

SOCIETAL DETERMINANTS OF WOMEN'S VULNERABILITY TO HIV INFECTION IN SOUTHERN AFRICA

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Changing the underlying factors that influence risky sexual patterns is crucial to longer-term control of the epidemic. Many factors influence these patterns: employment, migrancy, poverty and the distribution of wealth and services; ethics, laws, and other safeguards for human rights; cultural and religious mores with their requirements and prohibitions; wars, civil unrest, violence and exploitation; existing demographic patterns and population structure; and environmental factors including droughts and other stressors. At the level of the individual, these factors are mediated through immediate personal experience, genetics, and personality.

Gender inequity in southern Africa cuts across many, if not all, issues, both in contributing to the spread of HIV and impeding prevention efforts, and in the coping responses to the epidemic. Gender inequity—essentially, the exploitation of women—is a fundamental human rights issue to which the AIDS epidemic adds a new, frightening dimension. Now, gender inequity only too often means that sexual relations actually kill.

On the Surface

The superficial parameters of sexual risk of HIV are well known. They include the seroprevalence of HIV in a given

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population; the occurrence of multiple sexual partnerships or someone having sex with another person who has multiple sexual relationships; the frequency of sex in risky partnerships; non-condom use; the presence of other STIs; and the nature of the sexual activity. These affect the probability of someone having sex with an infected person in the first place, and the probability of infection per sexual act. For example, recent research indicates that, when another STI is present, the HIV concentration in semen is eight times the level without a co-infection, greatly increasing the risk of infectivity per act of sexual intercourse. Other factors that may contribute to risk include male non-circumcision and sex during menstruation. Risk reduction can focus on minimizing the likelihood of risky patterns of sexual partnership and/or risk per sexual encounter.

Moving back one stage, this focus demands explanation of the factors leading either to risky patterns of sexual partnership or to increased infectivity and risk of exposure per sexual act. These two issues may be addressed in different but complementary ways, although the same human rights concerns underlie both.

Risky Patterns of Sexual Networking

The riskiest sexual networking patterns are those that create sexual bridges between individuals and groups with high levels of infection and individuals or groups with low levels of infection. A number of patterns can be identified with these characteristics. In much of southern Africa, two common risky patterns are:

- Many men having sex with a small pool of female sex workers. The sex workers rapidly become infected by their clients, thus infecting other clients who transmit the virus to their regular girlfriends and wives. Linked with this, many men may have a succession of short- and longer-term girlfriends, who may themselves have other lovers; this type of pool also constitutes a potentially high risk for infection.
- Where age disparity occurs. Commonly older men may have sex with younger women, thus transmitting the virus from an age cohort with high levels of infec-

tion to age cohorts that may still have low levels of infection.

These risky partnership patterns are, in part, a response to poverty, migrancy, the separation of spouses, and related concerns; however, a fundamental issue is gender inequity. In complex ways, gender inequity is essential for these patterns to continue. If female and male sexual choice and pleasure are valued and respected, and if there is equal (and adequate) access to education and economic independence, it is difficult to envisage how these partnership patterns could continue, at least on a wide scale.

Infectivity: Risk per Sexual Act

The level of infectivity varies according to viral load, which is high soon after infection, before a strong antibody response has developed; later in the infection, when immunity is becoming impaired; and when other sexually transmitted infections are present, particularly (but not only) those causing genital lesions.

In Africa, most people do not know that they have been infected at all, let alone when, and few have access to the more sophisticated tests needed to monitor the evolution of HIV infection. Therefore, they are unaware of their own or anyone else's infectivity. Further, some studies suggest that the subtypes of virus common in Africa may have particularly high infectivity through the heterosexual route, although the evidence is not conclusive.

Risk of transmission is also increased through any activity that risks abrasion or tearing of sensitive membranes, for instance, when the sexual act is aggressive, involves anal intercourse or dry vaginal sex, or involves a teenage girl whose genital tract is not yet mature, or any female with an intact hymen.

What factors lead to the likelihood of sexual acts of higher infectivity? Again, gender inequity is a major concern in addition to poor access to health services and poor standards of health in general. In situations of unequal gender relations, rape, with high risk of transmitting infection, is not only commonplace, but often not taken seriously. For example, a debate has recently developed in Zimbabwe over whether date

rape exists. Young men have expressed the view that, if they are with a girlfriend and they want sex, they have to have it, so rape does not apply. As any self-respecting woman would struggle anyway, "no" is a sign of good upbringing, not a meaningful refusal to have sex. Likewise, rape is not a recognized offence within marriage.

