Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How

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The focus of my talk, as the title suggests, is on the what, why, and how of gender, sexuality, and HIV/AIDS. I would like to thank my colleagues and friends, Ellen Weiss from ICRW and Purnima Mane of the Population Council, for helping me put this talk together. The talk is limited to issues related to the heterosexual transmission of HIV because that has been the focus of my work over the last decade. I recognize that heterosexual transmission is only one aspect of the epidemic, but it is by no means irrelevant since the most recent statistics show that heterosexual transmission of HIV remains by far the most common mode of transmission globally.

We have known for at least a decade that gender and sexuality are significant factors in the sexual transmission of HIV, and we now know that they also influence treatment, care, and support. Both terms, nevertheless, continue to remain misunderstood and inappropriately used.

Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. It

is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other.

Gender is a culture-specific construct – there are significant differences in what women and men can or cannot do in one culture as compared to another. But what is fairly consistent across cultures is that there is always a distinct difference between women's and men's roles, access to productive resources, and decision-making authority. Typically, men are seen as being responsible for the productive activities outside the home while women are expected to be responsible for reproductive and productive activities within the home. And we know from over twenty years of research on women's roles in development that women have less access over and control of productive resources than men -- resources such as income, land, credit, and education. While the extent of this difference varies considerably from one culture to the next, it almost always persists (Sivard et al.1995; Buvinic 1995).

Sexuality is distinct from gender yet intimately linked to it. It is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behavior and is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality (Zeidenstein and Moore 1996; Dixon Mueller 1993).

At the Center at which I work, we talk about the components of sexuality as the Ps of sexuality – practices, partners, pleasure/pressure/pain, and procreation. The first two refer to aspects of behavior -- how one has sex and with whom; while the others refer to the underlying motives. But we have learned through data gathered over many years that there is an additional P of sexuality that is the most important -- power. The power underlying any sexual interaction, heterosexual or homosexual, determines how all the other Ps of sexuality are expressed and experienced. Power determines whose pleasure is given priority and when, how, and with whom sex takes place. Each component of

sexuality is closely related to the other but the balance of power in a sexual interaction determines its outcome (Weiss and Rao Gupta 1998).

Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favors men, translates into an unequal power balance in heterosexual interactions, in which male pleasure supercedes female pleasure and men have greater control than women over when, where, and how sex takes place. An understanding of individual sexual behavior, male or female, thus, necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power.

Research supported by ICRW and conducted by researchers worldwide has identified the different ways in which the imbalance in power between women and men in gender relations curtails women's sexual autonomy and expands male sexual freedom, thereby increasing women's AND men's risk and vulnerability to HIV (Weiss and Rao Gupta 1998; de Bruyn et al. 1995; Heise and Elias 1995). Let me first briefly go through the factors associated with women's vulnerability to HIV.

Women's Vulnerability

First, in many societies there is a culture of silence that surrounds sex that dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions. This makes it difficult for women to be informed about risk reduction or, even when informed, makes it difficult for them to be proactive in negotiating safer sex (Carovano 1992).

Second, the traditional norm of virginity for unmarried girls that exists in many societies, paradoxically, increases young women's risk of infection because it restricts their ability to ask for information about sex out of fear that they will be thought to be sexually active. Virginity also puts young girls at risk of rape and sexual coercion in high prevalence countries because of the erroneous belief that sex with a virgin can cleanse a man of infection and because of the erotic imagery that surrounds the innocence and passivity

associated with virginity. In addition, in cultures where virginity is highly valued, research has shown that some young women practice alternative sexual behaviors, such as anal sex, in order to preserve their virginity, although these behaviors may place them at increased risk of HIV (Weiss, Whelan, and Rao Gupta 2000).

Third, because of the strong norms of virginity and the culture of silence that surrounds sex, accessing treatment services for sexually transmitted diseases can be highly stigmatizing for adolescent and adult women (Weiss, Whelan, and Rao Gupta 2000; de Bruyn et al. 1995).

Fourth, in many cultures because motherhood, like virginity, is considered to be a feminine ideal, using barrier methods or non-penetrative sex as safer sex options presents a significant dilemma for women (Heise and Elias 1995; UNAIDS 1999).

Fifth, women's economic dependency increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favors, less likely that they will succeed in negotiating protection, and less likely that they will leave a relationship that they perceive to be risky (Heise and Elias 1995; Mane, Rao Gupta, and Weiss 1994; Weiss and Rao Gupta 1998).

And finally, the most disturbing form of male power, violence against women, contributes both directly and indirectly to women's vulnerability to HIV. In population-based studies conducted worldwide, anywhere from 10 to over 50 percent of women report physical assault by an intimate partner. And one-third to one-half of physically abused women also report sexual coercion (Heise, Ellsberg, and Gottemoeller 1999).

