



Gender and HIV/AIDS

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Abstract

The impact of gender on HIV/AIDS is an important dimension in understanding the evolution of the epidemic. How have gender inequality and discrimination against women affected the course of the HIV epidemic? This paper outlines the biological, social and cultural determinants that put women and adolescent girls at greater risk of HIV infection than men. Violence against women or the threat of violence often increases women's vulnerability to HIV/AIDS. An analysis of the impact of gender on HIV/AIDS demonstrates the importance of integrating gender into HIV programming and finding ways to strengthen women by implementing policies and programs that increase their access to education and information. Women's empowerment is vital to reversing the epidemic.

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1. Introduction

Within a single generation, HIV/AIDS has become the most far-reaching and damaging epidemic the world has ever seen. It now represents an individual and societal tragedy with huge implications for human security, social and political stability and economic development. This paper looks at a crucial aspect of the epidemic—the relationship between gender and HIV/AIDS. How have gender inequality and discrimination against women affected the course of the HIV epidemic? To what extent has the epidemic itself affected gender relations? Why for the first time at the end of 2001 did women account for 58% of all people

living with HIV or AIDS in sub-Saharan Africa? Why are women becoming more vulnerable to HIV infection than men?

The difference between sex and gender is well defined. “Whereas ‘sex’ describes a biological distinction between men and women, ‘gender’ is a social construct that differentiates the power, roles, responsibilities, and obligations of women from that of men in society” [1]. People are born female or male but learn to be girls and boys who grow into women and men. This learned behavior makes up gender identity and determines gender roles [1]. Gender, in its broadest sense, concerns “what is meant to be male or female, and how that defines a person's opportunities, roles, responsibilities, and relationships” [2].

We know women are more vulnerable to HIV

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than men because of biological and cultural factors. It is also clear that in many societies women have a lower social and economic status simply because they are women. A gender-based approach to HIV/AIDS involves examining how these biological and gender factors come together to increase a woman's risk of becoming infected. For example, women can have reproductive tract infections which make them more vulnerable to infection [2]. Also women lack power and economic independence to negotiate safe sex and insist on condom use. Indeed those who exchange sex for income can seldom mention safe sex at all. We also know that women face domestic violence, at times made much worse by conflict or insecurity and most often bear the brunt of social stigma and discrimination.

There is no doubt that the number of infections among women is growing faster than in men [1]. This means we must change our approach to prevention, access to treatment and care, voluntary counseling and testing (VCT), and, finally stigma and discrimination.

1.1. The HIV epidemic: where are we now?

In the early stages of the HIV/AIDS pandemic, infection was predominantly among men. This situation has changed dramatically. Today, 42 million people are living with HIV; 19.2 million of them are women (see Fig. 1). In 2002, 5 million people became infected with HIV with women representing 48% of all new infections (see Fig. 2). More alarmingly, women are becoming infected at younger ages than men. In developing countries, an estimated 67% of all newly infected individuals are between 15 and 24 years old [3].

2. Determinants of women's vulnerability

2.1. Biological

From a biological point of view, women are more susceptible to HIV infection than men—male to female transmission of HIV is between two and four times more efficient than female to male [4]. The presence of sexually transmitted infections also increases the risk of transmission and acqui-

sition of HIV by up to 10-fold, [1] and as most sexually transmitted infections (STIs) are asymptomatic in women, diagnosis and treatment is more difficult. Young women are especially vulnerable to HIV infection through sexual intercourse because the immature genital tract of girls is more likely to sustain tears during sexual activity, creating a higher risk of HIV transmission [2].

Women also have limited access or receive an inferior quality of care than men. Studies of other infectious diseases show that women frequently wait longer than men before visiting health facilities. Recent research reveals the possibility that a similar pattern holds for HIV care [5,6]. What appear to be biological differences in disease and clinical manifestations may in fact be a reflection of gender inequalities in society.

2.2. Social and cultural

The social and economic status and cultural expectations of both women and men can increase the risk of HIV infection. A woman's lower status can leave her more exposed to infection while men risk infection because of ideals of masculinity associated with risk-taking and sexual conquest [7]. For example, young women tend to have older, more experienced partners who are more likely to have STIs from previous sexual activity. Moreover, girls and young women may willingly initiate relationships with older men to exchange sex for material benefit, especially if they are very poor. In a study in Malawi, two-thirds of 168 sexually active young women reported having sex for money or gifts [2].

