HIV/AIDS: How the Virus Affects Women on A Global Level

By

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Introduction

More than 30 million people are living with the Human Immunodeficiency Virus (HIV), and globally, women make up for half of all infections. Although at the beginning of the AIDS epidemic female patients were nearly invisible, as the focus was on homosexual men, the current gender breakdown of HIV transmission demonstrates that females are now more vulnerable to getting infected than before. The term gender refers to the social roles and relations between men and women, including who does what kinds of work and how decisions are made. Gender is also multi-dimensional and influences economic, political, and social interactions and needs. When addressing health care risks, women and girls often have less information about HIV and fewer resources to take preventative measures in reducing their risk (UNIMEF, 2010). In addition, economic dependency and unequal power relations can make it harder for women to negotiate safer sex with men. Gender inequality and violations of women’s rights make women and girls particularly susceptible, leaving them with less control than men over their bodies and their lives. Sexual violence, which includes a brutal violation of women’s rights, increases the risk of HIV transmission, and in many countries evidence suggests that monogamous relationships such as marriage are also a major HIV risk factor.

Women impacted by HIV/AIDS are affected by the cultural ideas and representations of women in their community, as well as by the cultural norms that exist in their immediate environment. This paper aims to address and evaluate how women affected by the HIV virus are infected, treated, and perceived socially and culturally in the following countries: India, Ukraine, United States (the African American community), and Sub-Saharan Africa. While these countries do share some geographic and cultural similarities, women in each region demonstrate specific, unique risks and characteristics relative to the HIV virus.
Thesis

India, Sub-Saharan Africa, Ukraine, and the African American population in the United States were chosen as examples for this comparative analysis, in order to demonstrate the cultural diversity among the women which the HIV/AIDS epidemic has affected. The geographic diversity among these countries does not dispute the similarities these women share, including gender roles and social expectations. This descriptive and comparative analysis will demonstrate women’s susceptibility to this global epidemic based upon cultural and social factors, and will provide leadership recommendations for creating culturally relevant interventions that aim to stop this pandemic.

India
Background

India is the second most populous country in the world, where poor health outcomes are disproportionately affecting the economically disadvantaged and particularly women. With a population of more than 1.1 billion people (CIA 2010), resources for public health funding are scarce. Females make up slightly less than one-half of the population in India, and in rural areas, women have one of the highest maternal mortality rates in the world (Doshi & Gandhi 2008). A major concern for India as a developing nation is its population’s health and well-being. Women from lower castes have even poorer health outcomes and face even more disadvantages. Additionally, women are disproportionately affected by lack of employment opportunities, lack of educational access, and poor social status (Menen-Sen & Shiva Kumar 2001). All of these conditions place Indian women at a disadvantage when it comes to protecting themselves and their families against the HIV/AIDS epidemic that is spreading throughout the country.
Since India’s independence from Britain in 1947, political leaders have concentrated the country’s limited financial resources on industry and science. As a result, very few resources have been allocated to basic public health infrastructure systems to address the HIV/AIDS epidemic. At the beginning of the 1990s, as infection rates continued to rise, local responses to the epidemic were strengthened. In 1992 the government set up the National AIDS Control Organization (NACO), to oversee the formulation of policies, prevention work and control programs relating to HIV and AIDS.

The role of women in Indian society has not quite progressed to the status of men, as effects of discrimination against women include malnutrition, poor health, overwork, mistreatment, lack of education, lack of opportunity to obtain employable skills, and powerlessness (Doshi & Gandhi 2008). There are far fewer women in the workforce owing to lack of skills, and many of those who do work outside the home are underpaid and mistreated (Menen-Sen & Shiva Kumar 2001). Limited employment opportunities for women establish more vulnerability to and dependence on their partners/husbands. Indian women often have the burden of household and community work but are under-represented in governance and decision-making positions.

