

Gender, poverty and intergenerational vulnerability to HIV/AIDS

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'Poverty is the major assault on humanity.'

Nelson Mandela, closing speech, International Conference on HIV/AIDS, Barcelona 2002.

'After the death of her husband, the wife now has the problem of looking after the family: looking for food, paying school fees, and finding money for treatment when children fall sick. A lot of money was spent in treating him. The wife even had to borrow money. Now they are in debt.'

A woman speaker from Kibaale, Uganda (Oxfam 1998).

HIV/AIDS is one of the major obstacles to achieving the 2015 development targets in Africa, where it is now the leading cause of death. Women's limited economic options, and relative powerlessness, may force them into sex work in order to cope with household economic crisis. This exposes them to HIV infection and they in turn will transmit HIV to their clients. Young girls are particularly vulnerable to HIV infection, because of intergenerational sexual relationships, violence, and limited access to information. In addition, discrimination and stigma obstruct young girls' access to health services. Poverty causes increased migration to look for work. In some contexts, such as in Southern Africa, it is men who migrate, while in others such as Central America and Nepal, it is women. Migration increases the risk of infection to both the partner who leaves, and the partner who stays behind.

This article looks at HIV/AIDS, poverty and gender, and focuses on young girls and old women. It starts with some basic facts about HIV/AIDS, and then provides a framework for analysing vulnerability to the infection and to its impact, in relation to gender and age. It briefly outlines institutional responses, and ends up with conclusion and recommendations for development planners to combine gender and age analysis in any development or humanitarian work.

HIV/AIDS, gender and age

Traditionally, development programmes have tended to focus on men and women of reproductive age as the prime target for community projects, since this age is also the age at which people are at their peak of economic productivity. However, HIV/AIDS is leading to demographic changes and changes in the traditional roles and responsibilities of different age groups. These changes are forcing development planners to re-think their response to poverty. The demographic shift has also meant they have to re-think their response to gender inequality.

Gender analysis, in relation to HIV/AIDS, has tended to focus on women of reproductive age, and occasionally on young girls, because of their role as mothers for future generations. The HIV/AIDS epidemic has been fuelled by gender inequality. Unequal power relations, sexual coercion and violence is a widespread phenomenon faced by women of all age-groups, and has an array of negative effects on female sexual, physical and mental health. HIV/AIDS infection reveals the disastrous effects

of discrimination against women on human health, and on the socio-economic structure of society.

Vulnerability: girls and older women

New studies reveal extremely high levels of infections among young girls, which are higher than those for boys. This is mainly because of the fact that at young age, boys have sex with girls of similar age, while girls have relations with older men, who are more likely to be infected (Gregson et al. 2002). Sexual harassment of schoolgirls by older men contributes to the fact that HIV infection in South Africa starts, and AIDS peaks, five years earlier in young women than young men (Jewkes 1999). Poverty drives many girls to accept relationships with 'sugar daddies' (older men who are prepared to give money, goods or favours in return for sex).

The unequal power relations reflected in such relationships affect adolescent girls' ability to refuse unsafe sex, and expose them to sexually transmitted infections, including HIV/AIDS. Fear of sexual harassment by teachers, which may result in unwanted pregnancy, was cited as one of the factors that induce parents to stop girls' education (Oxfam GB 1998).

In order to avoid infection, some men want to have sex with young girls because as virgins they are free from the infection. The age at which a young girl is likely to be a 'virgin' is decreasing, resulting in girl children subjected to sexual violence. There is a prevailing myth in some South African cultures and elsewhere that sex with a virgin cures HIV/AIDS. It is worth remembering that in the Dark Ages of medieval Europe, a similar myth prevailed in relation to syphilis and gonorrhoea.

Violence against girls has recently been recognised as widespread phenomenon worldwide. UN agencies such as WHO, NGOs especially those concerned with women rights and the research community are raising concerns about this issue as reflected in the recent have been raised (WHO 2000, Jewkes 2002, Watts and Zimmerman 2002). Violence against women seems to increase in times of conflict and wars. Conflict can cause rapid social change, large numbers of refugees and displaced women and men, and the breakdown of social norms. Rates of coercive sex, sexual violence and HIV and STD infection are magnified and accelerated by conflict. The scale of violence against young girls during conflict situations is not known, but they are at particular risk, and face not only rape and sexual violence, but also the social rejection and punishment which often follows.

