Trócaire Development Review, Dublin, 2007, pp. 33-45, ISSN 0790-9403

HIV/AIDS and Gender[1]

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Gender inequality drives and is driven by HIV and AIDS, an epidemic that will continue as long as this inequality persists. This paper shows how the progressive feminisation of AIDS reflects the dominance of men over women. It brings together some of the evidence calling for an effective gender perspective on AIDS and argues that AIDS is only one expression of the way women are denied their dignity as full and equal human beings. Responding to global discrimination and prejudice against women calls for interventions beyond the domain of HIV and AIDS. For this reason, recent moves and statements from the Catholic Church and the UN are welcomed as signalling a long awaited global transformation.

AIDS and the gender factor

For millions of people, deprivation, disadvantage and disease are very closely intertwined. Personal and structural poverty and deprivation create conditions within which HIV and AIDS can flourish. Disadvantage, whether arising from sex, age, disability, place of habitation or other circumstance, can enhance these conditions. This is particularly the case with the disempowerment experienced by women, especially, but not only, those who are poor.AIDS needs to be examined from a gender perspective and not just from the standpoint of women. A major reason is because gender issues, power structures and attitudes lie at the heart of the epidemic. If these could be resolved, the epidemic could be checked. Gender relations are central to HIV

transmission. The principal route for the spread of the disease is sexual activity, with heterosexual intercourse accounting for at least 70% of AIDS cases worldwide. But a gender dimension is also integral to transmission from mother-to-child and among men who have sex with men. Apart from transmission, the gender factor features prominently in HIV and AIDS because of the greater biological vulnerability of women and girls to infection and the way their social, economic and legal disadvantages increase this vulnerability.

The impact of HIV and AIDS

In addition to the tragedy that they wreak in the life of an individual, HIV and AIDS do three things within society. They highlight existing societal problems; they magnify the scale and complexity of ongoing problems; and they create new problems.

Like a very strong spotlight, the AIDS epidemic highlights weaknesses, cracks and fault-lines in society, most powerfully in the area of gender. The stereotypes of masculinity and femininity leading to behaviour that fuel the epidemic; the different norms and expectations for male and female sexual activity; the structures that ensure the economic dependence of women on men; the worldwide prevalence of sexual violence by an intimate partner;[2] and the unequal division of household labour, particularly in caring for those who are ill. The epidemic has also brought to the fore a variety of other gender-related issues, such as the widespread reality of sexual expression,[3] the way societies confront and often suppress issues of sexual orientation, and the ambivalence of society in dealing with deep-seated taboos surrounding blood, sex, and death and in confronting drug-injecting use.

The AIDS epidemic also increases the scale of such issues and makes them so complex that they almost defy solution. While household food security has always been a challenge for women in poor families, the epidemic has magnified this task by reducing household incomes at the very time it creates additional burdens of care that, in the majority of cases, are borne by women and girls. Ensuring universal access for girls to quality education has long been a goal of global policy, but HIV and AIDS make achieving this doubly difficult because of the way AIDS-affected households withdraw girls from school for labour and child minding tasks.

Other new problems include ensuring access to life-preserving but costly antiretroviral drugs for millions of women who need them; enabling elderly grandparents assume a parenting role for grandchildren who are bereaved, impoverished and extremely vulnerable; and overcoming the stigma and discrimination against HIV-infected women, often driving them and their children from their homes without their belongings.

The feminisation of HIV and AIDS

The feminisation of HIV and AIDS refers to three things: the increase in the number of women and girls infected with the disease; the younger ages at which they are becoming infected and dying; and the negative impacts the epidemic has on their lives. Increasingly, the epidemic is infecting more women than men and in many parts of the world, particularly where heterosexual activity is the dominant mode of HIV transmission, the face of HIV and AIDS is progressively that of a woman.