Male cultural norms can also increase the risk of men and young boys becoming infected with HIV. Social norms reinforce their lack of understanding of sexual health issues and at the same time celebrate promiscuity. This vulnerability is further increased by a greater tendency to drink alcohol and use illicit drugs. Additionally, males are often forced to move away from their family of origin to find work or join the military which disrupts family life.

2.3. Violence against women

Violence against women, especially forced or

Number of people living with HIV/AIDS	Total	42 million
	Adults	38.6 million
	Women	19.2 million
	Children <15yrs. old	3.2 million
People newly infected with HIV in 2002	Total	5 million
	Adults	4.2 million
	Women	2 million
	Children <15yrs. old	800 000
AIDS deaths in 2002	Total	3.1 million
	Adults	2.5 million
	Women	1.2 million
	Children <15yrs. old	610 000

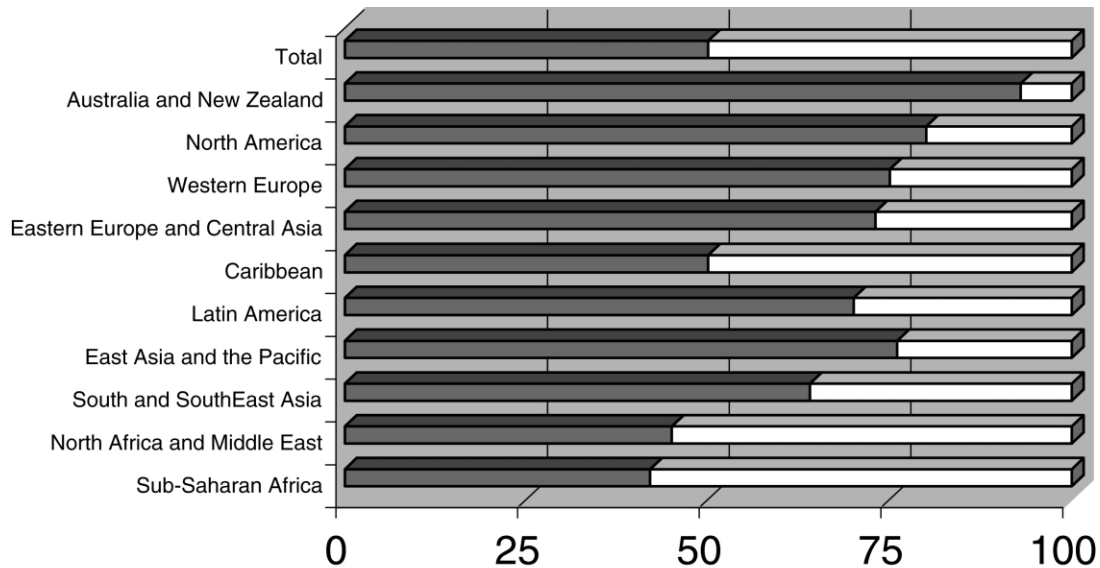
Source: UNAIDS, Report on the Global HIV/AIDS Epidemic 2002

Fig. 1. Global Summary of the HIV/AIDS Epidemic, December 2002. Source: UNAIDS, Report on the Global HIV/AIDS Epidemic 2002.

coerced sex increases women's vulnerability to HIV/AIDS. One recent study of young women in South Africa found that 30% of girls said their first intercourse was forced, 71% had experienced sex against their will, and 11% had been raped [8]. The threat of violence affects women's power and ability to negotiate the conditions of sexual intercourse, especially condom use. The threat of violence may also affect women's use of services such as testing for HIV and the extent to which they feel able to discuss their sero-status with others and seek social support. For example, more than half of the women who knew they were HIV infected, and who were surveyed by Kenya's

Population Council, said that they had not disclosed their HIV status to their partners because they feared violence or being abandoned [6]. Many women who are abused frequently are caught up in an ugly cycle of violence, drug abuse and unwanted sex which leaves them at a very high risk of becoming infected with HIV [9].