There are almost no statistics on the prevalence of HIV/AIDS among elderly women and men (UN 2002) This neglect also reflects the stigma attached to HIV/AIDS, and the denial of the sexual health needs of older people by the research community, including funders and policy makers. The vulnerability of older women as regards their relative inability to make decisions about the kind of sex they have (in particular, whether condoms are used), has not been widely studied. Neither has the prevalence of sexual violence against older women. More widely, the sexual health of older women especially in developing countries has been largely ignored, because reproductive health professionals have historically focused on the maternal role of women, rather than sexual and reproductive health as this relates to their age. Because young women are the mothers of the future, policy-makers are interested in their health. However, reproductive health of older women does not affect the health of

children, and therefore it is commonly ignored by health policy makers. There is also an implicit denial of sexual activities and hence sexual health needs of older women in many societies, as if they finished their reproductive functions once their child-bearing years are at an end.

Stigma and its impact on vulnerability

HIV/AIDS still carries with it huge stigma and discrimination. Fear and denial are common, because if you are in a country where you cannot access treatment without huge expense, testing positive is a death sentence. Older parents of AIDS sufferers are sometimes too frightened of the reaction of their neighbours to disclose that their children were sick or died because of HIV/AIDS.

The sexual health needs of young girls and older women are generally ignored, since they fall beyond the realm of maternal health and family planning. Access to information, and treatment for other infections which facilitate the transmission of HIV and onset of AIDS, including sexually transmitted infections, are limited because of weak public health services, health workers' negative attitudes, and the high cost of treatment.

In many places, people from groups associated with high incidences of HIV infection – including injecting drug users, men who have sex with men, and commercial sex workers - are subjected to a culture of fear and punishment when their HIV status is suspected. In some societies, women in general are blamed for transmitting HIV to men. Even if the husband gets sick and dies first, the widow could be forced to abandon her house and land because of such blame. The very young and the very old among these groups are particularly vulnerable to the impact of stigma and abuse, since their age means they have less power to resist.

Given the stigma of sexual violence, which can be very severe for survivors, and women's generally low status and voice in society, it can be difficult for women who fear having contracted HIV through sexual violence to access information, let alone demand treatment. It is possible to reduce the transmission of the HIV virus after exposure to it, through short-term treatment with antiretroviral medicines which inhibit the reproduction of the virus at the early stage of infection. Access to the medicines for rape survivors is not guaranteed in most developing countries. The drugs are very expensive, even if they are only used for the short period they are needed after exposure to HIV, because they are patented in many countries. This makes them beyond the means of anyone in poverty. There is strong public pressure in some countries, for example South Africa, for the government to provide such medicines free to rape survivors. Developing countries' governments can and should use mechanisms to override patent laws and make cheap generic medicines available free, or at an affordable cost, for rape survivors and for persons infected with HIV in general.

Stigma and vulnerability affects particular groups of men as well as women. Although men generally have more access to information on sexual issues than women, and more decision-making power regarding sexual behaviour, young men may not be able to access information on same-sex sex, or have enough power to resist or negotiate sexual relationships with older men. This may be the case with young boys who assist truck drivers on long journeys, or young offenders in prison.

At national level, whole communities and even political leaders may go to the lengths of denying the existence or significance of HIV, in order to avoid the necessity of facing its terrible consequences, or the costs of mitigation, prevention and treatment.

Vulnerability to the impact of HIV at household level

'I spend most of the time in hospital, I cannot do my garden because I have to attend to the sick patient so we end up harvesting a little.'

(Oxfam 1998)

Discrimination inhibits people, especially women, from revealing their status and taking action to stop further transmission. The cost of health care deters poor women from treating infections. Young girls and older women are often the last to seek health care, and the ones who care for sick members of the family, especially when the health system fails them. Oxfam's research in Uganda showed that men used private clinics to treat sexually-transmitted diseases, while women used traditional healers, who may not provide effective treatment (Oxfam 1998).

Growing poverty in many developing countries, particularly in sub-Saharan Africa, is exacerbated by the impact of HIV-related illness on young and middle-aged adults in the household, who are normally the breadwinners. AIDS-related illnesses have enormous negative impact on the social economic structure of the households, communities and societies in general. This exacerbates existing poverty and gender inequalities. The sickness of the main breadwinner adds the burden of care to the workload of women. Sooner or later, they are likely to become sick themselves. Frequent and long episodes of sickness also deprive the family of their means of production – for example, they are unable to tend the land. Lack of money because of inability to work further limits people's access to health services, and a vicious circle of illness and poverty develops, in which families sell their assets, borrow money and go further down the hill of poverty.

