

## African women faced with the AIDS epidemic

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Africa is the continent most severely affected by the AIDS epidemic, and it is African women who are paying the heaviest tribute. Why are they more vulnerable, despite the fact that more women than men are tested and treated for the disease? Alice Desclaux and Annabel Desgrées du Loû explain why men and women in Africa are unequal in the face of AIDS.

The AIDS epidemic in sub-Saharan Africa now affects women more severely than men (Figure 1). Among the population aged 15-49, 59% of HIV-positive individuals are women (13 million), and only 41% are men (9 million) [1].

What is the reason for this "feminization" of the epidemic, specific to the African continent? And how are women responding to the crisis? To answer these two questions, we will examine, stage by stage, the realities facing the women of Africa, and the options open to them. Is it possible for a woman to protect herself against HIV infection? How can she find out if she is infected, given that HIV-testing is still not widespread in Africa? When she discovers that she is carrying the virus, can she tell her partner? On a continent where access to treatment is still severely inadequate, what kind of health care does she receive? How is her childbearing affected?

### ◆ Preventing infection is difficult for women

There are two reasons for the higher prevalence of HIV infection among women than men: their greater

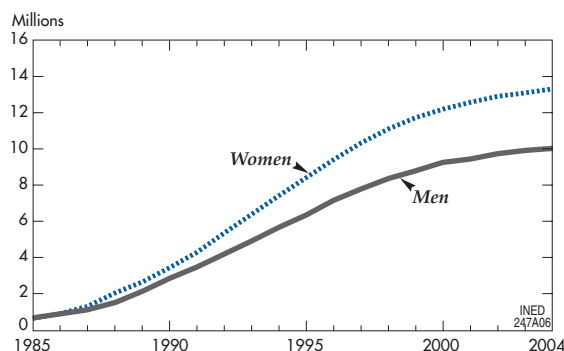
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biological vulnerability and, in societies marked by sexual inequality and poverty, their very frequent exposure to infection.

Women's biological vulnerability to HIV infection is due mainly to anatomical and infectious factors. During heterosexual intercourse, the risk of man-to-woman transmission is around double that of transmission from woman to man. This is because the female reproductive system has a larger mucosal surface area exposed to sexual secretions and microlesions. The sperm of HIV-infected men also contains a higher virus concentration than the vaginal secretions

Figure 1 – Number of women and men living with HIV\* in sub-Saharan Africa



(A. Desclaux, A. Desgrées du Loû, *Population & Societies*, no. 428, INED, Nov. 2006)

\* ill or infected with the virus but showing no symptoms  
Source: UNAIDS [1]

of infected women. Moreover, when a woman already carries other sexually transmitted diseases – often asymptomatic and therefore untreated – the risk of HIV infection is increased.

It is also difficult for women to protect themselves against infection. Even within a stable premarital or marital relationship, studies of sexual behaviour in different African countries show that both men and women are very reluctant to use condoms, which are associated with casual sex (partly because of the message conveyed by earlier campaigns to promote their use). For a partner to suggest using condoms is construed either as proof of infidelity or as a declaration of mistrust. In countries where the prevalence of HIV is high, where many individuals have multiple sexual partners (Figures 2 and 3) and HIV-testing is still rare, the risk of having a partner unknowingly infected with HIV is considerable. It is estimated that the majority of HIV-positive African women living in a couple were infected by their regular partner.

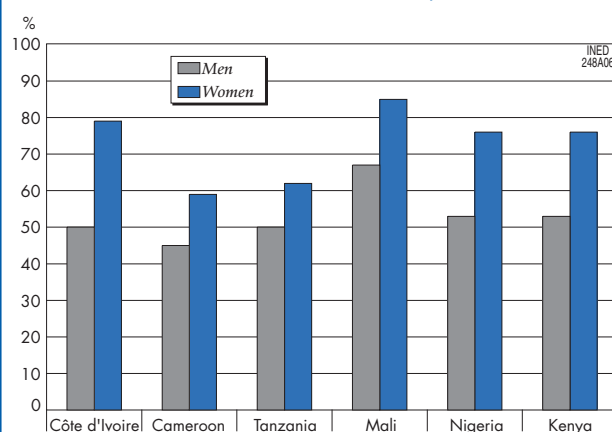
Women are increasingly aware of this danger. To prevent their husbands from “looking elsewhere”, a growing number of women either curtail or forfeit the traditional period of sexual abstinence after a birth which, in certain communities, lasts for up to a year or even until the baby is weaned. In Nigeria and Côte d’Ivoire, surveys have shown that women frequently talk to their husband about the problem of extraconjugal relationships and urge them to protect themselves and not “bring the disease into the house”.

Alongside these risks within the conjugal sphere, certain young women expose themselves to high-risk sexual relationships. Though they do not see themselves as prostitutes, they have sexual intercourse with older men in exchange for “gifts” in cash or in kind to supplement their income, or sometimes that of their family. In these dissymmetrical relationships, it is the man – the payer – who decides whether to use a condom, and the women have little say in the matter, even if they wish to protect themselves against HIV or other sexually transmitted diseases (Figure 3).

