neighbours to help when appropriate and when requested by the family.

Men need to be motivated to assume stronger care roles in the family, both for the sick and in general around child care. Health and welfare concerns cannot remain women's preserve. If this can be achieved, husbands may be less likely to desert women who are found to have hiv and will write wills or otherwise provide for their families when they themselves are dying.

Legal and human rights

At present, women's rights in many countries are curtailed. They may have little right to land, to inherit property, even to keep their own children when their husbands die. aids throws these problems into stark relief because more women are being widowed at a young age and will themselves face an early death. Safeguarding their children's future may be a desperate worry for these women, yet they may lack the means to provide for them without extended family support. In some countries, women are traditionally inherited by the deceased husband's brother. Their economic and social survival may depend on their acquiescence.

» ASPANE, in **Mexico**, helped Yolanda, 26 years old. She lived in a "house" of carton near a garbage dump in a Mexico City suburb with her 3-year-old son and 5-year-old daughter. When her partner died of AIDS and her neighbours discovered that Yolanda was also HIV-positive, they tried to drive her away. Yolanda sought refuge with her mother-in-law, but her daughter was sexually abused by a brother-in-law in that household.

In desperation, Yolanda turned for help to a charitable organization for abandoned children. After proving that her children were HIV-negative, so that the organization would accept them, the Department of Social Welfare helped Yolanda to transfer custody of the children legally to the organization. They went there when she died.

VIOLATIONS OF HUMAN RIGHTS

» *ASPANE in **Mexico** helps Rosa, who contracted HIV from her bisexual husband. He abandoned her and their four children when he learned that she, too, was HIV-positive. Rosa's in-laws blamed her for the HIV infection and consequently refused to offer her any help or information about her husband, who went into hiding for fear of being made legally responsible for child support.*

» *Deborah in **Uganda** lost her husband to AIDS and is herself very sick. Her brother-in-law tried from the very beginning to inherit her, but she categorically refused so as not to infect him and his wife. He repeatedly told her he does not care that she has AIDS and is willing to take the risk of becoming infected. He harassed her for almost a year; when she held firm and refused, he cut off all financial support to her and her four children. Once she refused him, she was ostracized by the entire family and cannot rely on them for anything, even moral support. Now, he is trying to claim the land that his brother left jointly to them* [34].

» *"When life became difficult in her native village of Melamchi in the **Nepali hills**, Geeta moved to Kathmandu where she worked as a housemaid. When her cousin promised her a better job in a carpet factory in India, she jumped at the opportunity: 'I didn't realise that I was sold to a Nepali brothel keeper in India until the lady told me to engage in business… I wept and wept. I was shocked to be sold by my own relative. I went mad. They admitted me into a mental hospital. After a year, I was ultimately forced into prostitution. I never liked it – that was not what I had wanted. But you can't fight against luck and fate.'*

Geeta was sent home with 200 Indian rupees (US$ 6.50) for her transport after she tested HIV-positive. Back in Melamchi, she found her mother had died and her father refused to take her back. Determined to begin a new life, she rented a liquor shop with her savings. The shop was successful until her HIV status became known in the village – then business collapsed and she was forced to close down" [36].

On the other hand, after the death of a husband, women around the world may be disinherited by the husband's relatives, particularly if they blame the woman for his death.

At another level, married women's confidentiality may be broken with relative impunity leading to violence or desertion if their husbands blame them for infection. Meanwhile, women may not be informed of their partners' hiv status. The right of partner notification versus strict confidentiality is being debated in many countries and different policies are being developed. For women the outcome is particularly crucial as infection often enters the family through the husband. Uninfected wives could, in theory, protect themselves but only if access to information is accompanied by the economic, social and legal means to take preventive action.

The rights of women living with hiv to bear children or seek an abortion are hotly debated. A British woman living with hiv was angered and upset by accusations that her choice to have a baby was selfish as the child risked infection or, if it lived, would certainly be orphaned fairly young [35]. In many developing countries a woman's status is highly dependent on motherhood; much more than in Britain it may be of great importance to an hiv-positive woman to have a child.

