



Gender and HIV/AIDS

Globally, the number of people living with HIV/AIDS stood at 42 million at the end of 2002, 5 million of them newly infected during the course of that year. Sub-Saharan Africa is by far the most affected region in the world. The number of global AIDS deaths at the end of 2002 was estimated at 3.1 million, of which 2.4 million occurred in Africa.

Almost as many women as men are now dying of AIDS. However, there are important differences between women and men in the underlying mechanisms of HIV/AIDS infection and in the social and economic consequences of HIV/AIDS. These stem from biology, sexual behaviour and socially constructed 'gender' differences between women and men in roles and responsibilities, access to resources and decision-making power. A number of studies have examined the role of gender inequalities on women's risk and vulnerability to HIV/AIDS. Comparable information on gender, men and HIV/AIDS is, however, very limited.

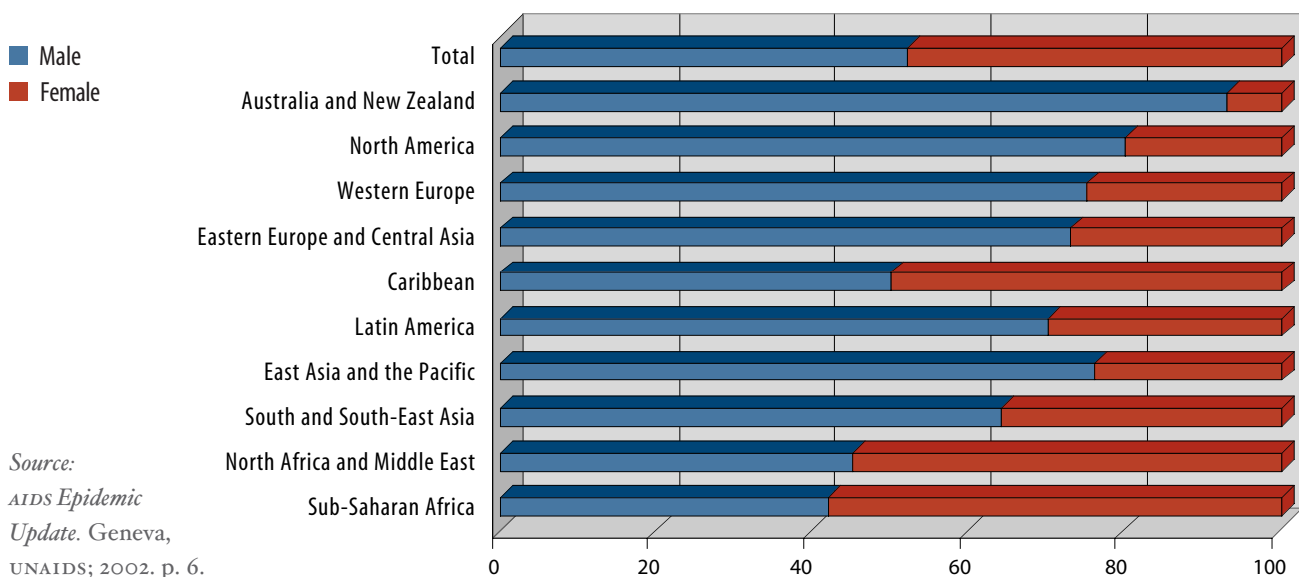
What do we know?

The gap in HIV prevalence rates among men and women is narrowing

In the early stages of the pandemic, HIV infection was predominantly among men in many industrialized and some developing countries. As of the end of 2002, however, almost 50% (19.2 million) of the 38.6 million adults living with HIV/AIDS globally are women. In Sub-Saharan Africa, 58% of HIV-positive adults now are women (see Figure 1).