Statistics from a number of countries show a rather extreme attitude. In Swaziland, for example, rape cases are rarely reported because women are typically blamed for the attack, and their word rarely believed without (male) corroboration. When rape is reported, the outcome is almost always acquittal or, at best, light sentencing. Although rape is common, the records for 1991, for example, show that only 243 men were charged and, of these, 208 were acquitted.

The fairly wide occurrence of dry sex in much of southern Africa (and further north) is another likely aggravating factor for HIV transmission. A woman may be viewed as more desirable if she has a dry, hot, tight vagina, achieved by the insertion of herbs, cotton wool, and various abrasives. Not just the physical sensation of increased friction is implied, but complex psychological interpretations and associations. The woman feels to the man more like a virgin, and he is thus in the simulated role of being her first lover; this implies she has never "belonged" to anyone else, she is his property. More pernicious are the implications for her sexual arousal. Non-lubrication means that the woman is not sexually aroused, this being the primary female response to sexual pleasure. Hence the sexual act may become something for male sexual pleasure alone, something he does *to* a woman, not *with* her for mutual gratification. This comes disturbingly close to the rationale for female genital mutilation (FGM). Most forms of FGM are likely to remove the possibility of female sexual arousal once and for all; the use of drying agents and lack of foreplay merely do it temporarily. The woman gains by being seen as clean, but she loses out on pleasurable sexual experience, and is viewed as a conquest; in addition, the risk of HIV transmission is likely to be increased.

Denial of female sexual response and pleasure is a major barrier to be overcome. Many men may not actually know the signs of female arousal, nor about female orgasm. Women

may be equally ill-informed about their bodies and may not feel entitled to pleasure, particularly given cultural norms and the breakdown of traditional systems of educating the young.

Marriage and Condom Use

Married women are a highly vulnerable category in much of southern Africa. Their risk stems primarily from their husbands' extramarital sexual activity rather than from their own. Yet the association of condoms with distrust makes it more difficult to initiate their use in this, the most sacrosanct of unions, than in any other. Data show that men use condoms most with sex workers, less with girlfriends, and least of all with their wives, however much they (as males) have been at risk of infection.

For the churches, whose primary prevention strategy is most often abstinence before marriage and fidelity within it, a serious dilemma arises. They need to face the reality that, as the majority of their congregations tend to be women—and women typically are more responsive than men to messages concerning health because of their role of caregiver in the family—this message is tantamount to a death sentence. How many girls grow up “saving themselves” for marriage, only to be infected as soon as they tie the conjugal knot? How many married women are consistently faithful to their husbands, even when they know their husbands have affairs, and still cannot insist on condom use?

Implications for Policy and Programs

The above discussion has highlighted some critical considerations for policy and programs for HIV prevention. These indicate the need for a central focus on gender inequity in all policies and programs, not just direct HIV or STD prevention, but in all development work. Action towards a more gender-sensitive and equal environment will help promote changes in specific risk factors, impacting both sexual partnership patterns and infectivity. Short-term and long-term responses are each required, with strategies that honestly question and challenge existing social mores as well as economic pressures nationally and in the region.

More specifically, a number of priority areas of activity may be identified. Cultural traditions and practices that promote high infectivity or risky sexual partnership patterns need to be transformed, particularly the social acceptability of multiple partnerships for men with no responsibility for health consequences, and the sexual degradation of women in its many forms. Attention must also be paid to the development and effective marketing or distribution of female-controlled protection, both female sheaths and microbicides, in culturally acceptable, affordable, and safe formulations. In order to move forward, efforts are needed to ensure that churches, governments, non-governmental organizations, and other players recognize the limitations of current prevention strategies. They need to explore openly and objectively how best to meet the needs of the most vulnerable—particularly married women and the young. Finally, better collaboration is needed between key players, notably those working in family planning, HIV prevention, and STD treatment and control, to ensure that their combined efforts are mutually complementary and optimally effective.

Many other issues could be also cited, but the central concern must be for strategies to develop human or social capital with, of necessity, particular emphasis on developing the potential of women and protecting their human rights. The sooner this can be recognized and acted upon as a central goal of development for all, rather than as a polarizing of the sexes, the sooner meaningful progress may be made not only towards gender equality but towards curbing and coping with the AIDS epidemic itself.