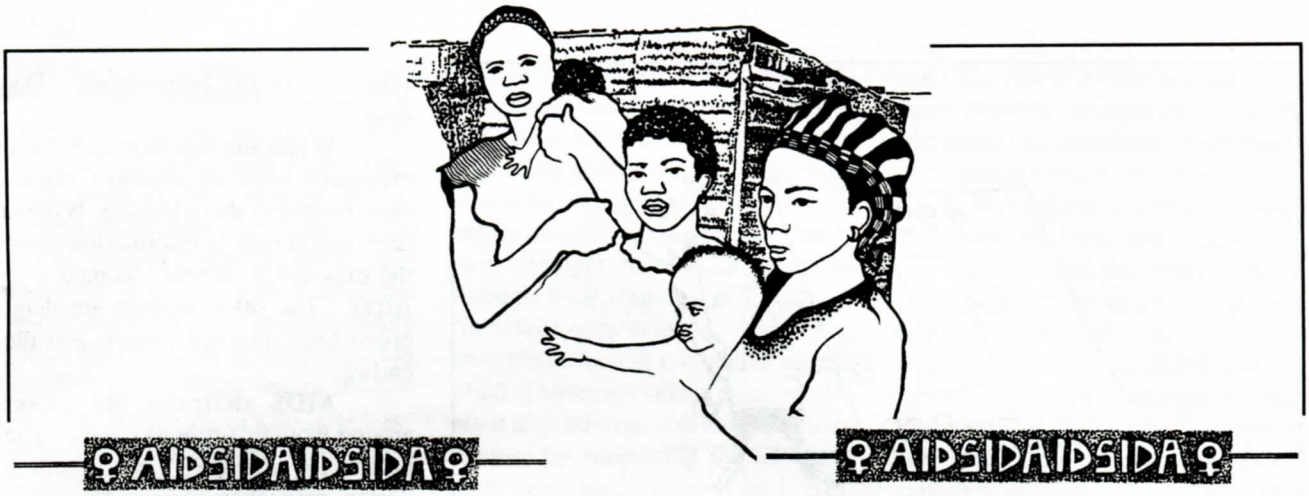


*Emerging Design*

# Aids and the Worldwide Community of Women

In much of Africa, parts of Latin America, in Eastern Europe, the Eastern Mediterranean, Asia and most of the Pacific, as many women have AIDS as men. By the end of this decade half of all people with AIDS will be female. Currently at least three million women worldwide are infected with HIV (the virus that leads to AIDS) and by the end of this year 600,000 women will have AIDS.

For women and men AIDS is more than a health issue. AIDS has severe economic, social and human rights consequences for all individuals. Women, however, are especially susceptible to the adverse affects of AIDS because legal and social status is not shared equally between men and women. Women worldwide have an insecure economic position, families and societies still put women at risk of violence and, on the whole, women are still expected to occupy roles that are subordinate or submissive - our position in society complicates our experience of AIDS!

In countries where the majority of AIDS cases are occurring between heterosexual men and women ( as well as in countries which fear the spread of AIDS into the heterosexual population), a clear message is coming through to women: get your partner to wear a condom.

The message is necessary, but limited and limiting! Part of the problem with the message is that it denies the realities of the lives of too many women around the world, and the extent of power that women have or do not have in economic, social and political structures. (Are personal relationships not a reflection of these structures?) These structures are reflected in State laws which contravene the rights of women. State laws still exist that deny women the right to own property, limit women's rights within marriage, deny custodial rights to children, and deny the opportunity of equal access to public life, education, literacy, training, full employment, and health care. Economic dependence on men is still institutionalized; submissive behavior in social and sexual matters and the ability to produce children are often women's only means to an economic base in many societies. This economic base is only available through marriage.

Yet marriage offers no protection against AIDS for women. Indeed, it is suggested that in most cases of AIDS among women, HIV is passed from husband to wife:

"More and more studies from Africa, Latin America and other regions of the world with high rates of heterosexual transmission of HIV indicate that the major risk factor in married women, and their children, is the pre-marital and extra-marital sexual activity of their husbands." (3)

For many women, to insist on condoms or to try and limit the sexual activity of husbands is to invite scorn or even rejection from the household. In turn, exclusion from family and marital support means that economic survival sometimes only comes through marginalised and poorly protected employment such as prostitution. This is particularly the case in developing countries where there are no income security provisions - and women are worst affected by AIDS in those countries.