A review of literature on the relationship between violence, risky behavior, and reproductive health, conducted by Heise and colleagues (1999) shows that individuals who have been sexually abused are more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs. This relationship is also apparent in the findings from a study conducted in India. In this study men who had experienced

extramarital sex were 6.2 times more likely to report wife abuse than those who had not. And men who reported STD symptoms were 2.4 times more likely to abuse their wives than those who did not (Martin et al. 1999). And from other research we also know that physical violence, the threat of violence, and the fear of abandonment act as significant barriers for women who have to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships that they perceive to be risky (Mane, Rao Gupta, and Weiss 1994; Weiss and Rao Gupta 1998).

Additionally, data from a study conducted in Tanzania by Maman, Mbwambo, and colleagues (2000) suggest that for some women the experience of violence could be a strong predictor of HIV. In that study, of the women who sought services at a voluntary HIV counseling and testing center in Dar-es- Salaam, those who were HIV positive were 2.6 times more likely to have experienced violence in an intimate relationship than those who were negative.

Men's Vulnerability

Let us move on now to the way in which the unequal power balance in gender relations increases men's vulnerability to HIV infection, despite, or rather because of, their greater power.

First, prevailing norms of masculinity that expect men to be more knowledgeable and experienced about sex, put men, particularly young men, at risk of infection because such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection, and coerce them into experimenting with sex in unsafe ways, and at a young age, to prove their manhood (UNAIDS 1999).

Second, in many societies worldwide it is believed that variety in sexual partners is essential to men's nature as men and that men will seek multiple partners for sexual release -- a hydraulic model of male sexuality that seriously challenges the effectiveness of prevention messages that call for fidelity in partnerships or a reduction in the number of sexual partners (Mane, Rao Gupta, and Weiss 1994; Heise and Elias 1995).

Third, notions of masculinity that emphasize sexual domination over women as a defining characteristic of malehood contribute to homophobia and the stigmatization of men who have sex with men. The stigma and fear that result forces men who have sex with men to keep their sexual behavior secret and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners, female or male (UNAIDS 1999).

Fourth, men in many societies are socialized to be self-reliant, not to show their emotions, and not to seek assistance in times of need or stress (WHO 1999). This expectation of invulnerability associated with being a man runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk.

Overall, these manifestations of traditional notions of masculinity are strongly associated with a wide range of risk-taking behavior. For example, a national survey of adolescent males aged 15 to 19 in the U.S. found that young men who adhered to traditional views of manhood were more likely to report substance use, violence, delinquency, and unsafe sexual practices (Courtenay 1998).

Power Imbalance and HIV/AIDS

In addition to increasing the vulnerability of women and men to HIV, the power imbalance that defines gender relations and sexual interactions also affects women's access to and use of services and treatments. For example, the Tanzanian study conducted by Maman, Mbwambo and colleagues (1999) found that there were gender differences in the decision-making that led to the use of HIV voluntary counseling and testing services. While men made the decision to seek voluntary counseling and testing independent of others, women felt compelled to discuss testing with their partners before accessing the service, thereby creating a potential barrier to accessing VCT services.

Women's social and economic vulnerability and gender inequality also lie at the root of their painful experiences in coping with the stigma and discrimination associated with HIV infection. HIV positive women bear a double burden: they are infected and they are women. In many societies being socially ostracized, marginalized and even killed are very real potential consequences of exposing one's HIV status. Yet, HIV testing is a critical ingredient for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child.

In a recent study conducted by researchers in Botswana and Zambia in collaboration with researchers from ICRW, men and women expressed concern for women who test positive because they felt that men would be likely to abandon a HIV positive partner. On the other hand, it was expected that women would initially get angry with a HIV positive partner, but ultimately accept him (Nyblade and Field 2000).

Overcoming Inequality

How is one to overcome these seemingly insurmountable barriers of gender and sexual inequality? How can we change the cultural norms that create these damaging, even fatal, gender disparities and roles? An important first step is to recognize, understand, and publicly discuss the ways in which the power imbalance in gender and sexuality fuels the epidemic.

There has been a definite shift in the international public and political rhetoric on HIV/AIDS over the last two years. The dominant discourse now reflects an increased acknowledgment of the role that gender plays in fueling the epidemic. Unfortunately, aside from a few exceptions, such public discourse on sex and sexuality is still invisible. There is an urgent need to break that silence because we know that talking openly about sex is the first step to reducing denial and bringing about acceptance of our collective vulnerability.

