

GENDER ISSUES IN HIV PREVENTION

Adrian D. Van Breda

adrian@vanbreda.org

Adrian D. Van Breda completed his doctoral studies in 2004 at the Rand Afrikaans University, focusing on multicultural scale development in social work. He received a Masters Degree in Clinical Social Work with distinction from the University of Cape Town in 1997. He established and ran the Social Work Research & Development department of the Military Psychological Institute for five years and is now deputy director of the Military Health Research Centre of the South African National Defence Force.

Paper presented at the Directorate Social Work Conference, 6-9 September 2005, at Kopanong, Benoni, South Africa.

Key words: HIV gender patriarchy sex

INTRODUCTION

“Gender is more than a variable to be manipulated; it is an organizing principle of society” (Hartigan, 1999).

Gender is a central construct in HIV prevention (Buseh, Glass, & McElmurry, 2002; Dunkle et al., 2004; Harris, 2002). This is particularly true given that HIV is spread primarily through sexual contact, which is in turn defined in gender terms (Corrêa, 1997). Furthermore, “the interaction between female biology and gender place (*sic.*) women in double jeopardy” (Hartigan, 1999). Any HIV prevention programme must, therefore, address gender issues in order to be effective (Ninan, 2003).

Such gender issues typically involve power differentials between men and women (Harris, 2002), as well as differences in socialization. These both impact on sexual aggression, self-protection, negotiation ability and access to information and resources. As such, gender can be considered a ‘driver’ of the HIV pandemic.

In the SANDF, gender issues in HIV prevention are addressed primarily through the Gender Equity Programme – a social work programme aimed at sensitizing military employees to gender issues within the context of HIV prevention. This intervention, run with mixed-gender groups, over a period of 3-5 days, addresses stereotyping, socialization, power and other gender issues.

Research is an essential element of HIV prevention programme planning, design and evaluation. Data are required that assist us in understanding the gender

dynamics that drive the spread of HIV, in order to develop targeted and appropriate HIV prevention interventions. Furthermore, data are required to determine the efficacy of these programmes and to monitor the reduction of these gender-based HIV drivers.

This paper reports on the findings of two large national surveys conducted within the South African Department of Defence (SADOD) in 2004 and 2005, with specific reference to gender drivers. Data are still young, and it is thus not yet possible to report on changes in these gender-based drivers. Rather, the focus of this paper is on understanding gender dynamics in the SADOD.

METHODOLOGY

Design. The SADOD conducts an annual HIV KAP Study (Bielfeld, 2002; Croucamp, 2002; Van Breda, 2004; Van Breda, 2005), which measures the Knowledge, Attitudes and Practices of military members towards HIV and safer sex. A cross-sectional research design was followed to determine the knowledge, attitudes and practices of the population at specific points in time, which allows for comparisons to be made of the population at different points in time. This methodology, often termed BSS (Behavioural Surveillance Survey) methodology (Family Health International, 2000), is “based on classic HIV and sexually transmitted disease (STD) serologic surveillance methods” (Utomo & Dharmaputra, 2001, p. 6).

Sampling. In both studies, a proportional quota sample was targeted. The rule-of-thumb when determining sample size is generally ten percent of the population.

This does provide a very large overall sample – about 7,300 respondents. However, sufficient respondents are required within each stratum (eg region) to allow for the detection of meaningful changes in constructs. Although disproportional sampling would allow for a smaller overall sample, it would require weighting of data, which is beyond the information technology capacity of the Military Psychological Institute. Simple, proportional, stratified/quota sampling is thus considered the most effective for this setting.

Although the same overall sampling methodology was used in both surveys, slightly different strata were utilised. In the 2004 survey, the strata used were region, Service (eg Army), gender and race. In the 2005 survey, the strata were region, Service, gender and military rank group.

In the 2004 and 2005 KAP studies, 5,082 and 5,867 members respectively participated in the study and returned adequately completed instruments. This accounts for 6.8% and 8% of the SADOD population respectively. Comparisons between the sample and population demographic profiles indicated that in both studies, the sample was a fair to good reflection of the population.

Measuring Instrument. Different instruments were used in the two studies. The 2004 survey utilised the same instrument used in the 2001, 2002 and 2004 KAP surveys (providing continuity across three studies). The 2005 survey utilised a new instrument (Van Breda, Madubula, & Benade, 2004) that incorporated indicators directly addressing gender issues. This break in the instrument means that data cannot be compared across the two studies – only cross-sectional analyses can be done.