### ◆ Inadequate HIV-testing despite progress through antenatal care

Many people are unaware of their serological status and this is one of the main obstacles to prevention. In Africa, it is estimated that less than 10% of the population have been tested for AIDS. Women undergo HIV-testing just as frequently as men, or even more so, but for different reasons, often because their partner is ill or because they suspect him of infidelity. Men tend to be tested when they are asked or obliged to do so in order to get a job, to join the army or obtain a visa. Out-

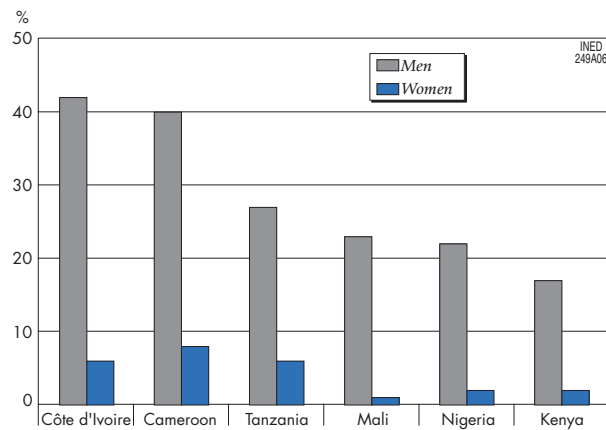
Figure 2 – Percentage of adults aged 15-49 who have had more than one sexual partner in the last twelve months in selected African countries



(A. Desclaux, A. Desgrées du Loû, *Population & Societies*, no. 428, INED, Nov. 2006)

Source: DHS • [www.measuredhs.com](http://www.measuredhs.com)

Figure 3 – Percentage of adults aged 15-49 who did not use a condom at last high-risk sex in selected African countries



(A. Desclaux, A. Desgrées du Loû, *Population & Societies*, no. 428, INED, Nov. 2006)

Source: DHS • [www.measuredhs.com](http://www.measuredhs.com)

side the large-scale screening campaigns, among schoolchildren and students for example, most women are tested under programmes to prevent mother-to-child transmission of HIV [2]. The virus may be transmitted by an HIV-positive mother to her baby during pregnancy, delivery or breastfeeding. When no preventive measures are taken, in a context where breastfeeding is often prolonged, the risk of transmission is around 25% [3]. Since 1999, simple and inexpensive treatments have been available to radically reduce the risk of viral transmission to the baby during pregnancy and delivery. Programmes are progressively being set up to offer HIV-testing, and treatment when necessary, to larger numbers of pregnant women. Women generally agree to be tested, even if the treatment offered during pregnancy is not followed up after childbirth.

Here again, there is an imbalance between the sexes: because it is the woman who carries the child, it is

she who is tested, and it is through her that the presence of HIV infection in the couple is discovered. Surveys of women tested during an antenatal visit show that they would like to inform their partner of the test result. However, though this is easy when the result is negative, fewer than one HIV-infected woman in two has the courage to tell her partner [3] (Table). Very hostile reactions such as violence or rejection are rare, but there is no way to measure the potential reactions of partners whose wives have not dared to speak out.

Under these programmes to prevent mother-to-child transmission, HIV screening tests are also available, generally free of charge, for the tested women's husbands, yet only a minority take up the offer: one man in five in Abidjan in 2002 for example, in a pilot programme where provision of advice and follow-up care to patients is encouraged [2]. These men believe wrongly that their own serological status must be the same as that of their spouse. Women who agree to be tested and who have a negative result have little room for manoeuvre when faced with husbands whose serological status is unknown because untested, and with whom it is difficult to use condoms because of the conjugal nature of the relationship.

Though they are developing rapidly, these HIV screening programmes still only cover a minority of pregnant women in Africa, mainly in urban areas. Only an estimated 9% of pregnant women have access to testing and prevention of mother-to-child transmission of HIV in low- and moderate-income countries.

### ◆ **Childbearing is still a priority, even for infected women**

Being HIV-positive has repercussions on sexual activity, but also on childbearing. For many years, specialists advised HIV-positive women facing the risk not only of infecting their baby, but also of leaving orphaned children after their death, to avoid becoming pregnant. Despite the backing of "public opinion", this message soon proved ineffective on a continent where motherhood remains a pillar of feminine identity [2]. Though aware of the risk of transmitting the virus to their baby, and concerned about their future and that of their children, women – infected or otherwise – are subjected to strong "childbearing pressure" on the part

*Table – Percentage of women who informed their spouse after testing positively for HIV during pregnancy, and percentage of spouses who reacted negatively*

Study	Percentage of women who informed their spouse	Percentage of spouses who reacted negatively	
		Argument, violence, but no rejection or divorce	Rejection, divorce
Abidjan, 1995-1999	40	3	5
Tanzania, 1995-2000	22 <sup>(1)</sup>	*	*
Kenya, 1997-1999	31	3	3
Burkina Faso, 1995-1999	18	*	4
Tanzania, 1996-1998	17	15	8

(A. Desclaux, A. Desgrées du Loû, *Population & Societies*, no. 428, INED, Nov. 2006)  
 \* not available  
 (1) 22% two months after the test and 40% four years later • Source: [3]

of their spouse, their family and their family-in-law, for whom it is a wife's duty to bear children. Given that African women tested positive for HIV during pregnancy often become pregnant again within the next three years (1), the key priority on this continent is to develop large-scale programmes for prevention of mother-to-child transmission.

