# Women, Poverty and HIV Infection

**BY JUNE LARKIN**

*L'auteure examine le genre chez les porteurs du virus SIDA à travers la violence faite aux femmes et les inégalités sociales. Elle attire notre attention en particulier sur le fait que la pauvreté et les inégalités selon les sexes font que le nombre de femmes victimes du SIDA est en progression constante dans le monde. Pour les femmes pauvres, le Sida est un risque de plus parmi la longue liste des dangers qui menacent leur survie.*

I was introduced to the gendered face of AIDS/HIV through my work with South African teachers and learners. As a collaborator on violence prevention programs for South African schools, I was confronted with the force of the AIDS epidemic and the gendered impact of the disease. The HIV incidence rate among South African girls is three-four times higher than boys (Brown) and, world wide, four-fifths of all infected women are African (UNAIDS 1999)

In South Africa, the legacy of violence that underpinned the apartheid state has led to extremely high levels of violence across the country. A history of oppressive political practices has embedded violence as a normal part of gendered relations (Human Rights Watch). The high incidence of rape in South Africa has been linked to the rapid spread of the HIV virus, particularly in females. Our program on gendered violence had to highlight this crucial link. Dealing with sexual violence is considered a key factor in the fight against AIDS.

The connection between AIDS and gender violence is not limited to the African context. Sexual violence is a problem for women worldwide although women's vulnerability to HIV infection varies. The disease has struck most severely in countries struggling with a crumbling infrastructure inherited from colonial rule. In the developing world, the collapse of local economies has resulted in conditions that increase the risk of HIV infections such as landlessness, an increasingly migratory labour force and rapid urbanization (Simmons *et al.*). In these harsh conditions, women have suffered disproportionately through their exclusion from the formal cash economy. The reduction of health care services through the imposition of austere structural adjustment programs has off-loaded the burden of AIDS care to women for whom economic survival is already a full-time job (Abrahamsen).

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With the rate of female HIV infection on the rise in Canada, it seems that we have much to learn from the African situation. A focus on local factors, however, has limited a broader understanding of the global forces that shape women's vulnerability to HIV infection (Farmer *et al.*). Although the developing regions account for 90 percent of the worldwide incidence of HIV/AIDS (Sewpaul and Mahlalela), the transnational nature of sex tourism, the growing drug trade and international business and recreational travel have made AIDS a global moving target. For women worldwide, the practices of drug use and transactional sex are often a direct consequence of trying to cope with limited economic resources (Connors).

The particular social and economic conditions that affect women vary across the world. More and more, however, women are linked by their subordination within a global economy that has created conditions of female impoverishment (Farmer and Kim). In Canada, the erosion of the social safety net has heightened the HIV risk for women. Cuts to social assistance and the essential services of child care, subsidized housing, legal aid and family violence programs are forcing women into situations conducive to HIV infection. The threat of AIDS may seem remote to women who are facing homelessness, unemployment, prostitution, and domestic abuse due to scarce economic resources but these are the women most at risk.

Murli Sinha uses the term "structural violence" to refer to the social forces that create conditions of HIV risk and he identifies poverty as one of the primary forces. Within AIDS research and commentary, however, economic factors are given scant attention in the discussion of HIV vulnerability. In this paper I want to examine poverty as a form of struc-

tural violence that operates as a conduit for the gender transmission of AIDS.

### Women and HIV/AIDS

Although the first reported case of a woman testing HIV+ occurred as early as 1981, women with HIV/AIDS have been an understudied population (Leenerts; Farmer *et al.*). The fact that nine out of ten infected women live in a developing country may be one reason the HIV risks for women have received minimal attention in Canada. Racist and essentialist notions of Third World populations as vectors of disease have operated to frame female infection as a disease of the "other." A focus on Africa and the stereotypes of sexually promiscuous Black women have deflected attention from the role of industrial countries in the spread of the virus worldwide. In the Caribbean, for example, socio-epidemiological researchers have demonstrated that AIDS is a North American import:

> ...the virus came to Haiti, the Dominican Republic, Jamaica, Trinidad and Tobago and the Bahamas from the United States, probably though tourism and transnationals returning home from abroad.... In a country as poor as Haiti ... AIDS might be thought of as an occupational hazard for workers in the tourist industry. (Simmons *et al.* 76)

In the popular commentary of AIDS, there is little mention of sex tourism and the men who travel to Asia for the services of commercial sex workers. In the North American context, myths around HIV/AIDS as a "gay" disease have further limited the exploration of gender factors that contribute to HIV vulnerability (Kalichman *et al.*).