In contrast, public health discourse, as seen in scientific journals and forums, reflects definite progress in understanding the importance of both gender and sexuality. But

because this increased understanding is fueled in large part by the need to interpret the dynamics of the AIDS epidemic, the analysis of gender and sexuality is situated firmly within a framework of disease. Sexuality as seen through the public health prism, therefore, is still a potential determinant of ill health and little else. As a result, safer sex is the mainstream theme within this discourse, while sexual health, pleasure, and rights remain on the margins.

It is also important to note that the progress in the public health discourse on gender and sexuality is not matched by progress in action. There is a substantial gap between the talk and the walk. This is partly because it is easier now to explain the why and what with regard to gender, sexuality, and HIV/AIDS, but there is less known about the how – how to address these issues in a way that has an impact on the epidemic. It must be said, however, that this relatively little information on the how is not due to a lack of innovation and trying. Although there are still no clear-cut answers and there is very little data to establish the impact of the efforts that have been tried, it is possible to look back and identify clear-cut categories of approaches--approaches that fall at different points on a continuum from damaging to empowering.

To effectively address the intersection between HIV/AIDS and gender and sexuality requires that interventions should, at the very least, not reinforce damaging gender and sexual stereotypes. Many of our past and, unfortunately, some of our current efforts, have fostered a predatory, violent, irresponsible image of male sexuality and portrayed women as powerless victims or as repositories of infection. This poster, in which a sex worker is portrayed as a skeleton, bringing the risk of death to potential clients, is an example of the latter which, from experience we can predict, probably succeeded in doing little other than stigmatizing sex workers, thereby increasing their vulnerability to infection and violence. There are many other examples of such damaging educational materials. A particularly common type is one that exploits a macho image of men to sell condoms. No amount of data on the increase in condom sales is going to convince me that such images are not damaging in the long run. Any gains achieved by such efforts in the short-term

are unlikely to be sustainable because they erode the very foundation on which AIDS prevention is based -- responsible, respectful, consensual, and mutually satisfying sex.

Approaches that Do No Harm

In comparison, gender-neutral programming is a step ahead on the continuum because such approaches at least do no harm. Examples include prevention education messages that are not targeted to any one sex, such as "be faithful" or "stick to one partner," or treatment and care services that make no distinction between the needs of women and men, not recognizing, for example, that women clients may need greater social support than men or that women might prefer female counselors and health care providers to male providers. While such gender-neutral programs are better than nothing, they often are less than effective because they fail to respond to the gender-specific needs of individuals.

Gender-sensitive Approaches

In contrast, gender-sensitive programming that recognizes and responds to the differential needs and constraints of individuals based on their gender and sexuality is another step forward on the continuum of progress. The defining characteristic of such interventions is that they meet the different needs of women and men. Providing women with a female condom or a microbicide is an example of such programming. It recognizes that the male condom is a male-controlled technology and it takes account of the imbalance in power in sexual interactions that makes it difficult for women to negotiate condom use by providing women with an alternate, woman-initiated technology. Efforts to integrate STD treatment services with family planning services to help women access such services without fear of social censure is another example of such an approach. We know that such pragmatic approaches to programming are useful and necessary because they respond to a felt need and often significantly improve women's access to protection, treatment, or care. But by themselves they do little to change the larger contextual issues that lie at the root of women's vulnerability to HIV. In other words, they are necessary, even essential, but not sufficient to fundamentally alter the balance of power in gender relations.

Transformative Approaches

Next on the continuum are approaches that seek to transform gender roles and create more gender-equitable relationships. The last few years have seen a burgeoning of such efforts. Two excellent examples of this type of intervention are the Men as Partners or MAP project being conducted by the Planned Parenthood Association of South Africa in collaboration with AVSC International and the Stepping Stones program. Both programs seek to foster constructive roles for men in sexual and reproductive health. The curricula for these programs use a wide range of activities -- games, role plays, and group discussions -- to facilitate an examination of gender and sexuality and its impact on male and female sexual health and relationships, as well as to reduce violence against women. What is novel about these programs is that they target men, particularly young men, and work with them and women to redefine gender norms and encourage healthy sexuality. These are just two of an increasing number of innovative efforts to work with men, women, and communities. There is an urgent need now to rigorously evaluate the impact of these and other creative curricula in the settings for which they were developed and to find ways to replicate their use on a larger scale.