**Vulnerability to Infection**

India’s vast terrain makes it difficult to examine the effects of HIV on the country as a whole, however, in 2009, following a global view of HIV infection, the estimate of HIV prevalence in India was reviewed and now stands at 0.3% (UNAIDS 2010). Although HIV emerged later in India than it did in many other countries, infection rates soared throughout the 1990s, and today the virus affects all sectors of Indian society, including commercial sex
workers, truck drivers, married and young women. The epidemic in India is primarily transmitted by heterosexual activity. This is similar to that in Africa but in contrast to the epidemic in the United States, in which the gay male community and blood transfusion recipients were initially affected (Centers for Disease Control and Prevention 1981-2). The primary modes of HIV transmission in India are heterosexual (85.7%), intravenous drug use (2.2%), blood products/transfusion (2.6%), perinatal transmission (2.7%), and other (6.8%) (Doshi & Gandhi 2008).

The HIV prevalence data for most states in India is established through testing pregnant women at antenatal clinics. While this means that the data are only directly relevant to sexually active women, they still provide a reasonable indication as to the overall HIV prevalence of each area (NACO 2007). Women account for approximately 40% of the HIV/AIDS prevalence in India, with the major mode of transmission being heterosexual activity. Infection rates among women and newborns are rising due to women’s inability to protect themselves and negotiate for safer sex.

Culturally, there are social precursors for the rapid spread of HIV in India, including the inability to talk openly and learn about sex and sexuality, pressures from family to give birth to an heir and an implicit threat to the marriage when a woman does not bear a child, the high prevalence and acceptability of domestic violence against women, the moral double standard imposed on men and women, and the lower status of women in general (Doshi & Ghandi 2008). The cultural pressure to bear children is so intense that when a woman has to choose between avoiding becoming infected with HIV by her husband but remaining childless or conception with the possibility of becoming HIV-infected, she often chooses the latter. As a result, three-fourths
of HIV-positive women in India were infected within a few years of marriage (Solomon, Chakraborty, & Yepthomi 2004).

Another factor for the increase in infection is Indian women’s lack of access to condoms (male or female) or other means of protection. In some situations, Indian women do not have the power to insist on the use of condoms with their partners, husbands or otherwise; such behavior could imply that the women themselves are being unfaithful or that they lack trust in their husband or partner. Attempting to use condoms can result in abuse, violence, or neglect, and for those reasons it is often not pursued. Because the first cases of HIV in India were identified among commercial sex workers, women in India have been blamed to be the cause for the epidemic. Although women are blamed, men constitute the majority of the cases (Doshi & Ghandi 2008). In more recent years however, more females are becoming infected than males as there are more women than men living with HIV in the 15-24 year age group.

**Cultural Factors**

The obstacles of cultural and societal taboos on discussing sexuality openly in the community play a role in scarce treatment options and there is little incentive for women to get tested or receive counseling. The social stigma that is associated with being HIV-positive in India greatly affects women’s willingness to be proactive about their health and creates fear of seeking information about their partner’s HIV status. Many women who are aware of their husbands/partners’ HIV-positive status find little comfort at home, because these women are financially and socially dependent upon the men in their families and often do not have the power or ability to protect themselves from becoming infected.
Recent studies have indicated that married, monogamous women in India are at an increase in their rates of HIV infection, and that the partners of these monogamous women are not faithful themselves, thus increasing these women’s vulnerability to both Sexually Transmitted Infections (STI) and HIV infection. The association between STIs and increasing risk for HIV infection is important to note for the following reasons: biologically women are more susceptible to STIs than men; STIs are primarily asymptomatic in women and when symptoms do occur, they are usually not attributed to STIs; and it is also more complicated to diagnose STIs in women (Doshi & Gandhi 2008). The women in India who are at increased risk of becoming infected with HIV and those who are already infected are divided into two main categories: commercial sex workers and wives of infected men.

Commercial sex workers have often been regarded with stereotypes and mistrust in India and worldwide. They generally have little power over their work environment and even their own selection. In many cases, as indentured to their madams or manager, they do not have the power to negotiate condom use or other means of safer sex with their clients. As a result, they are extremely vulnerable to exploitation. HIV rates among female commercial sex workers have been high since cases were first identified and culturally they are unfairly seen as the main source for HIV infection.