Unfortunately, the threat of violence greatly hinders promoting VCT. In a study in Dar es Salaam, Tanzania, for example, fear of partner's reaction was a major reason why women failed to test for HIV/AIDS. Other studies of HIV infected women report physical harm after HIV is diagnosed [10].



Source: AIDS Epidemic Update, UNAIDS 2002

Fig. 2. Sex distribution of HIV positive adults, 2002. *Source:* AIDS Epidemic Update, UNAIDS 2002.

2.4. Laws

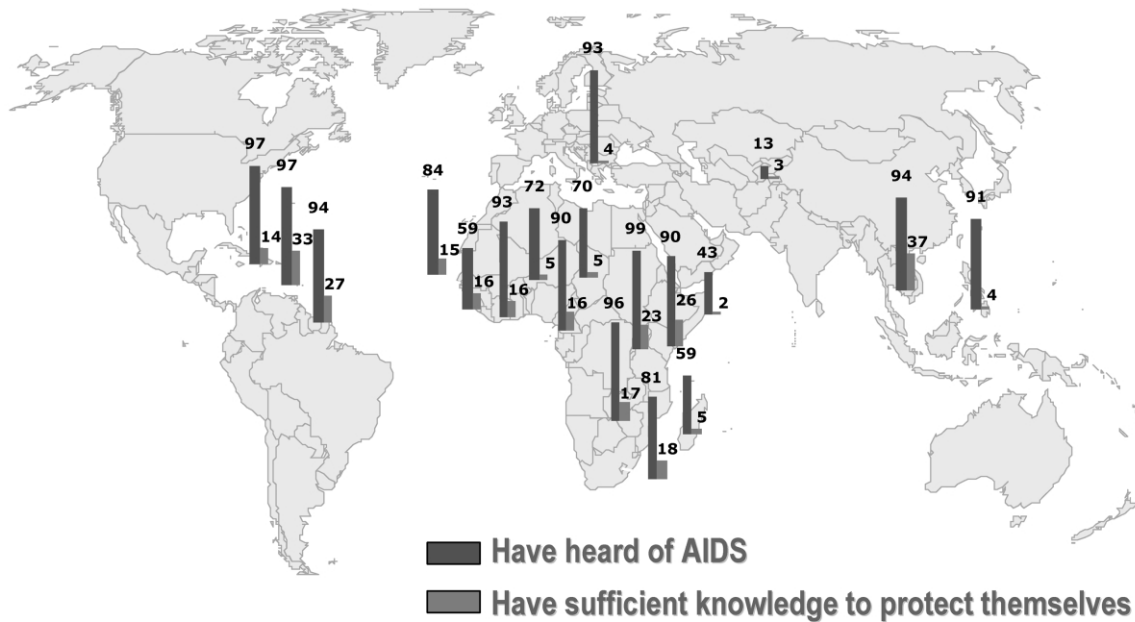
Laws that discriminate against women also contribute to women's increased risk of acquiring HIV/AIDS. In many societies legal impediments exist to women inheriting property, asking for divorce, or protecting themselves from forced marriages. In addition, customary law often favors male ownership and control over family resources [11]. These inequalities are further fuelled by discrimination within the family where decision-making power lies with men. This limits women's access to resources, including income, education and other assets. For example, a study in Mumbai, India found that women believed that the economic consequences of leaving a high-risk relationship were far worse than the health consequences of staying with their partners. They reported having little chance to instigate changes in their husbands' behavior [12].

In many countries early marriage of girls is still common, and even sanctioned by law. Young girls usually marry significantly older men, which creates a power imbalance in terms of experience,

authority, and control over sexual activity and resources [11]. It may also mean that girls are unable to continue their education or take employment. Older men are usually more sexually experienced than their young brides, who are thus at risk of acquiring HIV and other STIs.

