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Gender, Health, and Sustainable Development

**Proceedings of a
Workshop held in
Nairobi, Kenya,
5-8 October 1993**

Edited by
Pandu Wijeyaratne,
Lori Jones Arsenault,
Janet Hatcher Roberts, and
Jennifer Kitts



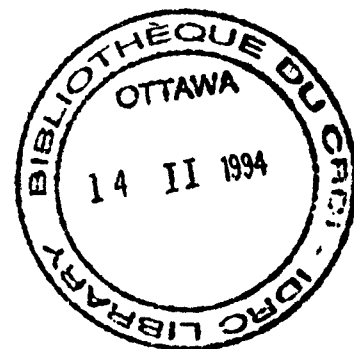
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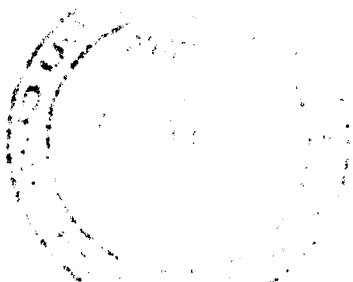
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"It's Difficult to Leave your Man over a Condom": Social Understanding of AIDS and Gender

Anna Strebel¹

Introduction

Over ten years ago, the Human Immunodeficiency Virus (HIV), which causes AIDS, was first identified. Since that time, the number of people affected by the disease has grown substantially, and the patterns of transmission have shifted considerably. Originally, AIDS was thought to affect mainly homosexual males. However, throughout the world, there has been a dramatic increase in the extent of HIV infection among women. The World Health Organization (WHO) estimated that by 1990, approximately three million of the eight to ten million HIV-infected people worldwide would be women. Furthermore, it is expected that by the year 2000, the number of infected women will equal that of men (Panos 1990).

In the United States, women have remained a relatively small percentage of the total number of HIV-infected people. However, the growth rate is currently two and a half times faster among women than men (Rodin and Ickovics 1990). Minority women are consistently worst affected, with over 70% of new cases among women of colour (Campbell 1990; Carpenter et al. 1991).

In sub-Saharan Africa, women constitute a far greater percentage of those infected than in the United States. Indeed, one in forty women are believed to be currently infected with the HIV virus (Panos 1990). While distribution across the continent has been highly variable, recent studies have found that the rate of infection is greater in women than in men (Ankrah 1991; Decosas and Pedneault 1992). For example, at a voluntary and confidential public HIV testing service in Uganda, seroprevalence among 872 clients was 35% among women and 24% in men (Muller et al. 1992). In South Africa, at the end of 1992, it was estimated that women accounted for about 180,000 of the total 320,000 HIV-infected people (Department of National Health Population Development 1993). In rural Natal/Kwazulu, results from an anonymous HIV seroprevalence survey showed that 1.2% of cases were HIV-infected, and that the prevalence among women was 3.2 times greater than among men. After six months, the rate had increased to 2.5%, and within the 15-30 year age group, most of the cases were women (Abdool Karim et al. 1992).

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There is a growing recognition of the extent to which AIDS is an issue for women, and this is reflected in the striking increase in research and writing on the topic. This research is beginning to produce a clearer understanding of the ways in which women and men are differentially affected by the disease. This has important implications for prevention and care initiatives.

Biomedical Factors

For women, the chief mode of transmission of HIV is heterosexual contact. Furthermore, there are indications that women are more likely to become HIV-infected through heterosexual transmission than are heterosexual men (Mantell et al. 1988; Rodin and Ickovics 1990). In this regard, there is increasing evidence of the possibility of a greater physiological vulnerability in women than in men (United Nations Development Program 1992). In addition, women frequently appear to have a poorer prognosis once infected and die sooner than men (Jones and Catalan 1989; Berer and Ray 1993). Another major feature of HIV infection in women is the fact that perinatal transmission from mother to infant forms the chief mode of transmission to infants. Approximately 30% of babies born to HIV-positive mothers are infected with the virus (Global Program on AIDS 1992).