Increasingly, Indian women are discovering that although they adhere to the values and cultural norms of monogamy and marriage, their husbands or partners may not, resulting in increasing numbers of STD infections, including HIV among married and monogamous women in India (Doshi & Gandhi 2008). The lack of power that Indian women have in many of their relationships has put them at the mercy of the men that surround them, and in this culture it has been difficult for women to be assertive and protect themselves from HIV infection. Women in
general, and especially women with HIV, are economically and sexually dependent on their husbands. They are expected to fulfill traditional family roles and often accused of bringing shame to their family even if it was the action of their husbands that brought on this “shame”. A study of long-distance truck drivers in South India showed that 74% of the HIV-positive drivers were married, 38.7% of study participants had an STI of some sort, and overall 86% of these men engaged in extramarital sex (Doshi & Gandhi 2008). The men who were involved in extramarital sex were also significantly more likely to have sexual contact with commercial sex workers, have multiple sexual partners, and have an HIV-positive diagnosis, in comparison to men who remained faithful to their wives and/or partners.

Recommendations

Educating the population about HIV/AIDS and how it can be prevented is complicated in India, as a number of major languages and hundreds of different dialects are spoken within its population. This means that although some HIV/AIDS prevention and education can be done at the national level, many of the efforts are best carried out at the state and local level in the official language. Each state has its own AIDS Prevention and Control Society, which aims to carry out local initiatives with guidance from NACO. Interventions need to incorporate specific safer sex practices within marriage as well as coping strategies and safety plans to avoid potentially coercive and abusive encounters within their homes (Gupta 2008). Given that HIV-infected women’s family lives can be affected, programs that increase their social and economic support and marital satisfaction may help to reduce the stigma associated with the virus and minimize individual risks such as domestic violence, marital dissatisfaction, and extramarital affairs.
Ukraine

Introduction

Ukraine is geographically the largest country in Europe, and economic growth has been slow but steady, following events such as the collapse of Communism in 1989 and the country’s independence from the Soviet Union in 1991. The impact of such a political transition was difficult to measure in a public health context, but the change in government and its policies did affect its citizens on a greater scale (DeBell, 2005). HIV/AIDS was a relatively new epidemic to the country, initially appearing in the mid-1990s. The transmission route for infection was originally known to be through injecting drug use and mainly among young men, but for the last several years infection has been spreading through unprotected, heterosexual sex. A lack of public health initiatives and low public awareness of HIV risk serves as a consequence of the government’s neglect of public health (DeBell, 2005). Cultural attitudes toward injecting drug users, sex workers, same sex relationships, immigrants, and people with communicable diseases remain punitive. A lack of social investment, widespread poverty, social and judicial constraints on decriminalization of drug use, drug trafficking and government corruption have been key influencing factors in not properly addressing the epidemic at a national level. Poverty, the marginalization of high risk groups, and ignorance of the health implications of personal behavior are the fuel that fire the spread of HIV (DeBell 2005).

Ukraine has one of the highest adult HIV-prevalence rates in Eastern Europe- 1.4 percent in 2003 and an HIV-incidence rate of 23.8 per 100,000 in 2005 (WHO 2007), which is among the highest in the world (World Bank 2006). Although rarely as deadly as HIV, other STIs cause health problems that should not be ignored, and co-infection with another STI can greatly enhance HIV-transmission rates (Dude, 2007). HIV infection by sexual contact is the most
common mode of HIV transmission among women in Ukraine (Burrano, 2007). As a result, there has also been a considerable increase in mother-to-child transmission of HIV since 1995. The significant increase in HIV infection among newborn children shows that women are contributing ever more to the spread of HIV/AIDS in this country. As of 2007, Ukraine has one of the lowest birth rates in the world and is experiencing a negative population growth (World Bank 2006). Women represent an increasing proportion of those infected with HIV, and a number of them are non-drug-using partners of intravenous drug users and may represent an important bridge between this high-risk group and the general population (Dude, 2007).