2.5. Education, knowledge and skills

Education or knowledge about sex is also an important determinant of HIV risk. Many cultures value ignorance about sexual interaction as a feature of femininity. In some societies girls are taken from school by their families to care for sick family members or to perform other household tasks, jeopardizing their education and future prospects [13]. This inequality affects a woman's ability to take informed decisions especially on risk reduction. Fig. 3 shows the proportion of young women who have heard about HIV and those who know how to protect themselves. For example, the study shows that 90% of young women aged 15–24 in Cameroon have heard about AIDS but only 16% of them have sufficient knowl-



Source: UNICEF/MICS & Measure DHS, 1999-2001

Fig. 3. Proportion of young women aged 15–24 who have heard of AIDS and have sufficient knowledge to protect themselves.

edge to protect themselves. In the Philippines, the numbers are 91% and 4%, respectively. Paradoxically, because men are expected to have more information and experience with sex, they are often less likely to admit what they don't know or understand. This increases the risk of infection and misinformation [1].

2.6. Poverty

HIV and poverty are inextricably linked. Poverty contributes to HIV/AIDS transmission and HIV/AIDS contributes to poverty. Women and girls are seriously affected both ways as they are among the poorest in society [1]. Although women's economic situation has been improving, there are still significant inequalities between women and men, and there is evidence that these inequalities play a role in increasing vulnerability and exposure to HIV [1]. A study conducted in Ghana in 1999 explored the context of disease transmission and identified factors that influenced women's ability to protect themselves from infection. The poverty experienced by many of the women during their

childhood years, as well as a societal belief favoring the education of males, restricted the participants' educational and vocational opportunities. As a result of limited education and skills, many women took boyfriends to assist them with the purchase of food and shelter, as a survival strategy. For most of these women, the use of condoms with sexual partners was restricted by the high value placed on fertility, the negative association of condoms with prostitution, and the women's limited ability to influence their partners [14].

Poverty among women also affects access to information. Men and women of high economic status know more about HIV prevention than those who are economically worse-off in almost every country where data are available [1]. A study conducted in Maputo, Mozambique, among 182 schoolgirls in two secondary schools, one attended primarily by working class students and the other by young middle-class students, suggests that while gender dynamics work against women overall, middle-class young women had fewer sexual partners, used condoms more often, seemed willing to challenge gender norms and were more assertive

than their working class counterparts. These factors mean that middle-class women also have a potential advantage in sexual negotiation. Working class women did not question gender power differentials, were less assertive and tended to be more dependent on their partners for material needs. This weakened their negotiating power in relation to safe sexual behavior and made them more vulnerable [15].

2.7. Migration

Poverty can also force people to migrate in search of employment. The resulting disruption of social and family relationships increases the likelihood of HIV infection. The fact that migrating men often leave their wives and families behind increases the possibility that they will visit sex workers, putting both themselves and their families at risk when they return home. Women who migrate also face increased risk of infection, as they may engage in sexual relations with other individuals for economic reasons or are forced to submit to unwanted sex, for example at border crossings or in exchange for physical protection.

2.8. Stigma and discrimination

Stigma and discrimination are a consequence of the epidemic but can also act as a driving force. The stigma surrounding HIV/AIDS has a particularly heavy impact on women. In many parts of the world, HIV/AIDS is incorrectly perceived as a 'women's disease' or 'prostitute's disease' causing women to avoid HIV testing or seeking care in order to avoid being ostracized, abused, and viewed as promiscuous [2]. Medical personnel in some parts of the world may refuse to treat women who are infected with HIV/AIDS. For example, a study was conducted in Thailand among physicians on attitudes and practices regarding zidovudine (ZDV) use, pregnancy termination in HIV-infected pregnant women and their willingness to care for such patients. Of the respondents 19% were unwilling to perform pelvic examinations, 31% vaginal deliveries, and 40% cesarean deliveries, on women known to be infected with HIV. The survey concluded that Thai obstetric providers were reluctant

to care for HIV-infected women, did not routinely use perinatal ZDV prophylaxis, and preferred to terminate pregnancies among HIV-infected patients [16].

3. Implications of gender differences for prevention and care

3.1. Prevention

Most infections among women, particularly in Africa, happen as a result of unprotected heterosexual sex. Therefore as most new HIV infections (75%) are transmitted via sexual intercourse, it is logical to focus on preventing sexual transmission of the virus. Targeted intervention strategies aimed at reducing the number of sexual partners, promoting condom use and treating sexually transmitted infections have achieved some success, but they are not enough to meet the needs of the most vulnerable groups, in particular women. Comprehensive strategies that include prevention efforts for women, as well as for other vulnerable groups such as young people or migrants need to be on a national scale. Efforts to prevent sexual transmission to individual women should focus on the biological and behavioral factors that increase their vulnerability to infection.