Across the world, AIDS is a disease that feeds on the social inequalities of gender, social status, race and sexuality. In societies where the epidemic is heterosexually driven, women are contracting the disease at a higher rate than men (UNAIDS 2000). Worldwide, women are the fastest-growing group of AIDS sufferers. In 1996, women accounted for 42 per cent of the over 21 million adults living with HIV infection (Connors; UNAIDS 1999). In Canada, despite an overall decrease in reported AIDS cases, the proportion of reported AIDS cases among women is increasing. Between the period 1985-1994 and the year 1999, the percentage of positive HIV test reports among females rose sharply from 9.8 per cent to 24.8 per cent (Health Canada 2000b). Aboriginal women are a particularly vulnerable group. The proportion of women among reported Aboriginal AIDS cases (49.6 per cent) is much higher than the proportion of women among non-Aboriginal cases (20 per cent) (Health Canada 2000a).

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Given the stark increases in incidence among women in both the industrialized and the developing world, women are now considered to be the population most at risk for HIV infection. In every country, poor women are the most highly affected group and women of colour are, by far, the most economically impoverished women (Farmer).

A focus on behaviour modification as the route to AIDS prevention, has lifted the epidemic out of the broader contexts of women's lives. Enormous power is granted to women's knowledge and behavioural practices while the social and economic constraints on women's agency are ignored. The attempt to fight HIV at the individual level has deflected attention from the social processes that shape the dynamics of HIV transmission (Farmer). The way Connors sees it:

> Structural factors-social class and economic status-far more then individual decisions and aspirations, explain why HIV increasingly affects women in the United States and elsewhere. (92)

The real sources of women's risk have been obscured by the failure to link poverty and sexual oppression to the spread of the disease. In the following sections, I consider the relevance of economic factors in issues related to women and the HIV/AIDS epidemic.

### Women and HIV risk

A male bias in AIDS diagnosis has resulted in women being considered at low risk for HIV infection. Even after the Centre for Disease Control (CDC) recognized that women were contracting the HIV virus, the definition of AIDS continued to be based on opportunistic illnesses registered in men (Simmons *et al.*). The initial case definition did not include gynaecological infections, cervical cancer, or other disease manifestations unique to women. When invasive cervical cancer was recognized as an indicator disease for women, the number of reported female AIDS cases in the United States doubled in a single year (Farmer).

The overall method of tracking HIV transmissions has led to a miscalculation and under-reporting of female HIV/AIDS cases. The delay in identifying female opportunistic illnesses means that a woman diag-

nosed with HIV may have been living with the virus for several years (Edelson; Jaffer and Pang). Without a formal AIDS diagnosis, Canadian women have been unable to access treatment, disability benefits, specialized housing and other services that can ease the management of the disease. Low income women, who are particularly vulnerable to the financial stress of AIDS, suffer additional hardships when AIDS-related services are unattainable due to a misdiagnosis of their illness.

Women's greatest risk for HIV infection is through forced or consensual intercourse with men. More than four-fifths of all HIV infected women contract the virus through heterosexual transmission. The risk of HIV infection during unprotected vaginal intercourse is as much as 2-4 times higher for women (UNAIDS 1999). During heterosexual sex, the exposed surface area of the vagina and labia women is larger than the vulnerable penile surface area (Simmons *et al.*). Semen infected with HIV contains a higher concentration of the virus than female sexual secretions. In general, the male-female transmission of HIV is much more efficient than female-male transmission. A single episode of unprotected intercourse is risky for women who may be receiving infected semen from a male partner. Young women are particularly vulnerable to infection through intercourse prior to menstruation when the lower reproductive tract is still developing (UNAIDS 1999).

The presence of an untreated STD can increase the risk of HIV transmission. Women are more likely than men to have an undetected STD because the sores and symptoms may be mild or difficult to recognize (UNAIDS 1999). Poor women worldwide have less access to seek medical services because they lack the financial resources for quality health care. The imposition of user-fees through structural adjustment programs imposed by the World Bank has contributed to the precarious health condition of women in developing countries. In Canada, the erosion of Medicare and the threat of a two-tier health care system pose grave concerns for the future health status of low-income women (Maher and Riutort).

Women's biological susceptibility to AIDS is increased when their sexual autonomy is compromised by poor socio-economic circumstances. A lack of economic resources can force women into survival sex where condom use is difficult to negotiate. When women are economically dependent on a male partner a demand for safe sex practices can result in abandonment or violence. The tearing and bleeding that can result from forced sex multiplies the risk of HIV infection (UNAIDS 1999). Abused women may not recognize HIV-related symptoms they believe to be a consequence of physical violence such as skin lesions or abdominal pain. Compared with men, HIV infected women have a significantly lower rate of survival. Domestic violence has been proposed as one factor that may explain the gender difference in AIDS mortality (Stevens and Richards).

