

Introduction: Gender, Inequalities, and HIV/AIDS

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This volume provides a critical and comprehensive assessment of the relationship between gender, inequality and vulnerability to HIV infection and AIDS. It brings together contributions from scholars and practitioners from across the world to explore the relevance of these core concepts to their understanding of the AIDS crisis and the politics of effective response. The chapters in *Gender and HIV/AIDS* examine current thinking about sexuality, masculinity, gender roles, and culture in relation to HIV/AIDS and global politics of intervention and regulation. In doing so, the volume maps the intellectual and empirical dimensions of a global debate concerning the gendered contours of an epidemic imbedded in the social relations and material realities of societies at large. The normative aspiration of the volume is to stress the enormity and complexity of the relationship between gender inequalities, sexuality and HIV and AIDS, and the impact this has on the lives of affected and infected people, as well as on our work as development practitioners, academics, and activists. We believe that taking gender into account in our response to HIV/AIDS will not only help our understanding of the character and persistence of the epidemic, but has the potential of contributing to both improved policy and to the genuine transformation of gender relations in wider society.

The epidemiological statistics show that today women are more vulnerable to HIV than men for a variety of biological and social reasons that will be discussed in this introduction and throughout the book. Policy-makers have recognized this phenomenon as the “feminization of AIDS” (CHGA n.d.; Global Coalition on Women and AIDS 2004; Germain and Kidwell 2005; Piot 2007). This awareness of women’s vulnerability has stepped up prevention work with women, and focused attention on HIV and gender. While this is a necessary development, it is not without controversy. Arguably, the focus on women reinforces patterns of stigma and blame directed at women, portraying them as either vectors or victims of the epidemic (AWID and Kinoti 2008; Busza, this volume). This is partly the result of how “gender” is often addressed in development policy, practice and scholarship, equating gender all too often with women. As a result of the tremendous difficulty of changing entrenched social relationships, policy rarely looks beyond “women’s inclusion,” overlooking the beliefs, norms and values that underpin inequality in

the first place.¹ The equation gender/women also overlooks the role of sexuality in shaping vulnerability. A focus on women's particular vulnerability with regard to HIV and AIDS alone does not have the transformative potential needed to control and finally halt the spread of HIV. This book recognizes and emphasizes women's vulnerability to HIV as a result of structural gender inequalities. At the same time, the contributors to this volume take a relational perspective and examine how gendered inequality and sexuality affects both women and men, and how gendered roles, expectations, and resulting economic and political differences affect people's capacity to protect themselves against HIV, to gain access to services, and to survive with HIV.

This introduction provides a general overview of the gendered aspects of HIV/AIDS. As this volume draws on research carried out in the US, Latin America and the Caribbean, Asia, and Africa, we will first give a short overview of the genealogy of HIV and comparative epidemiological trajectories. More than anything, this will show that although biologically there is one infectious disease (although with various sub-types), there are many different epidemics. The role of gender and sexuality in these different epidemics varies. In a second section we discuss the explanations that have been brought forward to explain why the epidemic's epicentre is sub-Saharan Africa. Although inconclusive, this discussion highlights existing discourse about sexual behavior and the persistence of HIV, and brings in other relevant factors such as global restructuring and global inequality. Gendered patterns of inequality and poverty which shape sexual behavior are discussed in a third section, followed by a short overview of current policy approaches. In this introduction we do not pretend to be comprehensive in our overview of scholarship, but we intend to provide a general context for the chapters that follow.

Where are We? A Short Genealogy of an Epidemic

In order to understand the relationship between gender inequality and HIV/AIDS in the contemporary world, it is useful to briefly look at the evolution of the epidemic. HIV is a virus transmitted through body fluids, mainly blood, breast milk, and fluids produced in sexual activity. This means that the exchange of blood, sexual intercourse, and injecting drugs, as well as the transmission from mother to child during birth or breastfeeding, are the most common ways in which HIV is transmitted. HIV is a truly global epidemic, affecting us all and persistently

1 Despite the shift from Women in Development (WID) to Gender and Development (GAD), "gender mainstreaming" still has all the characteristics of "including women" into male-dominated structures. For elaborations on such critiques, see, for example, the articles in *Women's Studies Quarterly* (2003), vol. XXXI (3 and 4), and Bhavnani, Foran and Kurian (2003). Recent increased attention to men and masculinities in both development scholarship and practice is altering this situation somewhat, although AWID (2008) expresses the fear of a turn in policy to "include men" and neglect women's rights once again.

spreading. However, the course of the disease also shows considerable differences according to where one looks, and affects different groups of people (see Table I.1). Data collection has improved considerably, with relatively reliable data available for most places in the world. The main difficulty with contemporary data is that many HIV infections go unnoticed until the late stages of AIDS and imminent death; as HIV is a “lentivirus”, a virus which takes a long time to show, this means that non- or late detection is a serious problem for policy.

Table I.1 Regional HIV/AIDS statistics and features, December 2008

Region	Adults and children living with HIV/AIDS	Cumulative no. of orphans	Percentage of women	Main modes of transmission for those living with HIV/AIDS
Sub-Saharan Africa	20.8 million	7.8 million	50%	Hetero
North Africa, Middle East	210,000	14,200	20%	IDU, Hetero
South and Southeast Asia	6.0 million	220,000	25%	Hetero
East Asia Pacific	440,000	1,900	11%	IDU, Hetero, MSM
Latin America	1.3 million	91,000	19%	MSM, IDU, Hetero
Caribbean	310,000	48,000	33%	Hetero, MSM
Eastern Europe and Central Asia	150,000	30	25%	IDU, MSM
Western Europe	530,000	8,700	20%	IDU, MSM
North America	860,000	70,000	20%	IDU, MSM, Hetero
Australia and New Zealand	12,000	300	5%	IDU, MSM
Total	30.6 million	8.2 million	41%	

Source: UNAIDS (2008) (5)