Data Analysis. Data were analysed in SPSS using the chi-square test (Pett, 1997). When data were analysed over time (comparisons across the 2001, 2002 and 2004 studies) the chi-square test for trend (Family Health International, 2000), also known as the Mantel-Haenszel chi-square test (Pett, 1997) and the linear-by-linear association test (SPSS, 2004), was used. Significance was set at $p < .01$.

RESULTS

2004 Study. Since the data collection instrument used in 2004 did not specifically address gender issues, only comparisons between men and women could be made to generate an understanding of how gender-issues influence HIV prevention. A number of significant differences emerged.

Men evidenced higher levels of risk behaviour than women in the 2004 study. They were more likely to have multiple partners, to have sex with sex workers and to have sex with nonregular partners while on course/deployments. Men evidenced higher levels of overall risk behaviour than women – 37% of men reported at least one risk behaviour, compared with only 13% of women.

There is, moreover, a general trend for men to show less reduction over time in these risk behaviours, compared with women – men showed no change in number of partners, use of sex workers and overall risk behaviour, while women showed decreases in all; men showed an increase in sex with nonregular partners while on course/deployment, while women showed no change over time.

On the other hand, men did show an increase in condom use, both with multiple

partners and while under the influence of alcohol, while women showed no change. This may suggest that while men continue to engage in risky sex, they are more inclined to use condoms. Women, by contrast, tend to show a decrease in actual risk behaviour and no change in condom use (among those who continue with risky behaviour).

Women tend to neglect self-protection in sexual relationships (cf. Hartigan, 1999).

Women (unlike men) showed no improvement over time in negative attitudes towards condoms nor in condom use with multiple partners when having risky sex.

Perhaps this is due to a lack of empowerment among women or a deficit in condom negotiation skills (Osmond et al., 1993).

Unlike men, women were less likely to have had an HIV test and evidenced a decrease in testing behaviour over time. This may be related to increased pressure on men to be tested during Concurrent Health Assessments (which are required for operational purposes), from which women are, perhaps, somewhat excluded. This trend may reduce the perceived vulnerability of women, resulting in less of a need to exercise self-protection in risky situations.

Men, compared with women, showed relatively low levels of Perceived Threat. In light of the Health Belief Model, the absence of a sense of Perceived Threat may reduce the sense of necessity to reduce risk behaviour among men, thereby inhibiting a movement out of the precontemplation phase of the Stages of Change.

Ultimately, however, men and women evidenced similar levels of 'adverse

outcome' – HIV positive test and/or symptoms of STIs.

In summary, the 2004 KAP Study suggests that men tend to engage in more risky sexual behaviour than women. Women who do engage in risky behaviour, however, are less likely than men (who engage in risky behaviour) to practice safer sex. This suggests a lack of self-protection among women who have multiple partners.

2005 Study. Many of the above findings were repeated in the 2005 KAP Study – men were significantly more likely to report having multiple sex partners, having nonregular sex partners, engaging in anal sex and purchasing commercial sex. Overall, 36% of men and 22% of women reported some form of sexual risk behaviour. In addition, condom use was found to be lower among women than among men.

Several gender-based indicators were measured:

- o **Women's Ability to Negotiate Safer Sex.** Participants were asked whether a woman who knew that her husband had a sexually transmitted infection (STI) had the right to refuse sex or ask that he use a condom. While three quarters of women (75%) supported these statements, only two thirds of men (66%) did. Respondents with STI symptoms were significantly less likely to support these statements than respondents without such symptoms (70% vs 59%).

- o **Patriarchal Beliefs Rejected.** Participants were presented with a set of items reflecting patriarchal beliefs¹ and asked whether they agreed with them or not. Only half the women (51%) and a quarter of the men (24%) did so. Those who did not reject patriarchal beliefs were significantly more likely to report drinking patterns that place them at risk for alcohol dependence, multiple sex partners (Verma, 2004) and symptoms of STIs (Dunkle et al., 2004).

- o **Gendered Treatment Seeking.** “Gender can differentially affect women and men’s health promoting behavior” (Hartigan, 1999). Participants were presented with symptoms of STIs and TB and asked whether or not they sought medical care for their symptoms. It was found that women were 12% *more* likely to seek treatment in the case of STI/TB symptoms than men (64% vs 57%).

In summary, the 2005 KAP Study supports the findings of the 2004 Study and adds additional light on patriarchal beliefs and women’s ability to negotiate safer sex. It appears that men (and to a lesser degree women) hold to gendered paradigms and that those with the strongest gendered paradigms are also the most likely to report sexual and drinking risk behaviour and symptoms of STIs.