Globally, the proportion of women and girls living with HIV continues to grow. In 1997, 41% of those living with HIV were women; by the end of 2003, this had risen to almost 48%.[4] While in sub-Saharan Africa 57% of the 23 million infected adults are women. This has led Stephen Lewis, former UN Secretary-General Special Envoy on HIV and AIDS in Africa, to state that in Africa "the pandemic is now, conclusively and irreversibly, a ferocious assault on women and girls".[5]

Women are becoming infected with HIV at an earlier age than men. At the end of 2003, an estimated 10 million young people between the ages of 15 and 24 worldwide were living with the virus. Of these, 6.2 million were young women and 3.8 million were young men – for every two young men, more than three young women were infected. Infection rates among men increase quite rapidly from age 25 onwards but remain below those of women until, from about age 35 onwards, the deaths of women begin to bring down the female prevalence rates.

This has major implications. First, the proportion of women with the disease will continue to increase, especially the proportion of young women of childbearing and child-caring ages. This in turn will lead to increases in both the number of infants likely to be born with HIV and the number of orphaned children.

Second, women experience AIDS-related illness at a younger age than men. A recent study in Zambia found that in a large

group studied over three years, 61% of all deaths occurred among women, and that women on average died younger than men.[6] This will change demographic structures and life expectancies, with major implications for the care of the upcoming generation. In most parts of the world, women live longer than men, but because of AIDS the average life expectancy in four countries (Botswana, Lesotho, South Africa and Swaziland) will be two years less for women than for men by 2005-10, compared with seven years more in 1990-95.[7] One outcome of this is that increasingly the burden of orphan care will fall on grandparents, but because of AIDS this pool will itself decline, especially among grandmothers.

The biological vulnerability of women and girls

UNAIDS, the Joint UN Programme on HIV and AIDS, has stated: "Vulnerability to HIV reflects an individual's or community's inability to control their risk of HIV infection".[8] A number of physiological and health factors reduce the ability of women and girls to control this risk. The fragile tissues in the sexual areas of the female body, the greater exposure to large volumes of high-risk body fluids, and the retention of such fluids for relatively extensive periods, make women more vulnerable than men to HIV infection. These and other physiological factors result in a risk of HIV infection of 20 per 10,000 peno-vaginal sex contacts for the female partner, compared with 3 per 10,000 contacts for the male partner. In other words, on physiological grounds alone, HIV transmission from male to female is seven times more likely than transmission from female to male.[9]

Moreover, it can be more difficult for a woman to detect she has a sexually transmitted infection than a man, which can bring a tenfold increase in the risk of HIV infection. The vulnerability of a teenage girl is further aggravated by the ease with which her immature genital tract can be lacerated and become infected while the risk of HIV infection doubles during and immediately after pregnancy.[10]

The social vulnerability of women and girls

Gender inequity and inequality in sexual expectations and behaviour compound women's biological vulnerability. Masculinity images in many cultures portray the male as the controlling partner, the initiator of sexual activity who is dominant in most sexual interactions. "Widespread stereotypes of masculinity, 'machismo' and what it means to be a 'real man', encourage male dominance over women, risk-taking and promiscuous sex".[11] Integral to this stereotype is the notion that a man "needs" sexual activity to establish his identity and that to exert sexual and physical domination over women defines what it is to be a man.

On the other hand, stereotyped femininity portrays women as submissive, docile, and compliant. According to this "feminismo" image, the interest of girls and women in sexual activity is motivated by three factors, singly or in combination: images of love and friendship and the need to maintain a satisfactory relationship; the prospect of childbearing; and social status, money and material resources.[12]

These concepts of masculinity and femininity lead to decision-making imbalances, with women almost invariably subordinate and submissive to men and therefore poorly placed to control their sexual lives. They often cannot decide when, with whom, and under what conditions they have sex, and may be forced to have unwanted sex.

Such concepts also lead to double standards on the sexual behaviour of women and men in traditional and modern societies. Men are expected to be sexually knowledgeable and experienced, whereas women are expected to be naïve; showing knowledge or interest in sexual areas may suggest they are immoral or "cheap". Promiscuity among men is much more acceptable than among women. As a result, boys and men tend to have more sexual partners than girls and women.

Two sexual practices common in many parts of the world increase this HIV infection risk among both men and women: sexual age-mixing and multiple concurrent partnerships.

Age asymmetries in non-marital sexual relationships are relatively common, with the female partner frequently the younger, often by several years. Girls' motivations include the search for a marriage partner, for love, for social status, for opportunities, for money, and for gifts.[13] Such relationships increase the HIV infection risk for the girl in a number of ways.