Transmission through blood still occurs occasionally, but is increasingly curtailed through improved medical procedures. Injecting drug users are highly vulnerable, especially in Asia (see Table I.1). In societies with good healthcare systems, mother-to-child transmission is minimal, while in countries where either drugs are not available or access to them is severely constrained, mother-to-child transmission is a serious concern. However, throughout the world the main mode of transmission is sexual activity. But vulnerability through sexual activity differs widely. For example, in 2005 1.2 million people were infected with HIV in the US. The majority of cases (53 percent) are found among men who have sex with men,

i.e., gay and bisexual men. Two thirds of infected people are male, but women are increasingly at risk through heterosexual contact. Injecting drug users and ethnic minorities, especially African Americans, are considered at risk (UNAIDS 2008). Despite the relatively high absolute number of people living with HIV in the US (Table I.1), the fact that the majority of cases are found among identifiable groups that can be approached and targeted makes the US epidemic, in policy terminology, “concentrated”. However, the spread among ethnic minorities and heterosexual women indicates that more than targeted policy is necessary to avoid a more generalized epidemic. For example, Tim Frasca (this volume) suggests that the spread of HIV among male migrant laborers with little to no access to mainstream service provision and health knowledge are at high risk.

In Europe, the HIV epidemic is also relatively concentrated among men who have sex with men, and is largely under control.² However, of all new diagnoses made in the UK in 2006, 42 percent were among migrants from sub-Saharan countries, which generates a whole new set of prevention and care problems. The UK seems to have the highest rise in new infections in Europe, although in how far that is due to improved testing and detecting is not clear. Surveys that indicate levels of undetected HIV suggest that there is an invisible rise in HIV infections in the UK (UNAIDS 2008).

Most Latin American countries show similar patterns as Europe and the US, with relatively small prevalence rates (0.5 percent) and concentrated among gay and bisexual men. However, leaders in Latin America also speak of a potential “feminization” of the epidemic as heterosexual women are increasingly affected, highlighting the need for prevention and detection policies directed at the general population (Landey 2008). Brazil accounts for a third of all HIV-infected persons in Latin America. Although the national prevalence rate is low, only 0.5 percent, high levels are found among men having sex with men, and among the poorer general population. The Brazilian epidemic is largely under control thanks to an early response and good prevention and treatment policies (e.g. Biehl 2007). Homophobia in Central and South America make this group very vulnerable to HIV, and UNAIDS warns against the possibility of “hidden epidemics” among gay communities in Central America (UNAIDS 2008). The chapter by Carlos Cáceres et al. in this volume outlines the related gendered and moral constraints that particular groups experience in Peru experience in protecting themselves against HIV.

The Caribbean shows epidemic levels with HIV prevalence above 1 percent. Haiti has the largest HIV epidemic in Latin America and the Caribbean (2.2 percent). UNAIDS (2008) reports that urban prevalence levels have stabilized and

2 Anecdotal evidence and recent scholarship suggests that phenomena such as “barebacking,” i.e., intentional unprotected sex, is on the rise in gay communities in the US, Australia and the UK. This generates a whole new set of social questions about gender, sexuality, and risk. See for example, Halkitis, Parsons and Wilson (2003), Crossley (2004).

even declined in Haiti but in rural areas this is not the case. The case of Haiti is particularly worrying, as long-term active intervention policies seem to have had little effect. Condom use is still low and prevention measures have not reached the young and sexually active. High poverty levels and gender inequality are crucial factors in explaining the persistence of AIDS in Haiti (Maternowska 2006; Kershaw et al., this volume).

In Asia, HIV is largely concentrated among injecting drug users, commercial sex workers, and in certain areas among migrant laborers. In China, low levels of knowledge caused by insufficient access to services among an impoverished sex worker population (commercial sex is illegal) feed into low levels of condom use. Likewise, HIV policies pay little attention to gay men, and condom use seems to be low, increasing the risks of a generalized epidemic. Recently, interventions are being increased and treatment has been made available (UNAIDS 2008; Xiaopei 2006).

Indian statistics seem low: 0.36 percent adult prevalence in 2006. However, that means that 2.5 million people were living with HIV in that year—the second-highest figure in the world, after South Africa. HIV prevalence among women attending antenatal clinics was higher than 1 percent in Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu (UNAIDS 2007). According to pessimistic estimates, the prevalence rate is expected to more than quadruple in the next decade—thus making the country one of the most infected countries in the world (CHGA n.d.). HIV prevalence was largely concentrated among sex workers and injecting drug users, and perhaps among men who have sex with men, although this is largely hidden. If not attended to, high HIV prevalence rates among sex workers quickly facilitate spread among the general population. The Indian case referred to in Cornish, this volume, shows that tailored interventions directed at sex workers can be very effective, as was also evident among Latin American sex workers. Sex worker collectives such as Sonagatchi (see Cornish, this volume) and Lotus Club (Busza, this volume) are highly effective interventions, but they are not without controversy. As Busza shows in her chapter, misplaced morality with regard to sexual activity generates resistance from authorities and from powerful institutions within the international community to fund and facilitate such interventions. Southeast Asia shows similar prevalence and epidemiological characteristics to India, with a seemingly stabilizing epidemic in most of the region, although infection rates are rising in Vietnam and Indonesia. Some observers speculate that if HIV is not soon addressed more convincingly, India and China will overtake Africa not only in absolute numbers of HIV-infected population, but as the epicentre of the epidemic (Barnett and Whiteside 2006, p.9).