Biological interventions should include prevention and control of sexually transmitted infections, and the development of vaccines and microbicides. Behavioral interventions aimed at women should focus on formal HIV/AIDS and health education, mass media campaigns, the social marketing of condoms and the use of antiretroviral drugs before birth.

3.2. Treatment and care

Gender inequalities have a significant impact on access to treatment and VCT.

Although both men and women are affected by the costs of HIV treatment, because women are often poorer it is more difficult for them to afford treatment. The cultural environment also greatly influences the way in which individuals seek health services. Women may be constrained by cultural practices that prevent them from seeking health

Table 1
Countering harmful gender norms

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- Encourage discussion of the ways in which boys and girls are brought up and expected to behave;
 - Challenge concepts of masculinity and femininity, based on inequality and aggressive and passive stereotypes;
 - Encourage men and boys to talk about sex, violence, drug use and AIDS with each other and their partners;
 - Teach female assertiveness and negotiation skills in relationships, sex and reproduction;
 - Teach and encourage male sexual and reproductive responsibility;
 - Teach and promote respect for, and responsibility towards, women and children;
 - Teach and promote equality in relationships and in the domestic and public spheres;
 - Support actions to reduce male violence, including domestic and sexual violence;
 - Encourage men to be providers of care and support in the family and community; and
 - Encourage understanding and acceptance of men who have sex with men.
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Source: UNAIDS, Report of the Global HIV/AIDS Epidemic 2002.

care services or because they feel uncomfortable with the possibility of being counseled or treated by males. Also in many societies, the responsibility for care and support falls on women. They often put their children and other family members before themselves and men's illnesses are often perceived as more important because it is generally the men who earn money for the family. A woman's contribution to family survival is usually undervalued and women's illnesses may be ignored until they are unable to perform daily tasks [2]. In a study of 2864 HIV-infected adults enrolled in the HIV Cost and Services Utilization Study (1996–1997), women were 1.6 times more likely to put off care than men [17].

Limited data exist on gender differences in the use of antiretroviral therapy, and where differences have been found, women were less frequent users [18,19]. Again, this is a pattern that is observed in other infectious diseases. It may reflect the lower priority placed on a woman's health needs, the burden of care she carries for her family, as well as obstacles she may face obtaining care at health facilities [20].

4. Conclusions

It is evident that although the prevalence of HIV infection is highest among women and girls not enough is being done to reduce women's risks, to protect them from sexual aggression and violence,

to ease their burdens or to support their coping and caring efforts.

Both women and men are put at risk of infection as a result of societal gender ideals and norms but women and adolescent girls are affected disproportionately. It is vital to integrate gender into HIV programming to curb the epidemic. As part of this integration process the World Health Organization (WHO) is identifying effective strategies and has developed practical guidelines for program managers and health workers to incorporate gender considerations into HIV programs.

As providers of care for women, obstetricians and gynecologists have a responsibility to identify factors that may put women at higher risk of infection from HIV/AIDS, including the presence of other STIs or identify women who are being physically abused. Gender issues should be incorporated in the curricula and training for new obstetricians and gynecologists (see Table 1): women should be seen as individuals with specific health care and support needs of their own and not simply treated to benefit the health of their children.

Protecting women should not be seen only as protection from unwanted pregnancies but also from infection. Recommendations for use of hormonal contraceptives or IUDs must be accompanied by the promotion of the use of condoms, including female condoms. The female condom should be promoted and made more readily avail-

able. Advocacy and research for providing women with HIV prevention technologies that they themselves can control, such as microbicides, need to continue.

In order to protect women from HIV infection, it is important to find ways to empower them by implementing policies and programs that increase their access to education and information. Women's empowerment is vital to reversing the epidemic.

Finally, the burden of care for those infected needs to be shared better between women and men, and women should be able to access needed medical, social and economic support both when they are carers as well as when they themselves are infected.

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