DISCUSSION

The results clearly show gender-based differences in HIV risk behaviour – women

¹ Men should always be in control of the things around them; Men should be in charge of women; Wives should do what their husbands tell them to do.

tend towards lower risk behaviour than men, however they also tend towards lower condom use (White, 2003). In addition, men report significantly higher rates of patriarchal beliefs than women; lower rates of treatment seeking in the event of sexually transmitted infections than women; and less belief in the right of women to regulate sexual relations within marriage. Furthermore, patriarchal beliefs are significantly associated with increased sexual partners, increased risk of STI infection and increased risk for substance abuse. Gender is clearly a significant and important driver of the HIV epidemic.

Men evidence aggressive and self-serving attitudes and behaviours (Boonzaier, 2005) – higher sexual risk, higher self-protection (condom use), less belief in women's rights to protection themselves, more beliefs that women are subordinate to men, less belief that HIV is a real threat to their safety.

These patterns give men a sense of power that is likely to be acted on – particularly men who have a history of STIs. This in turn makes women more vulnerable to sexually aggressive men.

Women evidence less risk behaviour (although still around one in five women do report sexual risk), but also less actual self-protection. It is also important to note that a quarter of women do not believe in the right of women to regulate sex with their husbands and that half of women did not reject patriarchal beliefs.

Women thus become collaborators in a patriarchal and gendered paradigm – endorsing patriarchal beliefs, denying the right of women to protect themselves and not exercising safer sex practices to protect themselves.

RECOMMENDATIONS

In light of these findings, the following recommendations for HIV prevention programmes in the SADOD can be made:

- o Women should be targeted with self-protection messages and skills. Condom negotiation processes and skills could be taught, and reasons for reluctance to use condoms explored. The Gender Equity Programme could explore this further, targeting gendered condom negotiation issues more explicitly.
- o Men should be equipped with better knowledge of HIV and safer sex, and to distinguish more effectively between fact and myth.
- o The perceived threat of men should be raised, perhaps by more effective use of tools such as the 'HIV Butterfly' and the 'Loaded Gun' metaphors (both in the Peer Group Training course). Further development of the ability of men to evaluate their vulnerability to HIV infection based on their actual recent behaviour could also facilitate this.
- o More focused attention should be given to reduce actual risk behaviour among men, with a particular emphasis on the number of partners.
- o Continued emphasis needs to be provided, in Gender Equity Programmes and in other HIV training and prevention activities, to reducing patriarchal beliefs – among both women and men. Mass media, visible support from senior members of the SADOD (both male and female) and sanctions against gender-based discrimination could support this process.

CONCLUSION

This paper has provided further evidence to support the premise that gender is an essential component of HIV prevention. These data portray men as sexual aggressors who believe in their own right to self-protection but not the right of women to self-protection and autonomy. Women, by contrast, appear to be more sexually cautious, but lacking in actual self-protective behaviour and collaborating with a patriarchal paradigm.

Continuing efforts, by both women and men, are crucial for these patterns to change.

REFERENCES

- Bielfeld, R. I. (2002). *National survey on the knowledge, attitudes and practice of DOD members with regard to HIV and AIDS* (MPI/C/2002/0006/A). Pretoria, South Africa: Military Health Research Centre, South African Military Health Service.
- Boonzaier, F. (2005). Woman abuse in South Africa: A brief contextual analysis. *Feminism and Psychology, 15*(1), 99-103.
- Buseh, A., Glass, L., & McElmurry, B. (2002). Cultural and gender issues related to HIV/AIDS prevention in rural Swaziland: A focus group analysis. *Health Care for Women International, 23*(2), 173-184.
- Corrêa, S. (1997). From reproductive health to sexual rights: Achievements and future challenges. *Reproductive Health Matters, 5*(10). Available: <http://www.hsph.harvard.edu/Organizations/healthnet/reprorights/docs/corr>

[ea.html](#) [2005, 27 July]

Croucamp, Y. (2002). *National HIV/AIDS KAP survey of SANDF members: 2001/2 comparison* (MPI/R/2002/0002/A). Pretoria, South Africa: Military Health Research Centre, South African Military Health Service.

Dunkle, K., Jewkes, R., Brown, H., Gray, G., McIntyre, J., & Harlow, S. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*, 363(9419), 1415-1421.