Latest estimates (2001) also show a higher prevalence rate for young women aged 15–24 years as compared to

Figure 1. Sex distribution of HIV positive adults, 2002



Source:
AIDS Epidemic
Update. Geneva,
UNAIDS; 2002. p. 6.

young men of the same age. A 1998 study in Kisumu, Kenya, showed that the prevalence of HIV infection among young women was 23%, while among young men of the same age it was 3.5%. This is probably due partly to biological factors (see below), but perhaps more importantly to the fact that social norms dictate marriage at an early age for women in many places, and that the sexual partners of younger women are often significantly older than the women themselves.

Are there differences between women and men in rates of sexual transmission of HIV?

- Studies conducted in the early 1990s in the US and several European countries have shown that, controlling for other risk factors such as sexually transmitted infections (STIs), it is much easier for a woman to contract HIV from sexual contact with a man than it is for a man with a woman. This is thought to be because women have a larger surface area of mucous membrane exposed during sexual intercourse, and also because they are exposed to a larger quantity of infectious fluids (semen) than men.
- The evidence on this subject, however, is still not complete. For example, a recent study from Uganda showed that the rate of male-to-female transmission of HIV-1 was not very different from that of female-to-male transmission. Viral load – the number of HIV viral particles in a sample of blood plasma – was the chief predictor of rates of heterosexual transmission of HIV-1. More virus meant higher rates of transmission.
- Anal penetration can occur in both male-male and male-female sex. This poses an especially high risk of HIV infection for the receptive partner because the lining of the rectum is thin and can easily tear.
- The presence of an untreated sexually transmitted disease in an individual can make that person up to 10 times more likely both to get and to transmit HIV. Since the majority of sexually transmitted infections (STIs) do not give rise to any symptoms in women, these are less likely not to be recognized or treated. STIs located in the anus and rectum are also often asymptomatic and thus unlikely to be treated, implying an enhanced risk of HIV through penetrative anal sex.

Pregnancy and childbearing raise specific issues for women

- Studies from industrialized countries indicate that pregnancy does not affect the progress of infection in HIV-positive women who show no symptoms, or in those in the early stages of infection. Care should be taken, however, not to generalize these results to the developing world, since there has been as yet little research on this topic in such settings. On the other hand, a recent study indicates that, in devel-

oping countries, there is a high risk of infant death associated with maternal HIV infection.

- Pregnancy-related complications, such as haemorrhage, expose women to risk of infection related to transfusion of blood or blood products.
- Since HIV can be transmitted through breast milk, breastfeeding presents a dilemma for many women. Those who decide to discontinue breastfeeding in favour of infant formula may reduce the risk of HIV transmission to their child, yet may expose the infant to diseases resulting from an unclean water supply, as well as to malnutrition. The use of infant formula can alert others to the mother's HIV status and lead to stigma and discrimination.

Gender norms increase vulnerability to HIV infection, especially in young people

- In almost all cultures masculinity is associated with virility. A UNAIDS report based on research conducted in seven countries (Cambodia, Cameroon, Chile, Costa Rica, Papua New Guinea, the Philippines and Zimbabwe) found that notions of masculinity encourage young men to view sex as a form of conquest. Other research found that since ignorance is construed as a sign of weakness, men are often reluctant to seek out correct information on HIV/STI prevention.
- The role of same-sex relations among young men in enhancing risk of HIV infection is often ignored in many developing country settings, where sex between men is socially stigmatized and often illegal. The limited availability of data contribute to the invisibility of this issue. Data for 1999 from the US shows that 50% of all AIDS cases reported among males of 13–24 years of age involved men who have sex with men.
- Early initiation of sexual activity among girls is directly related to the practice of early marriage for girls in many developing countries. Furthermore, the sexual partners of young women are often much older than the women themselves: research from 16 countries in Sub-Saharan Africa indicates that husbands of 15–19 year-old girls are on average ten years older than their wives. Early marriage may expose girls to an increased risk of STIs and HIV infection, especially if their partners are older and have had more sexual exposure.
- Studies conducted in Brazil, India, Mauritius and Thailand found that many young women knew little about their bodies, contraception and STIs. Many reported a fear of seeking information on sex or condoms, as this would label them as sexually active, regardless of the true extent of their sexual experience.
- For many women, being vulnerable to HIV can simply mean being married. Social norms that accept extra-marital and pre-marital sexual relationships in men, combined with women's inability to negotiate safe sex practices with their partners, make HIV infection

a risk even in women who have only had one partner in their entire lives. For such women, “remaining faithful” is no protection.