**Risk Behaviors**

One circumstance that can influence Ukrainian women’s sexual behavior and subsequent STI risk is the threat or experience of violence at the hands of their sexual partners. Although accurate information has been difficult to obtain, some studies suggest a high prevalence. Economic and social changes over the last two decades may be explanations for women experiencing physical and verbal abuse in the home (Dude, 2007). Increasing economic stress, particularly in formerly industrialized areas that have suffered severe economic decline, has led to a rise in incidents of such violence (UNDP 2003). Previous research has demonstrated that violence perpetrated by sexual partners has important consequences for the spread of HIV because of its influence on the sexual decision making process (Dude, 2007). Abuse at the hands of a sexual partner can impair a woman’s general capacity to assess risks, either due to physical injury to the brain or because physical abuse can often lead to depression, anxiety, and other debilitating mental health conditions (Dude, 2007).

Because their ability to assess risk is reduced, women who have been abused are more likely to engage in risky sexual and nonsexual behaviors, and may provide them with short-term
benefits at the expense of long-term sexual health consequences. Such behaviors could include using recreational drugs, engaging in sex work to afford drugs and alcohol, or pursuing additional sexual partners for emotional fulfillment (Turner, 2003). Physical violence can also affect a woman’s ability to assess her personal risk of acquiring the HIV virus because seeking information about her and her partner’s HIV status and risky behaviors may come at a cost. Women are reluctant to be tested for HIV infection or to disclose their positive status to their partners because they often are abused at the time of disclosure and are punished again when other family members are found to be HIV positive (Turnen 2003). Physical violence against women in Ukraine can increase their risky sexual behavior, and by reducing women’s sexual negotiating power, it can present a barrier to behavioral changes that involve their partner’s cooperation (Blanc 2001). Reducing their bargaining power leaves women less likely to negotiate safe sex even when they are aware of the risk of acquiring HIV and other STIs (Dude 2007).

Cultural Factors

Previous studies have indicated that past experiences of violence from sexual partners lowers a woman’s sense of control and self-efficacy even when she is no longer under immediate threat of abuse. This diminishment of a woman’s sense of personal efficacy can result in dangerous behaviors, even when she understands the risks of unsafe sex (Hulton 2000). A study aimed to determine whether violence from a sexual partner is associated with a woman’s increased lifetime risk of acquiring an STI demonstrated that Ukrainian women’s understanding of sexual health measures is incomplete. Almost all Ukrainian women have heard of AIDS and condoms and know where to obtain condoms; however, they are much less aware of the role of condoms in HIV-transmission prevention (Dude 2007).
In the early years of the HIV/AIDS pandemic, the majority of HIV-positive individuals in the northern hemisphere were men. Currently however, an increasing proportion of those individuals newly infected are women, including in Ukraine. HIV posed no significant problem in the Ukraine before 1995. Since then, there has been a considerable increase in the number of registered cases, specifically among women. One particular gender-based factor, which UNAIDS identifies as being among the key barriers to the success of HIV/STI-prevention programs, is the physical, emotional, and sexual violence men perpetrate against women (UNAIDS 2005). The reporting of abuse that occurred may have an indirect effect on HIV transmission because there is a higher probability that the woman reporting the abuse will be tested for STIs, receive help, and hopefully break away from the unhealthy and risky relationship. Unless effective preventive measures are taken, and unless there is more investment in development projects, an HIV/AIDS epidemic may become a serious threat not only in Ukraine, but also in neighboring European countries. The promotion of gender equality as well as investment in the education of girls and women should be improved to effectively prevent AIDS (Burrano, 2007).

**United States**

**Introduction**

A limited number of Americans knew about AIDS before the year 1981, when getting tested and reporting the disease become mandatory. By 1995, the number of U.S. cases reported had reached the half-million mark (Robertson IV, 2006). The impact of the HIV virus on the African-American community was devastating as the gap in infections between Blacks and Whites kept widening. AIDS-related deaths for African-Americans by the year 1998 were 10 times higher than for Caucasians (Robertson IV, 2006). During a seven-year period between 1992 and 1999, a growing number of persons living with AIDS were women, and the epidemic
increased most noticeably among women of color. In the year 2000 alone, African-American and Hispanic women represented 80 percent of cases reported in women (Robertson IV, 2006).