The issue of sex work also raises difficult legal and ethical problems. While soliciting remains illegal in most countries, sex workers remain vulnerable to abuse, are difficult to reach with hiv/std prevention and support programmes, and face increased stigma. Yet arrangements for sex work may involve minors, abduction and coercion; these aspects of the trade must be stopped. aids is giving rise to increased public outrage about these human rights violations.

Another neglected area is the rights of homosexual women and men to social acceptance, child care, mar-

riage and inheritance. Lesbian relationships are a preferred lifestyle for some women and generally carry a low risk of hiv infection. However, societal intolerance precludes many women from exploring this option even if they would like to. Male gay relationships are more common in some societies, but their very existence may be denied or condemned, leading gay men to marry and engage in bisexual contacts even if they prefer only to have sex with men. "Talk to any African government about homosexual issues and the spread of aids, and they simply tell you that homosexual activities only go on in the Western world," said Obi Zikora, president of Gentlemen Alliance, in Nigeria [37]. "The stigma attached to homosexuality frightens away many who should be examined from going to doctors."

As with sex workers, legal rights for homosexuals and lesbians need to be strengthened and societal intolerance challenged if they are to cope better with hiv and aids and not be driven underground.

Structural patterns

Economic policies widening the gap between rich and poor countries and rich and poor people within nations exacerbate the conditions for hiv/std transmission. For example, economic structural adjustment programmes may have a negative impact on rural and urban poverty, national debt and trade relations. These policies hamper countries' capacity to provide social, educational and medical support to affected families and communities, especially if food subsidies are cut and social, welfare and health expenditures are reduced.

The epidemic hits hardest the developing world and the poor inner cities of industrialized countries, which are least able to cope. Furthermore, poverty increasingly has a female face: undp estimates that 70% of the world's poor are women. As prevention efforts are

The epidemic hits hardest among the world's poor, 70% of whom are women (Photo: Roel Burgler)

stepped up, communities' abilities to cope must also be strengthened. Only through improving coping capacity will fear and stigma around aids be reduced, allowing prevention strategies to really work.

Within this framework, empowering women and reducing gender inequalities are critical. The structural basis of gender inequality must be challenged by promoting personal attitude and behaviour change. Women must gain access to the education, training and employment they need to achieve sexual relations on equal terms and to control their risk of hiv/std s. Cultural expectations that exonerate men from taking responsibility for health and welfare concerns must be transformed, along with the structural conditions of work, housing, migration, etc., that prevent this from becoming a reality.

» *Woman, **Zimbabwe**: "My husband passed away from AIDS when he was 35; he was ill for six months. He used to work as a general labourer in a big firm and only came home at weekends. We had eight children, but the last two both died. This leaves me with six children to feed. It is very hard. The two eldest have had to leave school to try and earn money, but I am trying to keep the youngest four in school.*

In the early stages of my husband's illness we could cope. It became difficult when he lost his job. We had to spend a lot of his savings on special food for him, and he lost his medical aid cover. I grow maize and try to make money selling crochet work, but it is not sufficient. I cannot get a proper job – in these days it is even more difficult as a woman because it is men who are expected to work.

My husband's workplace helped with the funeral and will pay me a small pension for four years. But he had not worked there long so the amount is low. My husband's brother is supposed to take care of us. He knows our problems but did not help at all during my husband's illness nor after his death. Now he wants to marry me, but I think it is in order to take my husband's estate, not to help us. I am lucky because my husband left a letter instructing that his property was to remain with us and that I should not marry his brother in the traditional way. Fortunately, the headman and the other village elders support this decision because they know that this brother did not help us when my husband was alive. Otherwise it would be very hard for me to refuse. I have to think of my children. But by refusing to marry I lose any hope of help from him.

If I die, the oldest children will have to take care of the young ones. I cannot trust my husband's brother, and I do not think his first wife would treat them well. My own two sisters cannot take the children because their husbands will not allow this. It is not traditional and they have their own families. The women take care of the children, but it is the husbands who must make the decision about this."