There is a strong possibility that the older male partner will already be sexually active and may already have contracted HIV. If the girl is young, her vagina may still be immature and easily torn. The girl has almost no power to insist on condom use, while there is always the risk of violence, especially if she attempts to end the affair. It seems very likely that this form of relationship is responsible for much of the HIV transmission in the 15 to 24 age group. The girl may also maintain relationships with males in her own cohort and can infect them in turn.

A feature of the gender inequality surrounding HIV and AIDS is the way women are blamed for the disease. In the case of intergenerational sex, the older male partner may infect his younger female partner who in turn may eventually transmit the infection to a partner in her own age group. She is held accountable for doing so. But there is much less focus on the accountability of her older partner who infected her in the first instance.

The situation in marriage is similar. In African society, as in many other parts of the world, married women or those in a steady relationship often face violence and abuse if they insist on condom use or refuse sex to their husbands or long-term partners. While many women without a partner are vulnerable to HIV, even more are vulnerable to infection because they are married and remain faithful to a partner who does not reciprocate this trust. Thus, among sexually active girls aged 15-19 years in Kisumu (Kenya) and Ndola (Zambia), HIV-infection levels were found to be 10% higher for married girls than for their sexually active unmarried age-mates.[14] Young women find themselves in a very difficult predicament: if they get married (or establish a permanent relationship), their HIV vulnerability will increase, even if they remain faithful to their spouse or partner; but remaining single or with no partner also heightens their vulnerability, largely because of their social and economic dependence on men.

Globally, multiple partnerships are reported more common in developed than in developing countries[15] but relationships where the individual maintains a number of sexual partnerships at the same time appear to be more common in some regions where HIV prevalence is high. These allow faster spread of sexually transmitted infections than the corresponding number of new sequential partnerships and multiple and concurrent partnerships have been identified as key drivers of the AIDS epidemic.[16] The situation arises frequently in the transport industry, where long haul truckers and railways workers may maintain second and third

homes along their route. Recent research has shown that being away from home is associated in both developing and developed countries with concurrency of partnerships.[17] In addition, many societies condone the practice of an older married man having a "girlfriend" on the side and understand the meaning underlying references to a "small house" or a "second office".

Concurrent partnerships are not a male preserve. Across the globe, concurrent sexual relationships feature in the lives of women as well as of men, though more so for men than for women, and also more so at younger than at older ages. They also occur where both women and men take part in sexual networking. A study in Malawi found that in seven villages 65% of sexually active adults were linked in one sexual network.[18] In such circumstances, the potential for HIV transmission from male to female or female to male is almost unlimited.

Vulnerability to HIV infection on economic and legal grounds

Economic factors further accentuate women's vulnerability to HIV infection. They remain dependent on men because they have limited access to capital or credit. Some societies do not allow women to own land and because they receive inadequate financial support from their partners, many women must apply their own ingenuity and resources to maintain their household. All too frequently the sale of sex becomes the only way for many of them to meet household survival needs.

Women also experience legal discrimination. The law may offer nominal protection but many widows experience considerable violations of their property and inheritance rights. Relatives may "grab" the property of their late husbands, evict the widows, strip them of their possessions, or force them to engage in risky sexual practices if they are to keep their property. The situation that Human Rights Watch has described for Kenya exists in many parts of Africa and South-East Asia:

> A woman's access to property usually hinges on her relationship to a man. When the relationship ends, the woman stands a good chance of losing her home, land, livestock, household goods, money, vehicles, and other property. These violations have the intent and effect of perpetuating women's dependence on men and undercutting their social and economic status.[19]

As well as failing to protect their rights, justice systems may also be weak in responding to cases of sexual abuse and rape. The legal attitude frequently reflects the thinking of a male-dominated society. "The courts often do not take (the) case seriously and, in the case of an older girl with a complaint of sexual abuse, the case may hinge on whether or not the judge believes she 'asked for it'."[20] The minimal protection offered by the courts increases the reluctance of families to seek justice for crimes of sexual abuse against women and children and the light sentences often handed down suggest these are not regarded as serious offences.