The HIV/AIDS epidemic among African-American women is on the rise, and risk factors are important when addressing effective prevention strategies. It has been proven through cumulative research that behavioral interventions can limit HIV risks among adult women (El-Bassel, 2009). In the United States in 2006, African American women had an HIV incidence rate that was 15 times higher than that of White women and nearly 4 times higher than that of Latina women. By looking at these discrepant rates it is important to understand and address what the driving force is for the HIV-AIDS epidemic among African-American women and what unique prevention challenges they face. The evolving nature of the HIV epidemic has required those working to develop treatment and preventative strategies to reexamine the behavioral risk patterns that have been associated with the disease (Whyte, 2008).

The phenomenon of down low sex, wherein men involved in monogamous relationships with women seek extra-relationship sexual relations with men, has gained attention, specifically in the African-American community. This phenomenon, wherein African-American men living in stable heterosexual relationships engage in extra-relationship sexual activity with other men, provides an example of the changing nature of HIV risk. Whereas HIV in the gay male community had been the most widely publicized route of infection, heterosexual cases, primarily among African-American women, have become the norm (CDC, 2003). When women involved in relationships in which down low sex occurs are unaware of it, they are unknowingly placed at increased risk of contracting HIV by exposing themselves indirectly to multiple partners (Whyte, 2008). If African-American women are already 23 times more likely than their White counterparts to become infected, unknowing exposure to infected men who have engaged in
extra-relationship sex with other men can only exacerbate the already increasing rates of infection (CDC, 2004). Also, because concurrent male partnerships and HIV infection have been identified in both younger and older men, the corresponding risks to female partners affect women of all ages.

**Risk Behaviors**

Cultural factors play a big role in the occurrence of down low sex. Studies indicate that African-American men who report engaging in sex with men are less likely than their White counterparts to identify themselves as gay, and are more likely to engage in regular concurrent sexual activity with women (O’Leary, 2007). High levels of gay stigma within the African-American community seem to contribute to the likelihood that men within the community will hide their sexual interactions with men while continuing to be sexually intimate with women. The issue of feeling the need to hide same-sex sexual interests is compounded when these men engage in unsafe sexual practices with male partners and then have unprotected sex with their female partners. If men want to ensure the women they are in a monogamous relationship and no outside sexual relations are occurring, they will be less likely to use a condom for safe sex practices. Not practicing safe sex has lead to higher levels of infection among African-American women who are unaware of the sexual behaviors their men are engaged in.

The disproportionate HIV rates among heterosexual African-American women are affected by the intimate relationships with male partners who covertly engage in unsafe sex with other men, and inadvertently increase the risk of infection. Women that fit this description and have been involved in research share that a common response to this situation is one of betrayal and feeling a loss of trust. Combined effects of relationship betrayal, homosexual activity, and HIV disease recurred throughout the women interviewed. These women were just as distressed
by how their partners became infected as they were about their own infection (Whyte, 2008). They described experiencing a continuing mistrust as they believed and acknowledged that their partner would likely continue the practice of extra-relationship sex with men. Although women that have been infected with HIV by partners on the down low express frustration and betrayal, the majority continued relationships and cohabitation with their partners. They expressed that the length of the union and previous happiness were major factors that offset the infidelity. Although these women might have had awareness of some form of infidelity in the past, discovery that their husband or partner had become infected through sexual contact with other men and then transmitted the virus to them was highly distressing and magnified the betrayal they experienced. These examples of HIV-infection among African-American couples demonstrate an example of the cultural behaviors expressed in dealing with the diagnosis.

Cultural Factors

When African-American women are infected with HIV, they experience shame that is related to religious beliefs and the social stigma associated with the AIDS epidemic in their community. Having to face that the partner they have been intimate with and have known for a long time partakes in gay or bisexual behaviors goes against their and the community’s religious convictions (Robertson IV, 2006). It is difficult for these women to comprehend that the man they believed shared their moral and religious frame of reference had homosexual tendencies. African-American women who are infected with the virus from men engaging in sex with other men also share the burden of HIV infection. Of the women interviewed, some continued their relationships and took on the caregiver role despite their own illness and the infidelity that occurred (Whyte, 2008). The women who chose to stay noted that they felt some responsibility
to offer assistance to their partner and take on the role of a caregiver. Maintaining healthy in the face of HIV was a major factor in sustaining these relationships.