Lack of access to health services and underfunding of services prohibits poor people from accessing other medicines which treat infections associated with HIV. Treatment of TB, opportunistic infections can prolong and improve the quality of life in the earlier stages of the HIV infections in absence of the costly antiretrovirals. Children, especially girls, are pulled out of school to help with the household work, caring for ill members of the family, and earning income for the family. They may adopt risky behaviour, for example exchanging sex for money or resources, as a last resort to bring in much-needed income.

To summarise, when individuals are infected, a chain of impacts on household follows:

ADD VISUAL HERE

Looking after the orphans

'The orphans are helpless - nobody takes care of them.'

(Participant in Oxfam research in Uganda, Oxfam 1998)

A major challenge for both the very young and the very old is the huge problem of caring for the orphans left behind after their parents die of AIDS. UNICEF estimates that there are currently 14 million children who have lost their mother and/or father to the epidemic.

Grandmothers often become the primary carers for these children. Traditionally supported by their children, grandmothers are instead becoming burdened with new roles including caring for their sick children and grandchildren, and bringing up grandchildren who are orphaned. This necessitates that they earn income, and/or work on the land to produce food for the family. Often ill-equipped to take on extra physical burdens of work, old women also have to face social stigma if they are suspected of looking after an HIV-infected person. As the disease takes hold of their children, their own social networks may break down, leading to more isolation of the caring women, and begging the question 'who cares for the carers?'

In some cases, orphaned children do not have relatives to look after them, and have to fend for themselves or look after each other. It is not uncommon in epidemic areas to have households headed by children. The girl tends to take on the traditional woman's role of producing food (earning income, or working on the land) and caring for other children within the household. The premature death of their parents leaves many children without the knowledge or skills they need to make a livelihood. They face the future without education, work training, or the many critical skills they would learn from their parents themselves. Many children, including migrants from rural areas, end up in the street, where they are exposed to risk including drug abuse, sexual abuse, violence and commercial sex: In turn, this way of life makes them susceptible to HIV infection, and increases their poverty.

Institutional responses

To date, government and NGO response to HIV/AIDS has focused mainly on three types of work: community mobilisation for prevention through the promotion of fidelity, condom-use and abstinence; advocacy on access to affordable treatments, targeted at medicine producers and international trade bodies; and work to 'mainstream' support to AIDS-affected individuals and communities into poverty alleviation work. The link between poverty, gender inequality and HIV/AIDS has led institutions of many different kinds – including government, NGOs of different sizes, United Nations bodies, and development donors - to talk about mainstreaming gender and HIV/AIDS together into development and poverty-reduction strategies.

Strategies for prevention

Campaigns to raise awareness on HIV and AIDS have to go beyond the simple message of using condoms, and address deep-rooted gender inequality (Doyal 20**) which exposes women to risks which are beyond their control.

In prevention strategies, young girls do appear as a target group. The education sector, and schools in particular, is often a prime target for HIV/AIDS prevention programmes, via sex education and knowledge of condom-use. However, this approach is defective because of the fact that many young girls are not in school to start with. In addition, health education programmes which aim to empower women and girls to use condoms often fail adequately to tackle the real problems with

unequal power relations (Kuo et al. 2002). In addition, the desired changes in the behaviour of young girls and boys cannot happen without programmes addressing such underlying power relations not only in empowering girls to say no, but also in empowering boys, teachers and other adults to respect the human rights of girls.

For example, health and education sectors can work together to develop prevention programmes in schools which enhance awareness of gender inequality among boys and school staff, as well as girls themselves. Such programmes need to expand beyond the school boundaries, to reach girls and boys who do not attend school. This could reduce girls' continuing vulnerability to violence, coercive sex and HIV infection.

Access to affordable treatments

The health sector in all HIV-affected countries, and donors, need to acknowledge that access to treatment is a crucial element in responding to HIV/AIDS especially in terms of decreasing the stigma and encouraging behaviour change which decrease the vulnerability of women at all ages.

Access to affordable treatments provides 'hope for the future', as stated by Nelson Mandela in his closing speech to the Barcelona conference. As stated earlier, most poor people in developing countries are denied treatment because of the high prices of medicines and the under-funding of health services.

Advocacy on the need to ensure affordable access to antiretrovirals for all pregnant women, to prevent mother-to-child transmission, has resulted in a number of national programmes around the world, including in Thailand and Botswana. However, beyond stopping transmission, treatment for mothers does not seem to be on the global policy agenda. Yet such treatment can prolong life. From a socio economic point of view, access to treatment for mothers would decrease the number of orphans, and enable children to grow up with parental care. However access to treatment should extend to cover fathers with HIV, and all others who need treatment. The example of Brazil, which provides three treatments to those who need it, demonstrates the cost-effectiveness of this approach in improving quality of life and productivity of infected people. In addition to halving the mortality from HIV and AIDS, the government managed to decrease the cost of health care in terms of cutting on hospitalisation. The net result has been economic gain, as well as adherence to human rights to access to medicines and health-care.