### ◆ **Women follow their treatment more assiduously than men**

Since 2003, antiretroviral drugs to treat AIDS have become much more widely available thanks to international initiatives to maximize their use. At the end of 2005, around 800,000 infected persons were receiving treatment of this kind in Africa. Practically everywhere, the cost of these drugs is partly or totally covered by treatment programmes, with patients paying only the cost of laboratory analyses and medical care. Contrary to what was observed when full treatment costs were charged to patients, most programmes treat more women than men. Though more women are affected by AIDS than men, this situation can also be explained by other factors.

A number of women obtain treatment following a pregnancy. If they are covered by a programme for prevention of mother-to-child transmission, it is easier for them to obtain aftercare following birth, even though prevention and treatment programmes in Africa are rarely coordinated. Women are generally more willing than men to undergo the medical follow-up associated with antiretroviral treatment: thanks to their frequent consultations at mother and baby clinics, they are used

(1) In France, three times more HIV-positive African women become pregnant again within three years than women of European origin.

to making regular visits to the healthcare services, even when not ill. Men behave more like customers, paying visits simply to obtain prescriptions and refusing to talk about their HIV infection once the symptoms have disappeared. Women also seem to take greater advantage of the healthcare support provided by associations, not because of any *a priori* difference in psychological attitude between men and women, but because of their different social roles [4]. Women are entrusted with responsibility for their children's health and are therefore familiar with the healthcare system and with the organization of preventive care, HIV-testing and long-term follow-up. They are thus willing to spend time at the hospital and may use their visits as an opportunity to establish useful contacts. Men, on the other hand, who are unfamiliar with the system and who cannot easily take time off work, more often cope with their disease alone, concealing their illness and thus depriving themselves of early treatment. The fact that women talk more openly about their disease with the doctor, with the family and with each other also affects their attitude to treatment, and they are better informed than men. They likewise appear to know more about the potential side-effects of antiretroviral drugs.

#### ◆ An extra burden for women: providing healthcare for the whole family

In practically all African societies, women are seen as "natural carers" for the entire family: husband, ascendants, descendants and siblings. This responsibility represents a heavy burden, which may begin very early in life: girls are often taken out of school to look after a sick parent. This practice is very worrying in southern Africa, where the prevalence of HIV is so high in certain regions that practically every family includes an AIDS patient. Caring for them is also psychologically demanding, especially since carers often do not know how the AIDS virus is transmitted and under-estimate its contagiousness. To avoid rejection, women are constantly obliged to keep things secret. They must confront the risk of transmission within the family, and the risk that they themselves may be infected, fall ill and die.

Anxiety is sometimes reinforced by the way in which medical advice is given, as is the case for preventing transmission through breastfeeding. Women are asked by medical personnel to choose between feeding their baby with powdered milk, which is expensive but protects the infant from the virus, and breastfeeding their child for a limited period, which is easier for the mother but does not eliminate the risk of transmission. Many women are too poor to buy powdered milk and breastfeed their baby even when aware

of the risks attached. In the words of a woman from Abidjan, "Every time I breast feed, I think I might be giving my baby the virus". This feeling of guilt is exacerbated by the attitude of the health institutions, which view the problem as a question of preference, though women generally have little choice in the matter.

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In Africa, men and women are unequal in the face of AIDS. Though more women are affected, they paradoxically benefit more from the new treatment programmes. Their approach to health and their regular contacts with the health services are one explanatory factor, as are the initiatives specifically designed to reduce their vulnerability, such as those developed over the last decade under the aegis of the United Nations Development Fund for Women (UNIFEM). Despite this advantage, and beyond the question of health alone, they remain more vulnerable to infection than men because of their social status. Not only is the AIDS epidemic a heavy psychological and health burden for women, but it adds an additional workload to their already demanding daily routine.

#### REFERENCES

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#### ABSTRACT

In Africa, more women than men are infected by the AIDS virus. More biologically vulnerable, women do not always have sufficient authority to impose the use of condoms or ensure the fidelity of their partner.

Prevention and HIV-testing, though still scarce, is more accessible to women than to men, thanks to antenatal healthcare. But for three in four women who discover that they are HIV-positive, socioeconomic insecurity, fear of dishonour and pressure to procreate prevents them from revealing their serological status. Paradoxically, they nonetheless receive treatment more frequently than men.