The presence of sexually transmitted diseases (STDs) has been shown to increase the risk of HIV infection. In women, symptoms of a STD are often less apparent than in men. STDs in women often go undetected, and therefore untreated, which results in an increased vulnerability to HIV infection (Standing and Kisekka 1989).

Therefore, there is compelling evidence that the epidemiology and natural history of HIV is different in women than in men. However, the biomedical features are only one factor that needs to be addressed. Recent writing has explored the extent to which the social construction of the problem influences vulnerability and responses to AIDS. Gender has emerged as a crucial variable in understanding the social dynamics of the epidemic. There are a variety of ways in which this happens, which will be discussed below.

Sexuality and Gender

An understanding of sexuality and gender is central to considerations of AIDS as a social problem. The traditional view of psycho-sexual development was that biologically-determined differences between males and females were the basis for the emergence of separate sex roles for men and women. These biological differences, combined with intrapsychic processes and social learning, were believed to result in typical masculine and feminine characteristics. Typical masculine traits include strength, assertiveness, rationality, as well as biologically-driven sex needs, while feminine characteristics include softness, dependence, passivity, emotionality and physical attractiveness (Miles 1992).

However, feminist writers have challenged this version of fundamental and unchanging differences between men and women. Many have outlined how sexuality is in fact socially constructed and historically located within a matrix of intersecting social, economic and cultural factors (Caplan 1987). It is argued that gender relations are not natural and biologically determined. Instead, they are based on differential relations of power in which patriarchy exerts substantial control over women in a variety of spheres. One of the most powerful forms of such social control over women's sexuality is the fear of violence from men (Smart and Smart 1978; Posel and Posel 1991).

These gendered power relations have significant implications for understanding the problem of AIDS. In order to avoid infection, women are advised to abstain from sex, practise monogamy or negotiate the use of condoms with their male partners. These options reflect a focus on a male, heterosexual construction of sexuality as depicted in the media and serve as a means of reinforcing social control over women's sexuality (Juhasz 1990). Women are consistently portrayed as being responsible for ensuring that safe sex is implemented (Worth 1989). However, this view upholds the prevailing notion of a male sex drive for which men are not responsible, but which women are expected to curb, and entrenches dominant gendered power relations (Hollway 1984; Holland et al. 1990). Thus, women paradoxically are required to exert control and make choices in a domain over which they have notoriously little control and few options (dos Santos and Arthur 1991; Hollis 1992). Moreover, these constructions of prevention see safe sex as a matter of individual concern and responsibility (Patton 1989). Finally, for many women sex has frequently been associated with danger (of violence, pregnancy, health risks) so that to talk of safe sex poses somewhat of a contradiction (Holland et al. 1990).

In light of these factors, feminists have suggested alternative responses to the threat of AIDS. In fact, for some the AIDS epidemic has provided an opportunity to refocus attention on the feminist project and to resume talking about sex (Ardill and O'Sullivan 1988). Fundamental to this approach would be the need to substantially change the power dynamics between men and women toward greater equality and more women-centred notions of sexuality (Kippax et al. 1990; dos Santos and Arthur 1991). This would involve the legitimization of alternative sexual practices, such as non-penetration and mutual masturbation (Miles 1992).

In addition, attempts to curtail women's sexuality and the advances of the women's movement by calling for monogamy need to be resisted (Kippax et al. 1990). In Africa, high rates of HIV and STD infection have often been attributed to the "unbridled promiscuity" of black women, so that prevention activities become a means of controlling women's sexuality (Vaughan 1990). In order to counter these possibilities there should instead be a focus on expanding women's sexual options, enhancing pleasure and desire (Thomson and Scott 1991).