The burden of care

In countries where AIDS is very extensive, the principal option available to those with HIV is home-based care, with hospital care only at critical junctures. The burden for this falls squarely on women and girls; men are rarely evident. Thus in Viet Nam women account for three-quarters of those who care for persons living with HIV.[21] When women fall sick, other women care for orphans from their own or their husband's family, greatly increasing this burden of care.

Although communities, NGOs and governments support home-based care, they fail to recognise the enormous human and financial costs for households, particularly women. Such care has been described as "an absurd misnomer for what amounts to additional forced labour for women".[22] It is doubtful whether a patriarchal society, or its patriarchal state and Church organs, really appreciate the implications for a veritable army of women volunteers of providing home-based AIDS care, almost as a matter of course, but also at extreme personal cost. As the major food providers, caring for AIDS sufferers greatly reduces the time women have to provide at least one meal a day. They may have to sell themselves for sex to buy food, encounters which invariably entail high risks of HIV infection.

The burden of AIDS care falls even more heavily on a woman who is herself pregnant or caring for young children. She may well have got the virus from her husband but her silence can lead to her own death and her infant's.

As mentioned, care responsibilities also extend to young girls who are often taken out of school to supplement the AIDS care provided and to perform household tasks such as minding younger children, petty trading, fetching water and firewood and

washing the bedclothes of AIDS sufferer. They miss out on an education that can prepare them for the future and ease them out of poverty and they fail to acquire the knowledge, skills, attitudes and values which could protect them against HIV infection.

Many women feel disempowered by attitudes that give priority to the health needs of men. Even if HIV infected, women must continue to manage their households, care for the sick and the young, produce food and generate income. A nurse at a health centre in Zambia reported that she had often seen women bringing their husbands to the clinic on a wheelbarrow, a bicycle and even on their back, like a baby; but she had yet to see a man offering even the support of his arm and bringing his wife for treatment.[23]

Many HIV-infected women cannot take time off from their household duties to visit a health centre supplying antiretroviral drugs and the bureaucracy surrounding antiretroviral therapy may be discouraging, especially for illiterate women.

The role of men

This discussion does not imply that the AIDS epidemic is not impacting heavily on men nor that women are free of responsibility for its transmission. Almost certainly it was men who spread HIV and AIDS initially and continue to spread it. Men may have opened the ghastly Pandora's box of the disease but have been singularly successful in passing on its contents to women.

The tragedy is that so many cultural norms are hostile to women and at the same time friendly to HIV and AIDS. The macho attitudes that epitomise masculinity for many men put countless women and men at risk of HIV infection. Failure to share household and care burdens equally places a heavy weight of responsibility and work on women and reduces the material and psychological support when men need it.

The phenomenon of homosexuality provides a further perspective on the male role. Denial by society and communities, hostility and discrimination, and human rights abuses combine to prevent acknowledgement of this worldwide social occurrence that may involve up to 16% of men at some stage in their lives.[24] Given the high infection risks attaching to unprotected anal sex, homosexual practices are a significant factor in HIV transmission. The danger of transmission can also affect women, for many homosexual men are married or in relationships with women and

thereby constitute a bridge for HIV transmission to women who ordinarily would be at low risk of infection. Thus, in Central American countries, UNAIDS reports high HIV prevalence levels among men who have sex with men, many of whom regard themselves as heterosexual or bisexual.[25]

> In many countries male-to-male sexual activity produces homophobia, stigma, discrimination and even violence, bolstered by social structures and attitudes that enshrine traditional gender norms of masculinity and femininity.[26]

The hostility to homosexuality is largely underpinned by two human rights abuses: failure to recognise the fundamental equality of men and women, and failure to accept that individual uniqueness may express itself in different sexual orientations. The result is the stigmatisation of homosexual practices, denial of its existence, increasing incidence of HIV among homosexual men and the criminalisation of sex between men. All are well calculated to keep HIV flourishing not only among men but also among the women who are their partners.

The way forward

It is clear that "gender is an inextricable part of the HIV/AIDS equation".[27] Likewise, HIV and AIDS are inextricably bound up with the lower status that society accords to women and girls and as long as this persists, the AIDS epidemic will continue to flourish worldwide.