Although North Africa has a so-called “nascent” epidemic, i.e., with low prevalence rates but potential for increasing infection rates, sub-Saharan Africa is today the epicentre of the pandemic. Some countries show very high levels of HIV, with Swaziland showing a 40 percent prevalence rate among the adult population, and Botswana, a relatively prosperous country, between 35 and 40 percent. These numbers are unacceptably high, even if new infections are decreasing in several

countries, and the number of people living with HIV seems stabilized (Barnett and Whiteside 2006; UNAIDS 2008). The African HIV epidemic shows the reality of the “feminization” of HIV: young women are most vulnerable, with some countries showing that young women are four times more likely to contract HIV than their male peers (e.g., in Swaziland, 23 percent of women between 15 and 24 were HIV positive in 2005–2007, against 6 percent of men in the same age group). Already in 1999 the signs were there: in the western Kenyan city of Kismusu, 23 percent of girls aged between 15 and 19 were infected with HIV, as compared to only 8 percent of boys (Buvé 1999). This difference persists among men and women in their twenties. Some 38 percent of women aged 20–25 tested positive for HIV in Kismusu, against 12 percent of men of the same age (Williams et al. 2000). As we will see, poverty and gender inequality severely influence high levels of HIV anywhere among women in sub-Saharan Africa (e.g. Boesten, this volume), but likewise elsewhere, such as in Haiti (Farmer 1992, 1999; Kershaw et al., this volume) among African American women and in Asia (Farmer 1999).

Explaining the Disparate Epidemiologies

The outlined epidemiological differences are difficult to explain. A first observation must be that HIV follows the lines of global inequality: the poorest regions in the world are hardest hit and have most difficulty containing infectious diseases in general, and HIV in particular. There is clear evidence that global restructuring has exacerbated many old problems while also introducing new ones of its own, and HIV/AIDS should be placed in this context. Across the world, the dominant drivers of globalization (multinational corporations, the multilateral institutions of global economic governance and the G8 group of powerful states) structure not only the contours of the epidemic in terms of transmission and new infections through their influence on patterns of labor mobility, economic performance and resilience, investment in healthcare services and education, and even their influence on the moral economies of the developing world, but also the outcomes once an individual is sick with complications of HIV infection (Berwick, Sykes and Achmat 2002).

But global inequality and poverty alone cannot explain disparate HIV prevalence throughout the world. Several not-so-poor countries in sub-Saharan Africa show the highest prevalence rates, namely Botswana and South Africa, while many very poor countries in Latin America and North Africa hardly show any sign of a problem of epidemic proportions. Based on extensive study of available knowledge, John Iliffe (2006) explains the seriousness of the African epidemic from a historical point of view. First, Iliffe argues, to contain any epidemic, it needs to be dealt with as close to its start as possible and vulnerable groups must be targeted to prevent a virus’ spread to the general population. Africa had the first epidemic (sufficient evidence shows that HIV was first encountered in humans in western Equatorial Africa), but since HIV has such a long incubation time, it had a

chance to spread into the general population to epidemic levels before it was even noticed. Thus, prevention of an epidemic was impossible because it was already there. In contrast, in the US and Europe, HIV was concentrated in identifiable groups, which were easier to target and which shared a sense of “community” based on sexuality, making a message about sexual behavior possibly easier to carry. In addition, Iliffe argues, the stigma upon this group made it easier to sensitize the rest of the population about the dangers of AIDS (p.60). Elsewhere, as in several Asian countries, epidemiological evidence showed a concentration of HIV transmission among institutionalized sex workers that were immediately targeted (and stigmatized) as vectors of transmission (see also Busza, this volume). Despite the identification of groups particularly vulnerable to HIV in Africa, such as young women and migrant laborers, no groups of institutionalized sex workers or mobile men could be targeted in order to carry effective prevention messages. The regional inequalities and the rapidly changing nature of postcolonial African economies, Iliffe argues, feeding into the insecurity of economic safety as well as changing social and moral frameworks, fed into the spread of HIV and its intangibility (2006, p.62).

While these factors might have influenced the rapid spread of HIV in certain parts of Africa, they cannot fully explain the concentration of HIV in sub-Saharan Africa, especially since HIV prevalence has stayed stable, and in some cases at low levels, in several countries with the oldest epidemics. Medical epidemiological factors that might play a role, such as the presence of more or less aggressive HIV types in different regions, have not proven to be conclusive either, although they do probably influence the course of an HIV epidemic (e.g. Morison et al. 2001, Epstein 2007). Other biological factors, often related to sociocultural patterns, do contribute to vulnerability to HIV, such as if men are circumcised or not, the higher infectivity of newly infected persons,³ the presence of untreated sexually transmitted diseases, and the immaturity of girls’ and young women’s genitalia.⁴

More sociological explanations directed at sexual behavior patterns and the contexts in which those patterns are generated have not been able to pinpoint a specific set of behaviors which could explain the geographical differences in HIV prevalence. Surveys which analyze sexual behavior patterns have not found

3 Studies of varying HIV viral loads during early infection has prompted estimates that half or more of all HIV transmission from men to women in sub-Saharan Africa could be occurring during the first two months after men become infected. See, for example, Pilcher et al. (2004) and Chakraborty et al. (2001).

4 We are unaware of persuasive evidence that links nutritional status to higher HIV infectivity; in other words, current evidence appears not to support the claim that malnourished persons are physiologically more likely to be infected with HIV than well-nourished persons. For a circuitous, though in other respects interesting, attempt to present such a link, see Stillwagon (2001). What is clear and generally accepted, is that once a person has been infected, nutritional status can significantly affect the pace and manner of that person’s eventual progression to AIDS.

sufficient variety to account singularly for the differences in HIV prevalence levels in various parts of world. It is generally assumed that the likelihood of HIV and other sexually transmitted infection (STI) transmission increases roughly in step with the number of sexual relationships a person has. Multiple partnerships often top the list of HIV risk factors and are commonly held to be one of the main reasons for high infection levels found in parts of sub-Saharan Africa and the Caribbean. However, behavioral surveys show that men in various African countries are no more likely to have multiple sexual partners than are men in many other parts of the world. In one survey, men in Thailand and Rio de Janeiro, Brazil, for example, were more likely to report five or more partners in the previous year than were men in Kenya, Lesotho, Tanzania and Zambia, while other research has shown men and women in Africa reporting the same number or fewer multiple partners than in many industrialized countries (Careal 1995; Epstein 2007).