However, some writers have cautioned that there needs to be recognition of the fact that women are not uniformly without power in gender relations, that women are actively engaged in constructing their sexuality, that there are contradictions and spaces which can be exploited in negotiating safe sex (Hollway 1984; Holland et al. 1990). Also, implicit in such a gender analysis is the understanding that responses to the problem are not seen in terms of individual responsibility and blame, but as opportunities for collective development of appropriate responses. While empowerment in sexual relations must involve individual behaviour, it also includes collective action at community and social levels (Patton 1989; Holland et al. 1991).

The Political Economy of AIDS

Much of the above debate has been located specifically within a feminist perspective. However, for others, these issues have been part of a broader view of the problem. Especially for minority women in the USA and women in Africa, there has been a recognition that race and class variables intersect with gender to compound the complexity of power relations (Ramazanoglu 1989; Stamp 1989).

In this work, it has been argued that because of their differential positioning in society, economic factors impact on men and women differently, so that women often lack power and social status, and thus access to economic resources. Therefore, they are usually poorer than men, and more likely to work in the informal sector or to be unemployed (Schoepf 1991; Ulin 1992). Frequently, therefore, they are economically dependent on men (Campbell 1990; Ankrah 1991).

In Africa, this situation is regarded as the result of a long-term process, whereby the intersection of colonialism and traditional culture gave rise to large-scale migration and urbanisation, initially of men but later also of women (Bassett and Mhloyi 1991; Larson 1990). This led to the presence in cities of large numbers of economically destitute women and female-headed households, which usually have less income than male-headed ones (Schoepf 1988; Ulin 1992). For many women, sexual relationships with men became a valuable source of income, as sexual exchange frequently involved the transfer of material resources (Standing and Kisekka 1989). The implication of this was that women might come to rely on a number of sexual partners and that for financial reasons they would be less likely to be able to insist on the use of condoms, thus increasing their risks of HIV infection (Schoepf 1988; Larson 1990).

There are other implications of gender inequality and poverty for the spread of HIV. Poverty frequently results in limited access to health care, as well as reduced access to education and employment. All of these factors are likely to result in reduced exposure to AIDS education, as well as care for those already infected (Strebel 1992). As discussed above, it is women who are more likely to suffer the consequences of poverty and, thus, be at increased risk of infection.

However, some writers have warned against a too simplistic analysis of economic factors. They are concerned that this could result in a false dichotomy which encourages some women not to recognize their own risk of infection. They suggest that the issues are more complex. To begin with, many studies have found that it is in fact women of higher economic status who become HIV-infected (Gwede and McDermott 1992). It has been suggested that it is the wives of men who are more affluent, more mobile and thus more likely to be able to pay for sexual favours, who are first infected (Larson 1990).

Also, women in single-headed households are not necessarily less able to negotiate safe sex because of greater financial need. While for some women single status is unavoidable, others are increasingly choosing not to marry because they argue that this strengthens their economic situation (Ramphela and Boonzaier 1988; Stamp 1989). These women may in fact be in a better position to insist on condom use.

It is important to acknowledge that women do not only have multiple sexual partners for material benefits (Pickering et al. 1992). It must be remembered that it is not numbers of partners, but specific sexual practices, which increase risk of infection, so that many monogamous women are also being infected (Carpenter et al. 1991; Berer and Ray 1993).

It has also been argued that a too narrow focus on economic factors may lead to limited attention being paid to the often contentious issue of traditional culture. A number of writers have elaborated on ways in which notions of culture are always linked to power and how men invoke these to legitimate and perpetuate oppressive practices toward women (Ramphela and Boonzaier 1988; Stamp 1989). In tackling AIDS prevention then, it has been suggested that these issues need to receive urgent but sensitive attention. Ankrah (1991, p. 972) has argued that:

The unassailable facet of African culture, the customary and legal right of males to unlimited numbers of partners, according to his wishes, should now be questioned as a value, because the heterosexual pattern of transmission puts all African men who have multiple partner sexual encounters at risk of HIV. Where culture and tradition, including polygamy, no longer advance a people, they should be jettisoned.