- Information from countries such as Thailand and South Africa indicates that poverty, lack of education and limited income-earning opportunities often force women into commercial sex work, exposing them to a high risk of HIV infection and other STIs.

Violence is an important factor in the transmission of HIV

- Some women experience the threat of, or actual, physical violence when attempting to negotiate safer sex through the use of condoms. Research conducted in Guatemala, India, Jamaica and Papua New Guinea found that women often avoided bringing up condom use for fear of triggering a violent male response.
- Violence in the form of coerced sex or rape may also result in the acquisition of HIV, especially as coerced sex may lead to the tearing of sensitive tissues and increase the risk of contracting the HIV virus. Studies in adolescents from several countries have found that an important proportion of them report that their first intercourse was forced, and this is particularly the case for women. Sexual minorities such as homosexual men also encounter sexual coercion in many countries, and are similarly at risk of HIV.
- Conflict situations aggravate a number of factors which fuel the HIV/AIDS crisis. These include the breakdown of families and communities, forced displacement, poverty, the collapse of health services and physical and sexual violence. Women more than men are at risk of rape and sexual assault in conflict situations, and consequently of HIV infection. Tens of thousands of women were raped in the Balkan conflict. In Rwanda, three per cent of all women were raped during the genocide. The proportion of women testing HIV positive among those who were raped was 17%, as compared to 11% among women who were not.

Gender is a factor in health-seeking behaviour

- Stigma associated with HIV/AIDS is a major factor preventing many women and men from accessing services. Women may be more affected by stigma and discrimination than men because of social norms concerning acceptable sexual behaviour in women, and because women are often more economically vulnerable than men.
- Gender differences in decision-making may also affect access to health facilities. For example, a study conducted in Tanzania found that while men made independent decisions to seek Voluntary Counselling and Testing (VCT) services, women felt obliged to discuss testing with their partners before accessing the service.

- The cost of HIV/AIDS treatment renders it unaffordable for most families in developing countries. While the price of treatment affects both sexes, women’s unequal economic power as compared to men may make access to treatment particularly difficult for them.

Health programme and service issues

- Much of the resistance to condom use encountered by condom promotion programmes is gender-related. A number of studies report that young women are reluctant to carry, or suggest using condoms for fear of being seen as promiscuous. Many young men dislike condoms for their interference in the enjoyment of sex, while sex in some contexts is associated with risk taking.
- It is estimated that perfect use of the female condom may reduce the annual risk of acquiring HIV by more than 90% among women who have intercourse twice weekly with an infected male. However, the price of the female condom (4–10 times that of male condoms) makes it inaccessible to most women.
- Stand-alone STI and HIV/AIDS-related services may deter women and young people from accessing care since, in such cases, use of services may be seen as tantamount to an admission of having a sexual infection, and thus lead to stigmatization.
- Health providers need to be aware of and sensitive to the possibility that women can be subjected to violence and other serious consequences within households or communities as a result of revealing HIV-positive status. In a 2001 survey conducted in Kenya, more than half of the women surveyed who knew that they were HIV positive had not disclosed their HIV status to their partners. They feared that disclosure would expose them to violence or abandonment. These adverse consequences of disclosure have also been documented in other settings.
- In many countries HIV/AIDS information and services are provided primarily through family planning, prenatal and child health clinics, which are typically not designed to reach men or meet men’s needs. As a result, men may be less likely than women to receive HIV/AIDS information, counselling and treatment services.