The African-American women that continue relationships with the men that cause their HIV infection continue being at risk due to the risky behavior of their partners. If their partner continues engaging in sexual relations with other men that are exposed to or infected by the virus, they continue placing themselves at risk and do not adhere to the behavior modification necessary for treatment. Issues of stigma among this population group may also affect and impact coping responses in significant ways. Traditional behaviors of extended family support during times of need among African-American families may not help women with HIV from experiencing rejection from their families and religious affiliations. Feelings of shame and embarrassment due to how the women were infected affect their willingness and at times, ability to seek appropriate health care, ultimately placing them at greater risk. Universal existence of HIV-related stigma compromises public health efforts toward prevention, treatment, and the provision of the support needed for effective management of the disease (Vyavaharkar, 2010).

Studies have shown that African-American women living with the HIV disease are at a high risk for depression, making them reluctant to disclose their HIV status, which further isolates them from much needed social support. Social support is a useful resource that helps minimize psychological stress, and it also plays a key role in buffering the negative effects of HIV-related stigma (Vyavaharkar 2010). A better understanding of how stigma and social support affect depression is critical to develop future programs that are designed to reduce depression, increase social support, and improve the quality of life among HIV-infected African-American women. It is also important that the culture of social support among this group is taken
into account when ensuring consistent medical care, in order to avoid under diagnosis and under-treatment.

**Recommendations**

When looking to implement interventions for African-American women who may be at risk for or have become infected with HIV, it is important to note the vulnerability of those women who believe they are at a low risk for contracting HIV due to their monogamous sexual relationships. Educational approaches that alert and assist African-American women to accurately determine the trustworthiness of their husbands or partners may lead to increased protective practices (Whyte, 2008). A large body of research has demonstrated that social support minimizes stress caused by HIV disease, resulting in better adaptation outcomes and lower psychological symptoms (Vyavaharkar 2010). Social support could also affect HIV-related stigma by providing a supportive environment that accepts a woman diagnosed with the disease, and provides positive experiences that can raise self-esteem while reducing psychological distress, such as depression. Future efforts to create effective intervention programs for HIV-infected African-American women should consider incorporating sources of support that women can turn to if needed, and can alter and decrease their perceptions of HIV-related stigma, as well as internalized stigma (Vyavaharkar 2010). It is imperative to educate health care professionals, case managers, and social workers regarding the role of HIV-related stigma in influencing prevention, care, and treatment of HIV infection.

**Sub-Saharan Africa**

**Introduction**

Sub-Saharan Africa remains the region most heavily affected in the world by HIV. In 2008, sub-Saharan Africa accounted for 67% of HIV infections worldwide, 68% of new HIV
infections among adults and 91% of new HIV infections among children. The region also accounted for 72% of the world’s AIDS-related deaths in 2008 (UNAIDS 2010). Women and girls continue to be affected disproportionately by HIV in sub-Saharan Africa. Women’s vulnerability to HIV in this region stems not only from their greater physiological susceptibility to heterosexual transmission, but also by the severe social, legal and economic disadvantages they often confront. The epidemic continues to have an enormous impact on households, communities, businesses, public services and national economies in the region. Sub-Saharan Africa may be the most economically marginalized region in the world, with less than 0.6 percent of the world’s gross domestic product and facing AIDS as the leading cause of death (Hodge 2010). In this region, women carry a disproportionate share of the AIDS burden not only because they are more likely to be infected with HIV, but they are also more likely to be responsible for caring for others infected with the virus.

In Sub-Saharan Africa, most people infected with HIV are parents with young children, and the magnitude of the epidemic has exhausted the available social and economic resources. The lack of available adults to care for orphaned children after a mother’s illness and death is a major concern (Hodge 2010). Such events leave the HIV-positive Sub-Saharan African woman to deal with her own infection, as well as shoulder substantial care giving responsibilities, all while sustaining without the necessary medications and health care resources that are effective in regulating the infection. One of the main themes that women in Sub-Saharan Africa deal with is poverty and the lack of resources available for proper health care. In addition, the spread of the disease affects women through the loss of family members, stigmatization, or both.
Risk Behaviors