Nevertheless, generalizing interpretations of “African sexuality” with a racist undertone are pervasive. This tendency has been most evident when explanations have revolved around notions of “culture” and “traditions,” with putative “characteristics” frequently assigned to entire regions and even a continent. One early and startling effort tried to associate different sexual and reproductive strategies with specific racial groups (Rushton and Bogaert 1989).⁵ More sophisticated efforts pinpointing the causes of HIV to an African sexuality have focused on the ideological or cultural dimensions of the epidemics, often laying emphasis on the need to change societal norms in order to reduce the spread of the virus. Among the best-known explorations of this sort have been those of Caldwell et al. (1989, 1991, 1992), although they have not always regarded cultural patterns of sexuality and reproductive behavior as free-floating ideological phenomena, cut loose from other societal changes. Nevertheless, their blunt generalizations of the sexual mores in Africa are widely criticized (e.g. Bujra, this volume). The main problem with perspectives that emphasize the existence of a traditional (i.e. static) and culturally specific (i.e. ideologically determined) African sexuality, is that they tend to neglect the interplay throughout history between infectious disease, social relations and material conditions,⁶ of which AIDS is just one recent case in point. Such vantage points tend also to pass over the fact that “culture” is heterogeneous, socially and historically constructed, and does not affix “naturally” to any place or group. Thus, one finds epidemics in southern Africa often attributed to a paradoxical confluence of sexual promiscuity and public bashfulness about sex, with these “characteristics” commonly attributed to “African culture” or “African traditions.” However, the evidence shows that, at least until the early colonial era,

5 For a brisk debunking, see Hunt (1996).

6 In southern Africa, Sidney Kark’s 1949 examination of the syphilis epidemic in South Africa has become one of the benchmarks in this tradition of epidemiology, which is neatly summarized in his claim that “The problem of syphilis in South Africa is so closely related to the development of the country that a study of the social factors responsible for its spread is likely to assist in its control”; see Kark (2003 [1949], p.181).

most societies in the sub-region were marked by high degrees of sexual education and regulation (Delius and Walker 2002).

Recently, scholars argue that it is not the *number* of sexual partners that people living in highly affected areas in sub-Saharan Africa have in comparison to people living in other societies, but the fact that large part of the population has more *concurrent* sexual partnerships, thus creating a web of sexual relations which carries infections undisturbed through a population (Watts and May 1992; Morris and Kretzschmar 1997; Garnett and Johnson 1997; Van den Borne 2005; Epstein 2007). These authors do not look at tradition or culture for explanations of this phenomenon, but generally seek answers in the structural changes that have taken place since the late colonial time. Changing economic contexts, global restructuring, and the following experience of social rupture might have fed into changes in sexual behavior. The interplay between gender inequality and poverty certainly adds to this mix.

Gender Inequality, Poverty and Sexual Behavior

According to the executive director of UNAIDS, Peter Piot (2006), “gender inequality, discrimination and stigma, marginalisation of vulnerable groups and violation of human rights” are the main drivers of the epidemic. Men and women’s productive and reproductive lives are largely shaped by gender roles and inequalities. Gender shapes the division of labor, access to land or resources, to political decision-making, and to decision-making at household level and indeed also intimate relations. Sexual behavior is highly gendered and is strongly related to social norms and moral economies. In most societies, heterosexual relationships are the norm, and within heterosexual relationships women are subordinate to men. Homosexual relationships might be marginalized or tolerated, or denied an existence. Such marginalization of different sexual practices impedes adequate addressing of HIV, and furthers the possibility of hidden epidemics, invisible and uncontrolled (Bala Nath 2006; Phaladze and Tlou 2006).

The taboo on sexual practices outside socially determined ideal-types (e.g. monogamous, heterosexual, within marriage, reproductive) is one of the main reasons for the persistence of AIDS: it further undermines prevention and it constrains people’s capacity to protect themselves. The taboos around sexuality, and the moral implications attached, feed into the fear for HIV as a sexually transmitted disease. This furthers the daily stigmatization and self-stigmatization of people living with HIV/AIDS, further preventing an appropriate and effective response (Bond, Chase and Aggleton 2002; Campbell, this volume; Boesten, this volume). Women are often more stigmatized than men, as are young people and homosexuals (e.g. Campbell et al. 2005, 2006). In addition, stigma is worsened and maintained by the intersections of social prejudice, which means that it contributes to existing inequalities (Campbell and Gibbs, this volume). The discrimination that follows from stigma has far reaching material and emotional costs, as captured

pointedly by the late Jonathan Mann: “violations of dignity have such significant, pervasive, and long-lasting effects that injuries to individual and collective dignity may represent a thus far unrecognised pathogenic force of destructive capacity towards well-being equal to the capacity of viruses or bacteria” (Mann 1998, p.148). As HIV victims throughout the world indicate, before physical death, there is social death, as stigma might kill (Manchester 2004; Robins 2005; Boesten 2007).

Committed physicians and policy-makers such as Mann and Piot recognized the social dimension of the HIV epidemic and the necessity to look beyond technical solutions and medical interventions. The interplay of socioeconomic inequality and gender has particularly devastating effects on women’s vulnerability in general, and to HIV in particular. As indicated above, more women than men are dying of HIV/AIDS and the age patterns of infection are significantly different for the two sexes. There are, however, profound differences in the underlying causes and consequences of HIV/AIDS infections in men and women. In explaining the vulnerability of women to the epidemic, a combination of factors are clearly involved, reflecting differences in biology (Seidel 1993), sexual behavior (Orubuloye et al. 1993, 1997; Baylies and Bujra 2000), social attitudes and pressures (Poku 2006a), and economic power and vulnerability (Schoepf 1993; Smith and Cohen 2000). Of particular importance here is the assumption that, increasingly, women are more impoverished than men, a phenomenon referred to as the “feminization of poverty” (Doyal 1995, 2002; Chant 2007). The notion of an increase in female poverty is strongly influenced by changing household compositions, fewer opportunities for women on the labor market, and greater caring responsibilities for most women, reducing their time for remunerated work. Processes of global restructuring and the structural adjustment programs of the 1980s and 1990s, which facilitated the general marginalization of women in the global economy, also facilitated these processes of the “feminization” of poverty, and in its wake, of HIV/AIDS. Continuing retrenchment coupled with casualization of the female labor market has resulted in the confinement of women to lower-paid occupations with its associated job and health insecurities. Take the example of Zuki in South Africa:

Zuki works as a security guard at a shopping centre in Johannesburg. Everyday she spends two hours getting to work because of the distances apartheid’s architects put between city centres and townships that serviced them. Zuki is grateful to have a job. Her two little ones are in Kwazulu Natal with their grandmother until Zuki can get stable work. She is on a month-to-month contract with the security company. She watches expensive cars all day, protecting their owner’s investments while they work. The company doesn’t want to take her on as staff so each month she faces the uncertainty of not having a job the next month. Joining a union is not an option—she’s not technically a staff member and anyway, she can’t afford to make trouble. Zuki’s boyfriend Thabo drives a taxi. Their relationship saves her cash because he drives her to and from work

every day—a savings of almost one third of her salary each month. She has another boyfriend at work who often buys her lunch. She has to be careful that Thabo doesn't find out. But last month Zuki discovered that she was HIV positive. (Poku 2006b, p.15)

Zuki's story does not stand on its own, but is a reflection of the vulnerability of millions of women across the developing world who are so economically marginalized that they exchange sex for money, food, shelter and other necessities, with the associated risk of exposure to HIV infection. In a situation where women have few options for supporting themselves, many may feel compelled to stay with a male partner even when this is putting their life at risk. A refusal to participate in unsafe sex may mean the withdrawal of material support leaving a woman and her children with no alternative means of survival. In a study of low-income women in long-term relationships in Mumbai, India, women felt that the economic consequences of leaving a relationship that they perceived as risky were far worse than the risk of contracting HIV/AIDS (Rao Gupta 2000). Research from impoverished communities around the world suggests that women take high sexual risks in favour of a livelihood for themselves and their families (eg. Gysels, Pool and Nnalusiba 2002; Van den Borne 2005; Maganja et al. 2007; Ferguson and Morris 2007). For some, paid sex work may be the only source of income despite the inevitable hazards, and adolescent girls are particularly at risk in such circumstances. Cross-generational relationships, in which economic and gender ascendancy is added to by the authority of age, are particularly risky (Setel 1999; Silberschmidt and Rasch 2001; Weissman et al. 2006).

In some communities, cultural norms state that women and girls are entitled to less than their male counterparts (Messer 1997). This will apply not only to money but also to a wide range of other resources including food, land, credit, time, status, healthcare and physical security. Though the nature of this gender bias varies markedly between communities, it is clear that in many settings it exerts a powerful influence on who gets what. In poor households women may end up being the most deprived of all while even in more affluent families gender bias may push women into invisible poverty. Such poverty pushes women further into taking high sexual risk in return for access to basic needs. But poverty also diminishes people's physical resistance. The most immediate effects of poverty on many women are probably physical and psychological exhaustion as they struggle to weave their own and their families' survival strategies in what are often hostile environments (Avorti and Walters 1999). This heightens their vulnerability to a range of other health problems which may often be cumulative in their effects. During the reproductive years in particular the demands on women may be very high while food may be in short supply. This can contribute to iron deficiency and anaemia which increases women's susceptibility to pregnancy-related disorders as well as a range of infectious diseases. In such a way, poverty exacerbates physical vulnerability to HIV among women.

But there are also specific sexual practices which contribute to women's increased vulnerability to HIV, such as dry sex, dowry, polygamy, widow inheritance, early marriage, and female genital modification (Bond 2004). The pervasiveness of such harmful practices differs from region to region, and even from community to community. In some regions in sub-Saharan Africa and elsewhere, their persistence is facilitated by plural legal systems, in which customary law and religious law can overrule statutory law, especially with regard to such "private" issues such as domestic violence or the conditions attached to intimate relationships (Bond 2004). In addition, women's weak legal position and lack of access to resources, increasing their dependence on male family members, weakens women's capacity to negotiate the conditions of sexual practice, including the use of condoms. In such a context, the emphasis on condom use in campaigns directed at women seems almost insulting. Perhaps unsurprisingly in this context, violence against women is proven to be widespread throughout the world (World Health Organization 2005). Violence against women is harmful in many ways and generally reduces women's physical and emotional capacity to care, to earn a living, and to decide over the relationships they maintain. Evidently, violence reduces women's capacity to negotiate the conditions of safe sex (Jewkes et al. 2003; Watts and Mayhew 2004; Dunkle et al. 2006; Program on International Health and Human Rights 2006; Boesten, this volume, Gupta, Small, and Kershaw, this volume). Partner violence, or the fear thereof, also influences women's willingness to go testing for HIV and be open about their health status (Maman et al. 2001).

Research has shown that men who perpetrate violence against their partners are less likely to use condoms (Ray et al. 2007, Gupta, Small, and Kershaw, this volume). For men and women to practice safe sex, we need to address violence against women, women's economic dependence, and harmful sexual practices, i.e., we need to address gender inequality. As suggested above, focusing only on the situation of women with an aim to "empower" them and support their economic activities does not necessarily change the underpinning assumptions of gender inequality and sexuality. Men need to be involved and both men and women need to act upon the fact that both need to protect themselves, each other, and their families against HIV infection. In the words of Baylies and Bujra (2000, p.1) and Bujra, this volume, men and women need to work towards mutuality in intimate relationships. The study of how notions of masculinity influence men's inclination to take sexual risks show that men need to be involved in the social changes that are taking place in the area of gender and sexuality (Mane and Aggleton 2001; Bujra 2002; Walsh and Mitchell 2006; Gutmann 2007; Robins, this volume).