There are gender differences in the social and economic consequences of HIV

Both women and men living with HIV/AIDS experience discrimination and stigma. However, there are gender differences in the way stigma affects women and men.

- A UNAIDS study across seven sites found that in each study site men with HIV were hardly questioned about how they became infected and that they were generally cared for. In contrast, women were often accused of having had extramarital sex (whether or not this was the case) and received lower levels of support.

- Men, on the other hand, may be under pressure to keep their HIV infection status secret for fear of dismissal from work, and of being unable to play their traditional gender roles as breadwinners.
- In studies undertaken in India, Mexico and the USA, women, much more so than men, had to shoulder the burden of providing care to household members suffering from AIDS-related illnesses, as well as of supporting their households financially when other earners were disabled by HIV/AIDS.

What research is needed?

- More research is needed on gender and HIV/AIDS issues for men, such as the impact of masculinity on vulnerability to HIV, as well as gender-related factors that impede men's access to HIV/AIDS testing and treatment.
- Increased investment must be put into research and development of microbicides or other effective female-controlled methods of preventing HIV transmission that do not prevent pregnancy and do not involve the use of a condom. Promising research on microbicides is already under way and should be expanded and supported.
- Research on gender differences in risk perception and behaviour across different age groups and in different settings would help design more relevant information, education and communication (IEC) interventions in HIV-prevention programmes.
- The role of non-consensual sex in increasing the risk of HIV infection in adolescent girls and boys is an important area for further research.
- More research is also needed on the response of health systems to HIV-positive adolescents, and on gender differences in the barriers adolescents face in gaining access to health services. Effective interventions should be designed to overcome these barriers.
- There is limited research on women's and men's perspectives on the design and delivery of HIV treatment and care. These include, for example, opinions on individual versus couple counselling, disclosure and partner notification processes, location of services, and differences in all of these by gender, age and setting.
- The ways in which different service delivery settings (e.g. Prevention of Mother-to-Child Transmission, Voluntary Counselling and Testing) influence the process of disclosure of HIV-positive status to one's partner, and the consequences of this for women and men, need to be better understood. This is necessary in order to design programmes that minimise adverse consequences such as intimate partner or family violence against HIV-positive women.

What are the implications for policies and programmes?

- Male and female condom promotion efforts need to recognize, identify and address gender issues including sexual and other forms of violence, that inhibit condom use.
- HIV/AIDS, peer education, and sex education programmes for adolescents that incorporate gender equality issues into their framework should be fostered. Such programmes should enable a better understanding of how norms related to masculinity and femininity may increase risky sexual behaviour, and help young people begin thinking about how to work towards equal and responsible relationships.
- Voluntary Counselling and Testing (VCT) services should take into account the risk of violence and other adverse consequences when evaluating different approaches to disclosure. For example, patients can be given the choice of counsellor-mediated disclosure if that would help minimise adverse consequences.
- Both men and women should be involved in Prevention of Mother to Child Transmission (PMTCT) programmes. Antenatal services can educate men about sexuality, fertility and HIV prevalence to raise their awareness and sense of responsibility. This would avoid reinforcing the belief that women alone are responsible for pregnancy and for HIV transmission to the infant.
- Community Home Based Care (CHBC) approaches that are currently being integrated into national AIDS programme strategies need to include a special effort to promote the role of men as care-givers in the family and community, and to provide adequate support and guidance to enable male participation. At the very least, such programmes should acknowledge that reliance on "home care" is, at present, largely reliance on "women's care".
- Indicators developed for monitoring the implementation of the Declaration of Commitment on HIV/AIDS adopted by 189 countries at the United Nations General Assembly Special Session on HIV/AIDS in June 2001 need to go beyond providing sex-disaggregated data. A review of these indicators and suitable modification to adequately reflect progress in addressing gender issues in HIV/AIDS would be very important for equity as well as effectiveness.