Gender norms related to masculinity can encourage men to have more sexual partners and older men tend to have sexual relations with much younger women (WHO 2010). In some settings, this behavior contributes to higher infection rates among young women (15-24 years) in comparison to young men. Norms related to masculinity, such as homophobia, stigmatizes men having sex with men, and makes their partners more vulnerable to HIV infection if such behavior is carried on secretly. Norms related to femininity can prevent women from accessing HIV information and services, for fear of how they will be perceived by their community. Only 38% of women in Sub-Saharan Africa have accurate, comprehensive knowledge of HIV/AIDS according to the 2008 UNAIDS global figures. Violence against women, including physical, sexual, and emotional, increases vulnerability among Sub-Saharan African women. In addition, gender-related barriers prevent women from accessing HIV prevention, treatment, and care. Women face barriers due to their lack of access to and control over resources, child-care responsibilities, restricted mobility and limited decision-making power (WHO 2010). When coping with HIV infection, women try to receive aid through any local support organizations whose aim is to play a role in the care and support of those people living with HIV/AIDS. Sub-Saharan African women also cope by depending on their spirituality through prayer, God, singing worship music, and other expressions of spirituality (Hodge 2010). Such cultural behaviors play a role in how women deal with living with HIV and which resources they can turn to.

In Sub-Saharan Africa there exists a relationship between poverty and HIV/AIDS, in that the socio-economic distribution of HIV infection is related to poverty-related factors which affect household and community coping capacities (UNDP 2010). In order to make sense of this
relationship, it is important to note the gender dimensions of poverty, being that in particular, the poorest households are female headed. Infection is concentrated in the socially and economically marginalized groups, with more women infected than men. One consequence of the high HIV infection rates among women is the increasing number of children with HIV through mother-to-child transmission (UNDP 2010). HIV infection is not limited to the poorest although the poor account for most of those infected in Africa.

**Cultural Factors**

The concern with the relationship between poverty and HIV/AIDS is that the capacity of individuals and communities to cope with the virus will depend upon their resources and assets—both human and financial. When the poorest households are found to be those that are female headed, then women in Sub-Saharan Africa are at greater risk for not only being infected with the HIV virus, but also being less likely to receive the proper care. We know that poverty is associated with limited human and financial resources, such as low levels of education with associated low levels of literacy and few marketable skills, generally poor health status and low labor productivity as a result. A contributor to the limited health status of the poor is the existence amongst many Sub-Saharan Africans of undiagnosed and untreated STIs which are now recognized as a very significant co-factor in the transmission of HIV (UNDP 2010).

Social and political exclusion often comes along with the condition of poverty. An indication of how poverty leads to conditions which expose the poor to HIV is the large numbers of the poorest households that are headed by women in Sub-Saharan Africa. Inevitably such women may engage in commercial sexual transactions, sometimes as commercial sex workers but more often on an occasional basis, as survival strategies for themselves and their dependants. The correlation between the effects of these behaviors on HIV infection among women is
evident, and to some extent, account for the much higher infection rates in young women who are increasingly unable to sustain themselves by other work in either the formal or informal sectors (UNDP 2010). In looking ahead, it is important to establish a sustainable plan that effectively addresses the epidemic while also recognizing the need for socio-economic development in fighting the HIV/AIDS virus.