There is also a need to find ways to intervene early to influence the socialization of young boys to foster gender equitable attitudes and behaviors. Recent research conducted by Barker (forthcoming) in Brazil suggests that one way to do this is to study the many adolescent boys who do not conform to traditional expectations of masculinity. By studying these "positive deviants," Barker was able to identify a number of factors associated with gender equitable attitudes among young adolescent males. These factors include: acknowledgement of the costs of traditional masculinities, access to adults who do not conform to traditional gender roles, family intervention or rejection of domestic violence, and a gender equitable male peer group. These factors underscore the importance of male role models, within the peer group and the family, who behave in gender-equitable ways. More such creative research on masculinity and its determinants is necessary in order to identify the best approaches to promote gender-equitable male attitudes and behaviors.

Other programs that seek to transform gender relations include efforts to work with couples as the unit of intervention, rather than with individual women or men. Couple counseling in HIV testing clinics to help couples deal with the results of their tests and in family planning programs that promote dual protection against both unwanted pregnancy and infection are recent examples of efforts that seek to reduce the negative impacts of the gender power imbalance by including both partners in the intervention. Some programs, however, have reported difficulty in being able to find and recruit couples who are willing to participate, although many couples who do participate describe couple counseling as a positive experience. Research is needed to identify ways to overcome the barriers to couple counseling and to test the effectiveness of this method in creating more gender-equitable relationships and in reducing vulnerability and stigma.

Approaches that Empower

And finally, at the other end of the continuum -- far away from programs that foster damaging gender stereotypes -- are programs that seek to empower women or free women and men from the impact of destructive gender and sexual norms. These are programs that empower women by improving their access to information, skills, services, and technologies, but also go further to encourage participation in decision-making and create a group identity that becomes a source of power – a group identity separate from that of the family because for many women the family is often the social institution that enforces strict adherence to existing gender norms. The Sonagachi sex worker project of West Bengal, India, is an excellent example of a project that sought to empower a community through participation and mobilization. What began as an HIV/AIDS peer education program was transformed into an empowering community organizing effort that put decision-making in the hands of the most disempowered -- the sex workers (West Bengal Sexual Health Project 1996). How can we replicate Sonagachi in multiple sites worldwide? What are the ingredients that contributed to its success in mobilizing and organizing a disempowered community? Without the answers to these questions Sonagachi will remain the exclusive exception rather than the rule.

In the ultimate analysis, reducing the imbalance in power between women and men requires policies that are designed to empower women. Policies that aim to decrease the gender gap in education, improve women's access to economic resources, increase women's political participation, and protect women from violence are key to empowering women. We now have two international blueprints--the Cairo Agenda and the Beijing Platform for Action--that delineate the specific policy actions that are essential for assuring women's empowerment. Since governments worldwide have committed to these blueprints, it would be useful for the HIV/AIDS community to join hands with the international women's community to hold governments accountable for their promises by ensuring that the actions recommended in these documents are implemented. Creating a supportive policy and legislative context for women is crucial for containing the spread of the HIV/AIDS epidemic and mitigating its impact.

Moving Ahead

It is clear that the sensitive, transformative, and empowering approaches to gender and sexuality that I have just outlined are not mutually exclusive. They must occur simultaneously and efforts should be made to expand the portfolio of options within each category. In this, as in other AIDS programming, we need a multipronged approach. We must continue to address the differing needs and concerns of women and men, while we work on altering the status quo in gender relations, in minor and major ways.

As we look to the future, let us be alert to the potential impediments to our success. Let us ensure that new, promising HIV/AIDS biomedical technologies, such as vaccines, which have the potential for making a substantial dent in the epidemic, are not impeded by entrenched gender barriers. Let us acknowledge that no biomedical technology is ever gender-neutral. To ensure equal access for all, women and men, girls and boys, we must work hard now, way before these technologies are ready for use, to identify the potential gender-specific constraints to their use and find ways to overcome them.

And let us work together to fight against two commonly held beliefs that continue to stand in the way of our efforts. The first mistaken belief is that empowering women will

disempower men. This is not true. Empowering women is not a zero-sum game. Power is not a finite concept. More power to one invariably, in the long-term, means more power to all. Empowering women empowers households, communities and entire nations.

And the second is the fear that changing gender roles to equalize the gender power balance conflicts with the value of multiculturalism and diversity. In point of fact, by changing gender roles what is being altered is not a society's culture but rather its customs and practices, which are typically based on an interpretation of culture. I believe that customs and practices that seek to subordinate women and trap men in damaging patterns of sexual behavior are based on a biased interpretation of culture that serves narrow interests. We know that the customs and practices associated with male and female roles and sexuality in many societies today are compromising the rights and freedoms of individuals and promoting a cycle of illness and death. This must stop. There can be no more powerful reason for change; gender roles that disempower women and give men a false sense of power are killing our young and our women and men in their most productive years. This must change. That is the message that must be communicated -- without any caveats, ifs, or buts. Thank you.

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