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### Women as carriers of AIDS

The lack of concern for the personal impact of HIV infection for women calls into question the perceived value of female bodies in AIDS-related research. For the most part, AIDS research and commentary targeting women have been focused on women as carriers of the disease. Women entered the AIDS discourse when the growing rate of heterosexual HIV infection raised concerns about women transmitting the virus through sex work or pregnancy (Tallis). The focal point was centred around encouraging changes in women's behaviour that would reduce the AIDS risks for unborn children and sexual clients. Notably absent from the discussion of mothers and prostitutes as AIDS transmitters was the role of men as vectors of the disease. One of the first AIDS textbooks, published in 1984, limited the coverage of women to a single chapter on prostitutes and children with no mention of men as "johns," fathers, or paying sexual customers who are implicated in the spread of the HIV virus (Rodriguez).

The western dichotomy of women as mother or whore has informed international AIDS prevention programs that are focused on the regulation of women's sexual behaviour. Female bodies are viewed as potential AIDS contaminators with little concern about the personal impact of the disease on HIV infected women. The transmission of maternal AIDS is considered a threat to nation building because the production of healthy off-spring is at risk (Booth). Proposed strategies for controlling maternally-transmitted AIDS include the spacing of pregnancies, improved sex education, and easier access to contraception. Curbing the reproductive power of poor and racialized women has been a strong focus in nation building and this practice is continuing under the guise of AIDS prevention. Such practices are primarily targeted at Third World and immigrant women considered too ignorant to understand the complexities of AIDS and poor women worldwide who are regarded as undeserv-

ing of children they may be unable to support.

The threat of the global whore stretches beyond the boundaries of the nation state. Sex workers are constructed as international contaminators responsible for the spread of the disease through sexual transactions with foreign customers. The hysteria about prostitutes as a source *of* risk means the possibility of HIV transmission from client to sex worker is seldom considered (Patton).

While some women may choose a career in the sex trade, many women turn to prostitution as an alternative to dire poverty. As reported by UNAIDS (1999), for many girls and women, "sex is the currency in which they are expected to pay for life's opportunities, from a passing grade in school to a trading licence or permission to cross a border (3)." The growing demand for low-risk sexual partners has led to increased child sexual exploitation and a growing rate of HIV infected girls. Most vulnerable are girls from developing countries who are sold into the international flesh trade to service male sex tourists.

The scapegoating of prostitutes and mothers in the AIDS/HIV epidemic obscures the larger array of economic factors that contribute to the global spread of the disease. Farmer sums it up this way:

> Dominant readings are likely to foster images of women with AIDS that suggest they have large numbers of sexual partners, but less likely to show how girls ... are abducted into the flesh trade, and even less likely to reveal how political and structural violence—for example, the increasing landlessness among the rural poor and the gearing of economies to favor export—come to be important in the AIDS pandemic today. (330)

## Cultural difference

Although indices of social inequalities are neglected in much of the research on AIDS/HIV, culture is often a dominant theme. Cultural factors are granted etiological power that shift attention from poverty, racism and other forms of structural violence that create HIV risk conditions for women from various cultural groups (Farmer). The promotion of "culturally sensitive AIDS education programs" for women is based on the theory that ignorance is the key factor in the disproportionately high HIV rate in racial minority women. Standard conclusions about education as the key to AIDS prevention in various cultural groups are often at odds with the data collected in research studies. In their analysis of a questionnaire administered to 1173 high risk African American/Latino women in the United States, the researchers found that ignorance about AIDS was not a general problem but went on to recommended "culturally sensitive education" as a primary prevention strategy (Farmer).

In many epidemiological studies, "race" is viewed as an explanatory variable, rather than a factor of risk. The rush to impose narrow culturalist explanations of the higher HIV rate in racial minority women reinforces racist constructions of women's sexuality that are divorced from larger systems of power and domination. What gets masked in cultural explanations of AIDS is the female face of poverty that cuts across racialized groups.

Women of colour do not share a common culture or set of origins. But, as Simmons, Farmer and Schoepf point out, "what they do share is a low social position within a context rife with economic and gender inequality" (62). In their stance against cultural explanations in the fight against AIDS, Farmer *et al.*) insist that,

> ... we ... have something more to offer. For example, we can do the important work of showing how structural violence and cultural difference are conflated. Too often, poverty and violence against the poor are collapsed into an all-accommodating concept of culture. We can show how "culturally sensitive" explorations have served to undermine explorations that have shaped the lives of others. (201)

## Conclusion

With the increasing rate of HIV infection in Canadian women we cannot afford to ignore the lessons of the developing world—"namely, that AIDS explodes in contexts characterized by social inequalities and dislocations (Simmons *et al.* 66)." Poverty and gender inequality are two reasons women are the fastest growing group of AIDS victims worldwide. For women living in poverty, AIDS is just one more risk on a long list of dangers that are part of everyday survival.

If we are to develop a meaningful response to AIDS we need to consider the way local and global economies are putting women at risk. The success of AIDS prevention programs will depend on our ability to minimize women's struggle against poverty and other forms of structural violence.

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