Women at high risk of exposure through sex work also have less power to insist on the use of condoms. Sex tourism, "associated as it is not only with the power of men from rich countries over poor women in developing countries", adds complexity to


the pattern of development of AIDS amongst women worldwide. (It should be stressed that in Australia sex workers have extremely low rates of HIV infection, especially when they have no prior history of intravenous drug use.)

Condoms, of course, have less relevance for women at risk due to other women's health issues. Childbirth and anaemia in countries whose health care systems are too poor for full blood screening still put women at risk through blood transfusions. Women who have been genitally mutilated may have increased exposure to HIV through lesions or skin breaks on the vulva. And , of course, women worldwide who are raped have no control over safe sex practices!

The precise number of AIDS cases among women is unknown because of little funding for research on women and AIDS. What is known, however, is that in general women lack access to basic health care in many parts of the world, and have unequal access to quality health care just about everywhere. Perhaps it is not surprising then that women with AIDS are not getting the care they need!

"Within the context of AIDS care, there is a growing recognition that women are not receiving equal medical treatment to that provided for men, both in respect to access to drugs and chemical trials and to hospital beds." (4)

Discrimination against women at the broadest level is felt most keenly by women who are ill. When that illness is AIDS, the consequences can be devastating:

"The impact of HIV and AIDS is a lot greater on women than on men - death is likely to occur even earlier because of the many physical, psychological, and socio-economic stresses and strains on women." (5)

And there is also little understanding of just how HIV works in women's bodies. The clinical model of AIDS has been developed through the experience of industrialised countries where the main groups experiencing the virus have been men. The model puts an emphasis on symptoms such as Karposi's Syndrome (KS) which women very rarely get. The model neglects the prevalence of cervical cancer being experienced by women who get AIDS. Other symptoms that women have include the sort of gynaecological symptoms that are too frequently written off as "women's problems" - vaginal yeast infections, vaginal discharges, changes in menstrual cycles, hormonal changes or hot flashes, and increased occurrences of Pelvic Inflammatory Disease.

While the research and documentation neglects women's experience, treatment also is lacking. Women have less access to information about the experience of other women with AIDS. Too often women are diagnosed later, ignored longer, and die earlier.

AIDS sharpens the issues around women's role as carers. The prospect of passing HIV on to children during pregnancy creates a massive dilemma for women, especially where there is no easy access to contraception or where practising contraception denies women access to the social and economic status of motherhood. In many urban areas of central, eastern and southern Africa there is a high rate of HIV infection amongst pregnant women:

"As of late 1988, over 100,000 HIV-infected infants (roughly half of whom are girls) may have been born in Africa since the start of the AIDS pandemic and this number will continue to increase over the next decade". 80% of these infants will develop AIDS before the age five. (6)

Society's response has been one of censuring women who are HIV antibody positive from bearing children - at the expense of women's reproductive rights, women's right to become carers!

Yet the role of carer of others (partners, children, parents) can also be a hard labour for women with AIDS. The role is an ongoing one, even if a woman is ill. When a woman with AIDS knows that, should she die, her child will be at risk of being on the streets, it is a fearful stress. Additionally, the work of nursing other HIV infected members of the household can place huge strains on the woman's own immune system when it is already under attack. Social and medical responses to women's needs are sorely lacking.

Beyond these issues for HIV infected women who are also carers,

there are broader ramifications for all women, and particularly for those in developing countries where AIDS care resources are abysmally inadequate. First, there is the expectation that women will provide nursing care, usually in an unpaid capacity, and this use of labour is never debited from the 'public health' budget. Secondly, when public health resources are redirected to AIDS care it often leaves women with less access to general health resources from which they can draw support in their role as carers.

Women traditionally have taken on the job of being gatekeepers for the health of society. We're good at it - and the experience may save us in the long run. Certainly many AIDS education programs at the international level focus on women as the major vehicle for the prevention of AIDS. Yet there are long term dangers if this role is foisted on us (and immediate dangers if we reject it out of hand). Already we have seen this pattern developing in the area of responsibility for contraception and family planning - with little liberation from the costs of responsibility despite the ongoing complaints of the international women's health movement over a very long period of time. The comparison is clear:

"Reliance on women as the primary source of health education overlooks the equal responsibility of men for the prevention of AIDS".(7)

The way this generalised responsibility is reflected in attitudes against particular women is clear. Prostitutes, for example, have been 'blamed' for the spread of AIDS:

"All too often, programmes to reduce the spread of AIDS through prostitution focus on prostitutes as 'vectors of disease', thus failing to recognise the role of clients in spreading HIV, and the risk this poses to prostitutes themselves - as well as to the other sexual partners of the clients." (8)

A specific consequence to women sex workers in some countries is that they are being forcibly tested, officially registered and made to submit regular health check-ups. In Australia there has been discussions about subjecting people with HIV to legal sanctions should they continue their employment as sex workers. Clearly any attempts to control infection through legal restraints is dangerous for whole populations. When legal controls reflecting prejudices are applied to women working as sex workers it also reinforces divisions among women by supporting the idea that there are 'good' women and 'bad' women in society. At a broad level there is the covert suggestion that sexually active women are 'bad' women, thereby subtly reducing sexual options for all women.

Some women are also concerned that fear of contagion may lead to increasingly younger marriage ages for women in some cultures; reducing the marriage age will be seen as ensuring that a new 'bride' is 'clean' of infection at the onset of marriage. In countries where it is current practice for girls as young as 15 to marry, the prospect of even earlier marriage has health consequences for women's bodies.

A simplistic focus on women's preventive role is dangerous because it comes all too close to an erroneous belief that we are all responsible for the spread of AIDS. It has the potential to subject us all to division, as women, and the risk of increased social control. The risk is greater and the costs more possible because of the depth and spread of traditional discrimination against women worldwide.

Nevertheless, women worldwide have not been just passive victims of the AIDS pandemic. Many strategic policy developments as well as AIDS support and education services have been spearheaded and informed by women. Models for the successful containment of AIDS have been based on analyses and processes explored and adapted by the Women's Liberation Movement in the late '60s and '70s. These processes include consciousness raising, self help and support amongst peers in creating positive changes. They are strategies which have worked within particular communities at risk of AIDS, and need to be included (and resourced) in the development of prevention programs at the broader level.

The reality of AIDS and the work required to contain it demands of us the ability to insist that the focus of campaigns is broadened to include highly political issues. These issues include the relationship between women and development, poverty and prostitution, the causes of intravenous drug use, the acceptance of terminally ill people within our community, the advancement of women's status worldwide and, ultimately, the equality of power in personal relationship between men and women. Above all, any pre-


## Harare, Zimbabwe: HIV/AIDS Crisis Centre

The Mashambanzou T-shirt (left) was produced to raise money for the HIV/AIDS Crisis Centre of the same name in Harare, Zimbabwe. (Mashambanzou means "time of day when elephants wash themselves" or "dawn of a new day".) The drop-in centre was instigated a year ago to meet the needs of people with AIDS living far from their families. The centre already produces its own vegetables and can provide free clothing. It will be run by two paid workers and offer advice, a support group, workshops, dance and theatre projects, while long-term plans are to provide weekend care or temporary accommodation for people with AIDS.

*Source: AIDS Watch, 1991 2nd Quarter. For information, write to: IPPF, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, UK.*

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vention programs aimed at women in the heterosexual community must address the fact that sex is a social process. Norms of sexual behavior reflect this social process and it's not good enough to tell women to encourage their men folk to wear condoms to make them feel safe.

What feels safe to women is the possibility of a different kind of sexuality - one that reflects the expression of an equal relationship, not just at the personal level between two people, but within society as a whole. If the current experience of women with AIDS sets us back further on the global agenda of advancement then AIDS is not our only risk. A consciousness of the impact of AIDS on women internationally is an essential element in the challenge to halt the victimisation of women.

**Footnotes:**

1. J. Hausermann, *The Effects of AIDS on the Advancement of Women, Rights and Humanity,* February, 1989.
2. J. Hewett, "Half want AIDS sufferers quarantined, survey finds", *The Age,* 1991.
3. J. Hausermann and R. Danziger, *Women and AIDS: A Human Rights Perspective,* Paper presented at VII International Conference on AIDS, Florence, June 1991.
4. Hausermann and Danziger, June 1991.
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6. Hausermann, June 1989.
7. Hausermann, June 1989.
8. Hausermann and Danziger, June 1991.

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J. Mulemwa, *Women and AIDS: Theoretical Overview and Strategy Initiatives,* 6th International Women's Health Meeting, Manila, 1990.
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*Source: Contraception and Health, Inc. Newsletter, October 1991. c/o Women in Industry, 83 Johnston St., Fitzroy 3065 Australia.*