Family Health International. (2000). *Behavioral surveillance surveys (BSS): Guidelines for repeated behavioral surveys in populations at risk of HIV*. Arlington, VA: FHI. Available: <http://www.fhi.org/en/aids/wwdo/wwd12a.html#anchor545312> [2004, May 25]

Harris, C. (2002, 21-26 July 2002). *How deconstructing gender identities could contribute to the solution of difficult development problems*. Paper presented at the 8th International Interdisciplinary Congress on Women, Department of Women and Gender Studies, Makerere University, Kampala-Uganda.

Hartigan, P. (1999). *Communicable diseases, gender, and equity in health*. Cambridge, MA: Harvard Center for Population and Development Studies. Available: <http://www.hsph.harvard.edu/grhf/HUpapers/gender/hartigan.html> [2005, 27 July]

Ninan, A. (2003). *'Without my consent': Women and HIV-related stigma in India*:

Population Reference Bureau. Available:

<http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=8278> [2005, 27 July]

- Osmond, M., Wambach, K., Harrison, D., Blyers, J., Levine, P., Imershein, A., & Quadagno, D. (1993). The multiple jeopardy of race, class, and gender for AIDS risk among women. *Gender and Society*, 7(1), 99-120.
- Pett, M. A. (1997). *Nonparametric statistics for health care research: Statistics for small samples and unusual distributions*. Thousand Oaks, CA: Sage.
- SPSS. (2004). *Statistical Package for the Social Sciences (Version 13.0)*. Chicago, IL: SPSS.
- Utomo, B., & Dharmaputra, N. G. (2001). *Findings of the Behavioral Surveillance Survey (BSS 1996-2000) on female commercial sex workers and adult male respondents (FCO # 87530 BSS V)*. Indonesia: Center for Health Research, University of Indonesia.
- Van Breda, A. D. (2004). *HIV KAP study 2004: Principle report (MPI/R/2004/0145/B)*. Pretoria, South Africa: Military Health Research Centre, Military Psychological Institute, South African Military Health Service.
- Van Breda, A. D. (2005). *HIV KAP study 2005: Principle report (MPI/R/2004/0158/B)*. Pretoria, South Africa: Military Health Research Centre, Military Psychological Institute, South African Military Health Service.
- Van Breda, A. D., Madubula, P., & Benade, E. (2004). *Design of the new KAP survey instrument (MPI/R/2004/0155/B)*. Pretoria, South Africa: Military

Health Research Centre, Military Psychological Institute, South African
Military Health Service.

Verma, R. (2004). From research to action: Addressing masculinity and gender
norms. *Indian Journal of Social Work*, 65(4), 634-654.

White, R. (2003). Abstinence, monogamy and condom use among Jamaican
adolescents: Culture, class, gender and the Health Belief Model. *DAI-A*,
63(9), 3359.

Gender Issues in HIV Prevention

Adrian D. Van Breda
Directorate Social Work Conference
5-8 September 2005

Gender Issues in HIV Prevention



Introduction

*Gender is more than a variable
to be manipulated;
it is an organising principle of society.*

(Hartigan, 1999)

Introduction

*The interaction between
female biology and gender
places women in double jeopardy.*

(Hartigan, 1999)

Introduction

- Gender as a ‘driver’ of HIV infections.
- Gender Equity Programme
- We need data to:
 - Understand gender dynamics
 - Develop targeted & effective programmes
 - Evaluate programme results
 - Monitor gender drivers

Scope

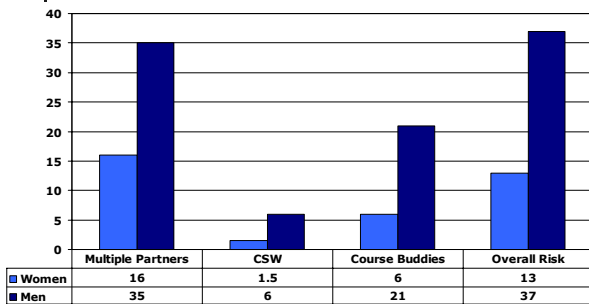
- Methodology & sample
- 2004 results
- 2005 results
- Discussion
- Recommendations

Methodology

- Four cross-sectional surveys:
 - 2001: 5.5%
 - 2002: 5.0%
 - 2004: 6.8% (n=5,082)
 - 2005: 8.0% (n=5,867)
- Gender distribution:
 - 24% women in sample (2004 & 2005)
 - 22% women in population