This implies that the response to the AIDS epidemic, in terms of prevention, treatment, and impact mitigation, will only succeed when robust, sustained and specific action is taken to reduce and eliminate the discrimination and unjust treatment of women. In other words, every step taken to raise the status of women and to recognise their equal status with men is a step against the epidemic.

In its most recent policy document on HIV prevention UNAIDS recognises the crucial role of gender equity in stemming HIV: "All HIV prevention efforts/programmes must have as their fundamental basis the promotion, protection and respect of human rights including gender equality".[28] The document further identifies action areas to address women's vulnerability to HIV and that action towards gender equality such as universal education for girls is necessary to reverse the

increasing feminisation of the epidemic globally.[29] Former UN Secretary-General, Kofi Annan, has also stressed the importance of girls' education: "To help reverse the epidemic, high priority should be given to poverty-reduction strategies, girls' education, women's economic opportunities and other basic reforms".[30]

The UNAIDS document acknowledges the need to move towards the broader goal of gender equality. This is necessary in the light of what HIV and AIDS can do in the area of gender relations. But even more fundamentally, it is necessary in its own right. AIDS or no AIDS, women and men are essentially equal. Making that equality a lived reality is a major challenge for every individual, community, institution and country.

It is heartening to know that both the Catholic Church and the UN have turned their attention to the persistent inequalities between men and women in their human rights statements. In his "Message for the celebration of the World Day of Peace 2007", Pope Benedict XVI refers to the "exploitation of women who are treated as objects, and of the many ways that a lack of respect is shown for their dignity". He also refers to "the mindset persisting in some cultures, where women are still firmly subordinated to the arbitrary decisions of men, with grave consequences for their personal dignity and for the exercise of their fundamental freedoms".[31] The UN is moving towards the creation of an enhanced and independent policy, advocacy and operational agency for women's empowerment and gender equality. The world has waited decades for reflections and moves such as these. What is needed is for both bodies to translate theory into practice not only outside, but also within their own ranks. Such action would signal a turning point in the lives of women worldwide, and especially of women infected or affected by HIV and AIDS.

The AIDS epidemic has highlighted the tragedies that gender inequality can bring in its wake. But it also points to the need for wholesale transformation of the social, economic, legal and political structures of society that will see an end to practices and attitudes that offend against the dignity of women and men alike. Here, as in other spheres, the epidemic acts as a catalyst, calling on people and institutions across the world to create a more just society, characterised in practice as well as in theory by respect for the basic principle that "all human beings are born free and equal in dignity and rights".

Footnotes

[1] This article is a development of the text of the Trócaire Annual Lecture delivered by the author at St Patrick's College, Maynooth on 13 March 2007.
[2] Wellings et al. (2006)
[3] See Smith and McDonagh (2003), p.25
[4] See UNAIDS (2004), p.22
[5] Lewis (2002)
[6] See Chapoto and Jayne (2006), pp.40, 41
[7] See UNDP (2006), p.266
[8] See UNAIDS (2006a), p.105
[9] Abdool Karim (2005)
[10] NWHRC (2006)
[11] See Jackson (2002), p.88
[12] See Kempadoo and Dunn (2002), p.170
[13] Leclerc-Madlala (2006)
[14] See UNAIDS (2004) p.10
[15] Wellings et al. (2006)
[16] Halperin (2006)
[17] Wellings et al. (2006)
[18] Kohler and Helleringer (2006)
[19] Human Rights Watch (2003), p. 6
[20] Ibid., p.60
[21] UNAIDS (2004), p. 130
[22] Lewis (2003)
[23] IRIN (2004)
[24] Foreman (1998)
[25] UNAIDS (2006b), p.51
[26] See Kelly (1998), p.65 for a discussion of the patriarchal understandings that appear to be seminal to the commonly hostile approach to homosexuality.
[27] IATT (2005), p.1
[28] UNAIDS (2005), p.13
[29] Ibid., p.18
[30] United Nations (2006), s.59
[31] Pope Benedict XVI (2006), s.7

References

Abdool Karim, Q. (2005), "Heterosexual transmission of HIV – the importance of a gendered perspective in HIV prevention", in S. S. Abdool Karim and Q. Abdool Karim (eds) *HIV/AIDS in South Africa*, Cape Town: Cambridge University Press