The fact that taking treatment can prolong life would also give men and women a motive to submit to voluntary testing and counselling, and might change their behaviour to reduce the risk for themselves and for others. For example, awareness/prevention programmes, which include treatment, may stop older men from sexual violence against young virgin girls and infants if they know they can get properly treated. The Barcelona conference emphasised beyond doubt that prevention and treatment are crucial elements of one strategy to respond to HIV AIDS. Prevention efforts without treatment causes death, increases stigma, and hence increases transmission. On the other hand, treatment without prevention could lead to risky behaviour; evidence for this is emerging in some developed countries. UNAIDS and other concerned groups working on HIV/AIDS, including many NGOs, are advocating for a continuum of care approach which covers prevention, treatment, care

and support for those infected and affected by the epidemic. Such an approach provides a coherent and effective response to the HIV/AIDS epidemic. Treatment could also play a crucial role in decreasing the stigma and discrimination attached to HIV/AIDS.

'Mainstreaming' support to HIV-affected people

Mainstreaming is a process by which the institutional capacity to deal with HIV/AIDS epidemic is enhanced in terms of mitigating the impact of the epidemic on the populations with whom they work, and within their own institutions.

Policies and programmes have to develop responses to the impact of the epidemic on the development process, bearing in mind the demographic changes which result from AIDS-related sickness and death. For example, traditional agricultural extension programmes train men or women farmers of reproductive age. In the era of HIV and AIDS, these programmes have to go out of their way to encourage participation of the very young and the very old, and respond to their needs. This may necessitate the development of new methods of agriculture, as well as new methods of community outreach. For example shifting to labour-saving techniques would enable the old and the young to farm.

The education sector needs to respond to the fact that children, particularly girls, are even less likely than before the HIV/AIDS epidemic to be able to stay in school long enough to acquire skills for the future. Flexible schools, enabling girls to combine looking after younger siblings with productive activities with education, can provide skills training as well as conventional education to ameliorate against the impact of HIV/AIDS.

Development organisations also have to look at the impact of HIV/AIDS on their own sustainability and survival. Whether the institution is a government department at the district or national level, or an NGO, or a donor agency, they all face HIV/AIDS as employers. They must address staff problems in terms of sickness, absenteeism, high cost of treatment, low production, and the impact of stigma and ostracism on staff, which may be worse for women.

Conclusion

In many developing countries, poverty, and inequality between women and men, are both strongly linked to the spread of HIV/AIDS. Gender and age analysis shows the ways in which women and girls of various ages are vulnerable to the infection, and in need of support to enable the survivors to overcome the economic and social effects of the epidemic. In responding to HIV/AIDS and poverty alleviation strategies are interconnected. Therefore health and development workers need to work on holistic policies and programmes to reduce poverty and address HIV/AIDS. For example, poverty leads women into unsafe sexual encounters, and speeds the onset of AIDS-related illnesses. Violence against women and girls is aggravated in societies where high instability or conflict exists. All these factors contribute to the fact that there are more females than males newly infected every day. They also result in women being likely to contract HIV and fall sick with AIDS at a younger age than men.

At the other end of the age spectrum, the burden of caring for the sick and orphans is gradually falling on grandmothers, who are not socially supported to carry this load. Many of them are not physically fit enough to care for themselves and their young dependents, and some of them will have HIV themselves. Neither the sexual health of older women, nor their socio-economic needs as family carers, tend to figure in HIV-prevention or poverty-alleviation programmes.

Development agencies and policymakers have not yet fully taken into account the demographic changes of HIV and AIDS, although there is a growing awareness of the critical need to do this. Combined gender and age analysis is a necessary step to help development agencies and institutions to design policies and programmes which decrease vulnerability to the epidemic, and mitigate against its impact on health and livelihoods.

The Barcelona conference mobilised political commitment at high level to the need to address HIV/AIDS in a comprehensive way. Continuum of care approach needs commitment and enough funds to provide prevention, treatment and care for infected and affected people. Strategies to decrease gender inequality and address the different needs of the diverse groups infected and affected by HIV/AIDS are urgently needed. The donor community was urged to provide the massive funding needed to address HIV/AIDS. Governments of developing countries are also urged to make political and funding commitments to mobilise a wide response to the epidemic.

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Endnotes

1 Except where indicated, all figures in this box are from 2001 UNAIDS report

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