**Future Recommendations**

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<th>India</th>
<th>Ukraine</th>
<th>United States (African-American)</th>
<th>Sub-Saharan Africa</th>
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<tbody>
<tr>
<td>HIV Prevalence Among Women</td>
<td>.3%</td>
<td>1.1%</td>
<td>.25%</td>
<td>5.2%</td>
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Since the first cases of AIDS were diagnosed more than 25 years ago, the depiction of women in the scientific and political discourse of HIV/AIDS has been dramatically transformed (Higgins 2010). Close identification of the virus with gay men, and later injection drug users, meant that researchers failed to recognize or focus on heterosexual transmission for many years. Over time, the role of gender on transmission of the virus helped create clarity regarding how women were being affected and infected at an alarmingly high rate. To some degree, infected women were seen as vectors, either as pregnant women passing the virus to their infants, or as prostitutes by engaging in sexual relations with men in the general population. Although the fact that heterosexual men were active transmitters of HIV wasn’t detected until later, women throughout the world suffered physical abuse, intimidation, social and cultural stigma, and discrimination.
In India, commercial sex workers are viewed with mistrust in their culture and are socially stigmatized for their profession. However, they are at greater risk for becoming infected and experiencing violence in the workplace. Married and monogamous Indian women who experience physical and sexual violence from husbands face a significantly increased risk of HIV infection as compared to women who are not abused. In Ukraine, HIV infection by sexual contact is the most common way of HIV transmission among women, and since 1995 there has been a considerable increase in mother-to-child transmission. Physical violence by a sexual partner is also a determining factor for HIV infection, and such violence has been associated with the government’s neglect of public health and the wide gap between the rich and poor. In the United States, women diagnosed with HIV/AIDS in the African-American community have the highest rates of infection among any group of women in the country. Involvement with men that may be engaged in behavior including multiple partners, bisexual behavior, and drug abuse or misuse, may lead to increased probability of HIV infection among heterosexual African American women (Harris 2009). Women in Sub-Saharan Africa constitute 60% of people living with HIV. This includes women that are in monogamous relationships, female sex workers, and injecting drug users. The relationship between poverty and HIV transmission is an important factor for addressing the alarming rate at which Sub-Saharan African women are diagnosed with the virus. In this particular region, individuals, families and communities are impoverished by their experience with HIV/AIDS, and there is enormous strain for families to cope with psychosocial and economic consequences of the illness.

When planning effective preventative efforts for HIV-infected women, there are a number of issues that must be addressed and planned out for sustainability. Among the highlighted countries, women experience major inequalities among themselves and the men in
their community. It is imperative that interventions in these locations be structured; meaning, interventions that work by altering the context within which health care is produced or reproduced. Plans must locate the source of HIV-transmission by addressing political, social, cultural, and economic factors that shape and constrain individual, community, and societal health outcomes.

Addressing gender roles in each country would be one way of understanding what places women at risk for infection and how to develop the societal structure that would decrease women’s vulnerability to this epidemic. The local governments, as well as international development organizations, will need to increase their focus on women’s rights and promote the notion that these rights will enhance their status within society and ultimately, reduce their risk for HIV infection. Recognition and knowledge of gender-based expectations in each particular region can also be crucial in preventing the spread of HIV. Programs that focus on educating men can be equally important in protecting women from HIV, but also carry the ability to transform men’s perceptions and attitudes towards their partners, families, and women in general. These recommendations must be utilized when planning an effective intervention specific to a particular culture and/or community.

Another method for establishing a sustainable intervention that aims to diminish HIV vulnerability and transmission among women is by focusing on the structural and environmental factors that shape HIV infection. Most of the research on structural factors that facilitates transmission and its concentration within particular geographic areas and populations can be grouped into a small number of distinct but interconnected categories: economic (under)development and poverty; mobility, including migration, seasonal work, and social disruption due to war and political instability; and the effects of governmental and
intergovernmental policies in reducing or eradicating HIV transmission. Research addressing environmental factors, while evaluating specific interventions in detail, may manifest into a properly-funded and well-executed sustainable programs in the specified regions. The challenge lies in the difficulty of developing public health interventions that are capable of altering the political economic conditions specific to shaping both the collective and individual vulnerability to HIV infection.

**Conclusion**

HIV/AIDS interventions that have been targeted and effective include interventions developed for heterosexual women, female commercial sex workers, male truck drivers, and men who have sex with men, keeping in mind that these behaviors are particular to causing HIV transmission only in particular regions of the world. New methodologies are necessary to design, document, implement, measure, compare, adapt and evaluate the effects of the structural interventions. The challenge is that by nature, structural interventions involve large-scale elements that cannot be measured or easily controlled by research designs.

Although prevention research has identified effective behavioral interventions for women at a global level, new infections continue to occur. Innovative methods are being sought to successfully implement a long-sustaining intervention that will take into account the specific characteristics affiliated with HIV transmission among women in India, Ukraine, the United States (African-American population), and Sub-Saharan Africa.
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