Chapoto, A. and Jayne, T. S. (2006), "Socioeconomic characteristics of individuals afflicted by AIDS-related prime-age mortality in Zambia", in S. Gillespie (ed.) *AIDS, Poverty and Hunger: Challenges and Responses*, Washington: International Food Policy Research Institute

Foreman, M. (1998), *AIDS and Men - Old Problem, New Angle*, Panos HIV/AIDS Briefing Number 6, December, London: Panos Institute

Halperin, D. (2006), "Why is HIV prevalence so severe in (Southern) Africa", presentation to Expert Think-Tank Meeting on HIV Prevention in High-

Prevalence Countries in Southern Africa, Maseru, Lesotho, 10-12 May 2006, Gaborone: SADC Secretariat

Human Rights Watch (2003), *Policy Paralysis: A Call for Action on HIV/AIDS-related Human Rights Abuses against Women and Girls in Africa*, New York: Human Rights Watch

IATT (UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS) (2005), *Fact Sheets*, Geneva: UNAIDS

IRIN (Integrated Regional Information Network) (2004), "Zambia, the ultimate sacrifice", IRIN PlusNews, 5 March

Jackson, H. (2002), *AIDS Africa: Continent in Crisis*, Harare: SAfAIDS

Kelly, Kevin T. (1998), *New Directions in Sexual Ethics: Moral Theology and the Challenge of AIDS*, London: Geoffrey Chapman

Kempadoo, K. and Dunn, L. L. (2002), "Factors that shape the initiation of early sexual activity among adolescent boys and girls", in *Meeting Adolescent Development and Participation Rights: The Findings of Five Research Studies on Adolescents in Jamaica*, Kingston: UNICEF and UNFPA

Kohler, H.-P. and Helleringer, S. (2006), "The structure of sexual networks and the spread of HIV in Sub-Saharan Africa: evidence from Likoma Island (Malawi)", PARC Working Paper Series, WPS 06-02, Population Aging Research Center, University of Pennsylvania

Leclere-Madlala, S. (2006), "Intergenerational sex in Sub-Saharan Africa", presentation to Expert Think-Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa, Maseru, Lesotho, 10-12 May, Gaborone: SADC Secretariat

Lewis, S. (2002), Statement by Stephen Lewis, the Secretary-General's UN Envoy on HIV/AIDS in Africa, UN media briefing, Barcelona: International AIDS Conference, 3 July, 2002

Lewis, S. (2003), "Gender and HIV in Southern Africa: a discussion with Stephen Lewis, UN Special Envoy on HIV/AIDS", Southern African Regional Poverty (SARPN) Network Brief, February 2003, Pretoria: Human Sciences Research Council (HSRC)

NWHRC (National Women's Health Resource Center) (2006), *Women & HIV, National Women's Health Report*, vol. 28, no.2

Pope Benedict XVI (2006), *Message for the celebration of World Day of Peace 2007*, Vatican City, 8 December

Smith, A. and McDonagh, E. (2003), *The Reality of HIV/AIDS*, Christian Perspectives on Development Issues Series, Maynooth: Trócaire

UNAIDS (2004), *2004 Report on the Global AIDS Epidemic*, Geneva: UNAIDS

UNAIDS (2005), *Intensifying HIV Prevention: UNAIDS Policy Position Paper*, Geneva: UNAIDS

UNAIDS (2006a), *2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition*, Geneva: UNAIDS

UNAIDS (2006b), *AIDS Epidemic Update, December 2006*, Geneva: UNAIDS

UNDP (2006), *Beyond Scarcity: Power, Poverty and the Global Water Crisis: Human Development Report 2006*, New York: UNDP

United Nations (2006), "Declaration of commitment on HIV/AIDS: five years later", Report of the Secretary-General to the Sixtieth Session of the United Nations, UN document A/60/736, 24 March

Wellings, K., Collumbien, M., Slaymaker, E., Singh, S., Hodges, Z., Patel, D. and Bajos, N. (2006), "Sexual behaviour in context: a global perspective", *The Lancet 2006*: 368, 1706-1728