Prostitution

Another manifestation of the impact of gender relations on AIDS is in the practice of prostitution. Commercial sex needs to be understood in terms of women's subordinate position in society. On one hand, their limited access to economic resources makes material exchange for sex an important source of income; while on the other, their oppression in patriarchal society positions them as the objects of men's "natural" sex drive (Posel and Posel 1991; Pauw 1993). While prostitutes are usually depicted as vectors of HIV, who are inevitably contaminated and infective, actual rates of infection vary enormously and a number of studies have in fact found that prostitutes do not necessarily have higher rates of infection than other women (Mantell et al. 1988). However, poor women, who are understandably under pressure not to refuse client demands for unprotected sex, are more

likely to be at risk, as are women intravenous drug users, especially users of crack (Mantell et al. 1988; Tan et al. 1989; Campbell 1990). There has been considerably less attention paid to the needs and problems (like violence and discrimination) of sex workers, and very seldom has the focus been on their clients (Pauw 1993). Moreover, early constructions of AIDS as a problem of "others", oversimplified the boundaries of commercial sex and failed to recognize the variety of forms and circumstances of sexual exchange for many women struggling to survive with limited resources (Standing and Kisekka 1989). However, it is not only women who are involved in such sexual exchange. The expanding epidemic in southeast Asia has highlighted the role of sex tourism in the spread of HIV, and the involvement of youth of both sexes, often street children, in sex for money (Ford and Koetswanang 1991).

Sexual Violence

Another consideration in examining the impact of gender inequalities on AIDS is the risk of HIV infection as a result of sexual violence. Social constructions of traditional sex roles, together with women's limited control over their lives, make sexual violence a potential threat for many women. Women who are sexually harassed or raped face the possibility of HIV transmission from an infected assailant (Berer and Ray 1993). Another facet of violence toward women is that, given their lack of power in gender relations, there is the danger that women who refuse sex or insist on condom use or fewer partners may face domestic violence (Strebel 1992).

Further Issues of Gender

Gender inequalities are also evident in the field of research into AIDS. Despite the fact that women make up an increasing number of those infected with HIV, they remain at a disadvantage regarding diagnosis, treatment and care. Rosser (1991) has attributed this to the pervasive male bias in science and medical research. Generally funds have been limited for research into women-related aspects of AIDS, except when it concerns their role as vectors of vertical transmission. This has frequently led to the late diagnosis of HIV infection and the under-reporting of AIDS cases among women. Moreover, women are often not included in drug trials, so they are less likely to have access to future vaccine and treatment options (Kurth and Hutchinson 1990; Levine 1990). Hankins & Handley (1992, p. 967) have argued that:

A concerted effort on the part of clinicians, researchers, funding agencies, and decision-makers is required for redressing the inequities in both the gender-specific knowledge of the natural history, progression, and outcome of HIV disease and the adequacy of medical and psychosocial care for women with HIV infection. The unique features of HIV infection in women have been subject to both scientific neglect and policy void.

It is significant, therefore, that the "soft option" of awareness-raising and education, which is often largely in the hands of volunteer, non-professional women, is focused primarily on women; while the "hard science" clinical research into vaccines and treatments is in the hands of "expert" professional male scientists and conducted largely on men.

It is widely recognised that women are the majority of those in care giving roles, both in the formal health sector, where they make up about 75% of the health services labour force, and informally in the community and at home (Jones and Catalan 1989; Strebel 1993). It is often assumed that this is women's "natural" role as nurturers. Women then have to add the load of caring for infected family members to their already substantial duties in the domestic and formal employment spheres (Schoepf 1991). With little power and status to demand the necessary financial and emotional support, women may easily become isolated and over-extended.

Finally, the fact that women are able to transmit the virus to their infants raises complicated and often contradictory issues regarding reproduction. Calls for women of childbearing age to avoid pregnancy or undergo abortions occur within the context of their already limited control over social and personal facets of their lives (Bayer 1990; Hollis 1992). Debate around reproductive choices also focuses only on the behaviour of women and excludes men's responsibility in decision-making (Kurth and Hutchinson 1990).