As the above review indicates, the vulnerability of women is the result of gender inequality. However, this gender inequality cannot only concern "women as victims" (and less so as vectors), as men need to protect themselves, their partners, and their families just as much as women do. In addition, women's economic dependence cannot be solved without rethinking the gendered nature of economic activity and of family structures. Policy-makers have realized the necessity to involve men, however, to the frustration of women's rights activists,

this seems to have averted attention from women's rights (AWID and Kinoti 2008). Programs directed at men need to include a woman's perspective and vice versa, to avoid singular targeting which undermines the potential for mutuality in intimate relationships and society at large. Different sexual practices and identities should be recognized there where this is not the case, and potential vulnerabilities related to sexual practices should be discussed.

The general notion of seeing gender as relational, involving both men and women, does not discard the fact that the circumstances, conditions, and premises of gender relations and sexuality are not highly diverse across the communities throughout the world. This suggests that it is necessary to encourage those who fund and design prevention programs to understand these diverse situations and to custom-tailor messages to specific local needs, "local" here meaning both geographically and socially local. Pushing for one overarching 'best' message has proven to be ineffective (Ross 2005; Epstein 2005). But that does not mean that there have not been any successes: Uganda showed strong leadership at the top and creativity at the grassroots when it reversed the course of its epidemic in the late 1980s to the mid-1990s. The Ugandan experience was remarkable in the extent to which it achieved diversity in prevention messages; this was done by establishing a political environment which encouraged many actors with many messages (Low-Beer and Stoneburner 2003, 2004). However, the Ugandan success, as well as the successes of Senegal and Thailand, has proven difficult to emulate elsewhere, not least because these successes were not the result of a single intervention (although the 100 percent condom use policy in Thailand was indeed a single intervention, its success was largely due to the specific organization of prostitution, and is thus not necessarily applicable elsewhere). The challenge for all leaders involved in AIDS work at all levels—international, national and communal, men and women, adults and young people—is to understand just how few technical solutions we have, how aggressive is the threat amongst us, and how important it is to seek solutions in the diversity of responses possible. Uniform prescriptions from outside may end up wasting resources and lives (Green 2003; Halperin et al. 2004).

Where are We Likely to Go?

Despite the many years of work with regard to gender equality, development, and HIV/AIDS, inequality is still rife. Discrimination against women both in sexual relationships and in broader social relations is embedded within the social, cultural and religious assumptions and discourses of most societies struggling with the HIV epidemic. The international mobilization around HIV/AIDS mainly focuses on technical solutions, frequently without attention to the specific inequalities affecting people's vulnerability (Frasca, this volume). Interventions directed at voluntary counselling and testing (VCT), condoms, STIs, mother-to-child infections (MTCT), and more recently treatment, including the roll-out of antiretroviral treatments (ART) do not look at the sociocultural or economic

impediments people encounter in protecting themselves and others. Although these interventions are absolutely necessary and strongly contribute to containing the epidemic, they do not address either the gendered causes or consequences of HIV/AIDS or the gendered dimensions of each of these solutions themselves, e.g., the focus on the child without attention to the long-term health of the mother implicit in MTCT, the lesser access of women to STI treatment, the determining role of men (and violence) as regards condom use, the barriers to knowledge and treatment among marginalized groups, including migrant laborers, women, and young people, the lesser access of women to medical care or income, the denial of the existence of different sexualities and/or the discrimination of gay people, and the (economic) barriers to access to ART.

Likewise, the non-technical solutions being promoted in this mobilization avoid the underlying dynamics of the disease: calls for abstinence, for example. Placing a demand for a particular form of interpersonal behavior (abstinence and monogamy) onto a context where both cultural and economic factors push men and women into opposing behaviors shows a staggering lack of insight into the nature of society and individual behavior within it. Although, when practiced, abstinence and monogamy are good strategies to avoid HIV infection, ample evidence—a continuous epidemic for example—indicates that in reality these are not good enough as prevention messages. Moreover, the particular interventions being introduced to promote abstinence, further stigmatize and discriminate against women, particularly the new emphasis on virginity testing in some communities, once again placing responsibility for the spread of HIV onto women, despite their lesser control over sexual relations (Campbell et al. 2005).

Prevention has been and is still largely dominated by the “ABC” formula (Abstinence, Being faithful, and Condom use) in various combinations and with differing emphases. The problem with ABC is that it confuses the outcomes of successful HIV prevention programs with the message needed to achieve effective results. Transformed into a technical formula, some ABC advocates ignore that each of these components may be more or less effective or relevant depending on social factors such as cultural, political and economic circumstances in particular communities, the life cycle of people, and the stage of the epidemic—early or late. As we know since HIV was recognized as a sexually transmitted disease, abstinence, fidelity, or condom use are the successful outcomes of any behavior change strategy for HIV/AIDS (and these are proven goals for all STI prevention). It is less well understood how to bring about A, B, and C.

As long as we do not have a vaccine, we cannot claim to have a good strategy ready for the future. While antiretroviral medicines have fallen in price and are becoming more widely available through the Global Fund, PEPFAR, the Gates Foundation and the Clinton Foundation, it remains difficult to make them really universally available. This is partly still caused by high costs of the drugs themselves and the difficulty in reaching poor and rural communities, but the need for comprehensive healthcare, poverty reduction, gender equity and the elimination of human rights abuses and stigma are just as important. Examples

of the effective roll-out of antiretroviral treatments, e.g. in Haiti and Botswana, are hopeful; however, so far these programs have not reduced the spread of HIV (UNAIDS 2008).