A Case Study: Accounts by South African Women About AIDS and Gender

From the above we see that gender intersects with the issue of AIDS in a range of complex and pervasive ways, which clearly have profound implications for prevention and care interventions. Some of the detail and inter-wovenness of this relationship is captured in a study conducted into women's discourses of AIDS in Cape Town, South Africa. Focus group discussions were held with almost one hundred black women (and a few men) from antenatal and sexually transmitted disease clinics, community political organisations, and with domestic workers, teachers and students. One of the dominant themes in their talk centered around gender issues, and particularly focused on notions of power and responsibility.

A given for many women was that men had the power to determine the nature of sexual relationships. This meant that men had multiple sexual partners and women were not entitled to protest or expect men to admit to this behaviour. They saw this as either natural, or the result of outside forces like socialisation and political oppression. However, they recognised that gendered power relations were also more complex than this: firstly they believed that women did have some power, and might themselves have multiple partners; and moreover they saw that women were able to be assertive in some contexts and so ought to be more challenging regarding safe sex. Yet these exhortations to confront gender relations seemed to reflect a potential space for action rather than one which many women actually inhabited, and they saw many obstacles to challenging the status quo.

Another key dimension of the gender focus was the contradictory issue of responsibility. While they were aware that safe sex required shared responsibility to change behaviour, they recognized that this was not an easy task. First, they felt that men did not, and would not, take responsibility for prevention, in the same way as they did not do so in reproductive matters. However, women generally did take responsibility for health issues and so a prevention method which women could control was essential. Another position was that women should take responsibility for "getting" men to practise safe sex; all of which depended on women having such power in the first place. Yet the acceptance that safe sex was "women's work" generated difficult dilemmas for women. They recognised that there were many barriers in relationships to such action: partnerships were invested with different meanings at different stages which made the introduction of condoms tricky for either long-term or transient couples; attempts to introduce safe sex practices posed a challenge to conceptions of romantic love, fidelity, promiscuity; and the stakes in doing this were high, as women could be physically punished or deserted as a result. On another level, they were concerned that by assuming responsibility for AIDS prevention, women were in fact making AIDS a women's problem, and so taking such responsibility away from men. The irony then was that it was men who engaged in unsafe sex and had the power to implement changes. However, many women recognised that the positions were not that unambiguous: women were not only victims of male irresponsibility, they too were reluctant to take the necessary action; while not all men were unconcerned and unwilling to change their behaviour.

This range of varying and sometimes contradictory understandings of gender and AIDS gave rise to a variety of reactions among participants: they expressed sentiments of blame toward men, guilt at their own impotence, and especially strong feelings of fatalism. A few voiced the possibility of united power, to work together to identify problems and solutions.

Conclusions

Clearly an analysis of gendered power relations is central to understanding issues involved in the spread of AIDS, as well as to generating realistic and effective interventions at the levels of both prevention and care. Such an analysis does much to shift perceptions of the disease as a matter of individual blame and responsibility by providing a broad, structural framework of societal influences. By the same token, the solutions that it suggests are likely to be at the macro-level, involving long-term, structural change. Such proposals might, however, not be easy to centre, as seems evident from the fact that most interventions have in fact been at the individual and small group level. Moreover, these understandings might be less helpful in generating specific concrete and strategic options.

One of the most striking features of the social focus on gender and AIDS is that by far the bulk of the extensive and varied research and intervention work has centered on women. At the same time it has been accompanied by a virtual absence of similar attention to heterosexual men. This almost exclusive focus on women undermines any serious attempts to address issues of gender and AIDS and in fact serves to perpetuate dominant

gender stereotypes. Male sexuality and power need to come under the spotlight if the analysis is to reflect the complexity of issues involved and generate realistic and effective solutions.

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