The impact of HIV/AIDS on individuals and their families is devastating. The impact of the epidemic for highly affected societies permeates all aspects of social, economic, and political life (Barnett and Whiteside 2006). Considered from the perspective of viral survival and reproduction the life cycle of HIV meshes well with the human life cycle, ensuring that each infected generation leaves behind orphans who are more susceptible to infection than the preceding generation because they are less well socialized, less educated (Poulsen 2006), less well looked after and more likely to become infected. As the epidemic develops further, sero-prevalence levels rise and more people will carry HIV as a chronic disease. This will pose a risk for each generation until the epidemic is brought under control through vaccines and/or effective prevention. Despite the notable successes in Uganda, Thailand, and Senegal and more isolated cases, prevention programs have so far been of very limited effectiveness, especially in countries with a generalized epidemic. The continuous spread of HIV across the globe does not show anything that could by any stretch of the imagination be described as success in prevention. In fact, perhaps we should stop calling this thing an “epidemic”—an event with a foreseeable end—and instead admit that HIV is now “endemic”—a presence with which we will all have to live (and die) for as far as we can see ahead.

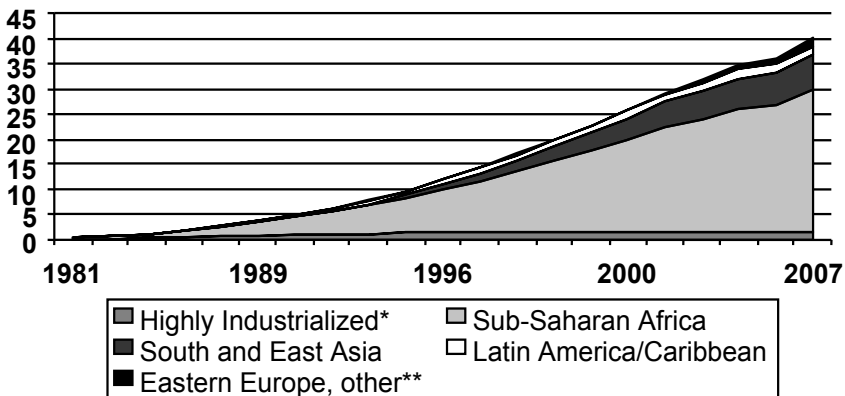


Figure I.1 People with HIV/AIDS, cumulative regional totals (millions)

About the Book

The book is divided in three sections. In the first section, “Gendered Vulnerabilities”, the authors explore how gendered inequalities and sexualities influence people’s

potential exposure to HIV. In the first chapter, Campbell and Gibbs explore the difficult position of female sex workers and the multiple layers of marginalization they often experience. Using a social-psychological viewpoint, Campbell and Gibbs unpack the multiple marginalizations using the intersectionality of gender, HIV, occupation, and poverty as a point of analysis. These intersecting disadvantages feed directly into the persistence of HIV-related stigma, while at the same time, stigma directly supports gender inequality. HIV-related stigma is well described in scholarship, but not well theorized and understood, making it difficult to break the cycle of stigma–gender inequality that perpetuates the HIV pandemic. The authors further our understanding of stigma by analyzing it not only as layered, but as functional and productive. The theoretical model the authors develop is applied to three interventions that intended to reduce gender inequality among sex workers in Cambodia, South Africa, and India, showing that intersecting inequalities which influence stigma can be challenged by taking small steps towards the empowerment of those whose agency is minimalized.

In the second chapter, Salazar, Sandoval, Maziel Girón, and Cáceres use extensive research carried out among different populations in Peru to analyze how gendered vulnerabilities play out in sexual practices, and thus influence men and women’s sexual health. In Peru HIV is largely concentrated among men who have sex with men, but women are increasingly vulnerable as well. The “sexual scripts” prevalent in Peru, the authors argue, allow women little leverage in negotiating condom use. While gender norms encourage men to have multiple partners, and gay encounters might play a part in these, they are not encouraged to use condoms either, seeing condoms as inconvenient and unpleasant. The authors also look at the transgender community in Peru, in which sex work plays a large role. Condom use appears to be accepted among transgender people and sex workers, but the widespread use of alcohol (and often cocaine) in casual and/or paid sexual encounters limits consistent use. Alcohol also plays a role among young urban women’s changing behavior. While young women have entered spaces previously forbidden to them and go out and drink with their male peers, their consumption of alcohol is often used as an excuse for casual sexual encounters. For young women, it relieves them of responsibility for casual encounters that are still seen as damaging to a woman’s reputation, while men might use a woman’s consumption of alcohol as an excuse for unwanted sexual advances, including rape.

Using ethnographic material, Boesten focuses on the personal stories of people living with HIV/AIDS in Chapter 3. Looking at the poor segments of two Tanzanian roadside towns, she asks if the availability of community support networks, and recently, VCT and ART, mediates the sexual behavior of HIV positive women and men. The stories of several HIV-positive women shows that many feel compelled into sexual relationships in return for economic support, even if they know the potential consequences of such behavior. The structures of poverty and gender inequality impede many women to speak up about their health status, care for themselves and their children without male support, and negotiate safe sexual relations with their sexual partners. With VCT and ART only recently becoming a

genuine option for poor Tanzanians who previously did not have readily access to hospitals, many of the interviewed women told stories of emotional and physical despair. The burden of imminent death overshadowed by a stigma enveloped in sexual taboos, paralyzed many couples in discussing their mutual suffering. As these stories show, poverty, gender inequality, stigma and self-stigma leading to secrecy and denial, all challenge the potential positive benefits of VCT and ART. As such, the chapter shows that once again technical solutions are frustrated by social and economic impediments.

In the last chapter in the section on gendered vulnerabilities, Gupta, Small, and Kershaw use gender inequality and struggles over power as an explanatory framework to unpack the underpinnings of the HIV epidemic in Haiti. The authors observe a direct link between the high levels of violence against women and HIV risk, a relationship also observed in, for example, South Africa (Dunkle et al. 2004, 2006, 2007). Perpetrators of violence against women are also more likely to have unsafe sex, as higher levels of STIs are found among violent men and victimized women. Similar to the case of poor women in Tanzania as described by Boesten, women's economic dependence on men pushes them into sexual relationships over which they have limited control. Fear of violence and loss of vital economic support discourages women to disclose their HIV status to sexual partners, perpetuating the cycle of gender inequality, poverty, and HIV transmission. The political instability and continuous impoverishment of the Haitian population pushes people to seek livelihoods elsewhere—national and international migration is common. However, poor Haitians often end up in poor neighborhoods elsewhere where their marginalization continuous and HIV often thrives. The political turmoil has also increased and sustained gendered violence, including high levels of sexual violence. The authors conclude that the intertwinement of structural gender inequality accompanied and sustained by poverty and violence underpins the continuous spread of HIV, and can thus only be tackled if these structural problems are addressed.

The second section of the book, “Targeted Interventions”, looks at three particular policy contexts. Joanna Busza examines how global approaches to HIV prevention among sex workers have shifted over time, and how these have influenced the possibilities of intervention at the grass roots. She observes three stages in the global approach to prostitution and sex work, from “vectors,” to “vulnerable,” to “victims.” First, women were seen as vectors, “reservoirs” of virus, and were targeted to contain the spread of the virus to the general population. The results were top-down policies that promoted condom use and regular health check-ups that proved successful in some cases. During the mid-1990s a change took place. Sex workers were now seen as also in need of protection themselves: they were “vulnerable.” This approach led to more bottom-up participatory policies and projects that intended to empower sex workers. Busza describes one such successful project in which she was personally involved in Cambodia, called the Lotus Club. The project suffered under the third shift in global policy, when the Bush government took a “victim” stand towards prostitution. As women were seen

as mainly victims of trafficking and exploitation, they needed to be rescued, not supported in their empowerment as sex workers. The direct policy consequence of this approach, Busza recounts, was the cutting of funds for innovative project such as the Lotus Club.

In Chapter 6, Flora Cornish looks at collectives such as the Lotus Club as agents of social change: they actively challenge existing gender inequalities. Thus, similar to the observations of Bujra in Tanzania and Robins and Colvin in South Africa (see below), Cornish suggests that HIV interventions can and should, in the long run, contribute to gender equality. Challenging male control over female sexuality is necessary in order to give women more autonomy over their desires and sexual behavior, and this in turn, is crucial to stop further transmission of HIV. The projects Cornish describes were successful, she argues, because instead of focusing solely on HIV, they focused on sex workers' strategic gender interests, which would then result in improved health. Activists and leaders among sex workers managed to take out the internalized moral stigma attached to the sex work in favor of a discourse which emphasized rights. This politicizing process does not only result in symbolic power, but translates into organizational gains and concrete project activities, which furthers the empowerment process, help reduce gender inequality, and improve people's capacity to protect themselves against HIV. However, Cornish warns, if the individualistic and "technical" medical culture of the field of health does not genuinely widens its theoretical understanding of the necessity of structural social change in gender relations in order to halt the epidemic, then it is doubtful if such successes can be scaled up.

Tim Frasca also critiques the technical approach towards HIV/AIDS. In his chapter, Frasca observes that, while the gendered vulnerabilities of men are increasingly taken into account in research on and policy directed at the African epidemic, this is not the case in the US. According to Frasca, a "gendered reading" of HIV prevention in the US still focuses largely on women's vulnerabilities, without taking into account how masculinities influence men's sexual behavior and their attitudes towards safe sex. This lack is worsened, Frasca argues, by the "technification of HIV." Since treatments are available, the focus of HIV interventions has increasingly been on identifying HIV positive people in order to include them in the treatment and care system. However, this, in combination with the ideological backlash on talking about sexuality in policy circles, has led to a neglect of prevention measures and health promotion. A group that is often ignored, male migrant workers, is left especially vulnerable to HIV.

The last section of the book looks at how the changes that are taking place in social relations to help stop the spread of HIV can have positive effects for gender relations more generally. Janet Bujra builds on decades of research in East Africa to explore if and how "local" discourses with regard to sex have changed in response to the AIDS campaigns of the last 15 years. Bujra observes that the global and national focus on safe sex in the era of AIDS suggest a certain democratization of sexual relationships, and in doing so, explicitly or implicitly, of gender relations. Scholars, activists, and policy-makers who see "African sexuality"

as particularly immune to such changes, Bujra argues, have often resisted this democratization, or “mutuality through dialogue.” However, the sheer reality and proximity of HIV/AIDS in daily life force both men and women to reconsider and renegotiate the conditions under which sex is discussed, and for some, in which sex is practiced. Using extensive data from a study in Lushoto, Tanzania, she observes that hierarchies based on generation and gender are being questioned and indeed challenged through the necessity of discussing sexual behavior. Sex being the ultimate site of power struggles, changing the practices that facilitate HIV transmission will have to go hand in hand with fundamental changes in gender relations, and hopefully improve women’s position in the long run.

That HIV/AIDS interventions must and do change notions about gender among the targeted population is also the observation of Steven Robins and Christopher Colvin in the last chapter in this collection. Looking at grass roots groups of HIV positive men in South Africa, the authors unpack the tensions between “new” notions of gender, rights, and citizenship, and local realities and persistent notions of masculinity and femininity. Recently, a literature emerged discussing the redefinition of citizenship as biological (Rose and Novas 2005), therapeutic (Nguyen 2005), sexual (Adams and Pigg 2005), and responsible (Richey 2006, Robins 2004). In dialogue with this literature, Robins and Colvin find that the claims to the “global totality” of this experience of change does not hold when one looks at local transformations, which are often more messy than this literature suggests. The participants in the men’s groups that the authors studied have changed rapidly under the influence of their HIV positive status, being forced to “responsibilize” their behavior in order to survive. Nevertheless, this new consciousness, and the changes in daily life it enforces, coexists with “old” notions of masculinity and femininity. Similar to often slow and contradictory nature of changes in gender relations under the influence of HIV-induced “sex talk,” as observed by Bujra in Tanzania, the men in this South African study do change attitudes and behavior, but it is not always easy to see if and how these changes will be structural.

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