2004 Results

Risk Behaviour in 2004



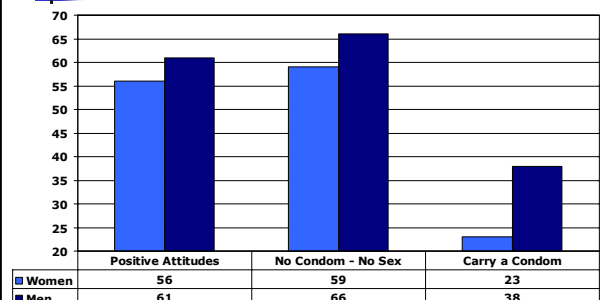
Risk Behaviour over Time

	Multiple Partners	CSW	Course Buddies	Overall Risk
Men				
Women				

Condom Use over Time

	With Multiple Partners	Under the Influence
Men		
Women		

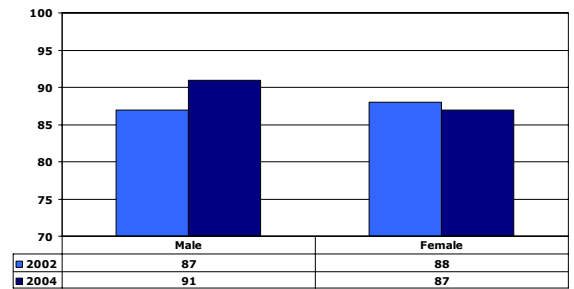
Condom Attitudes in 2004



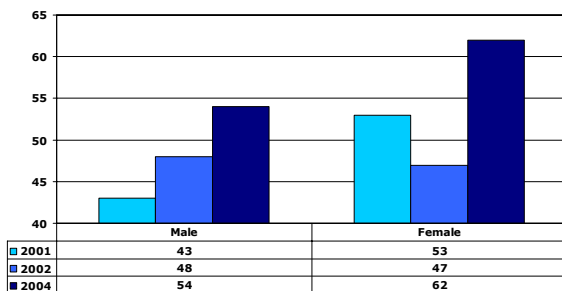
Self-Protection over Time

	No Negative Attitudes	Condom Use
Men		
Women		

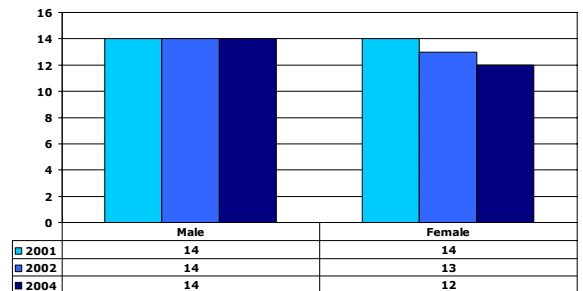
HIV Testing



Perceived Threat



Adverse Outcome



2004 Summary

- Men engage in more risky behaviour than women
- Women who engage in risky behaviour are less likely to practice safer sex
- Men seem more attentive to self-protection than women

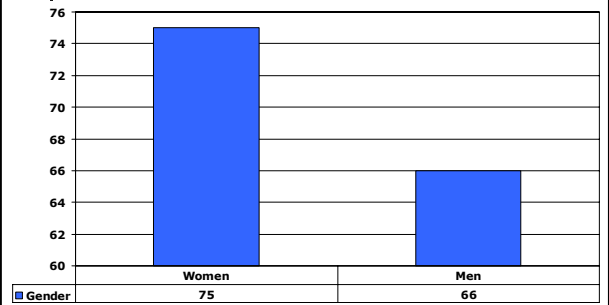
2005 Results

- Most of the 2004 results were confirmed:
 - Men engage in more risky behaviour than women
 - Women who engage in risky behaviour are less likely to practice safer sex
- Three new gender-based indicators

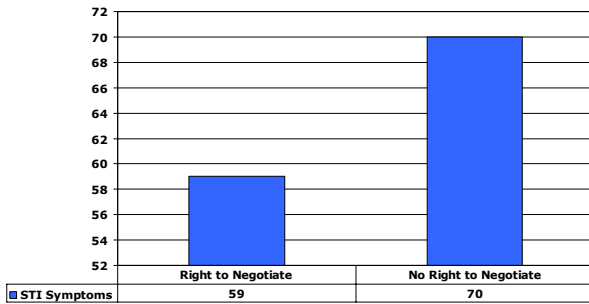
Women's Ability to Negotiate Safer Sex

- When a wife knows her husband has a sexually transmitted infection, does she have the right
 - to ask him to use a condom?
 - to refuse to have sex with him?

Women's Ability to Negotiate Safer Sex: Gender



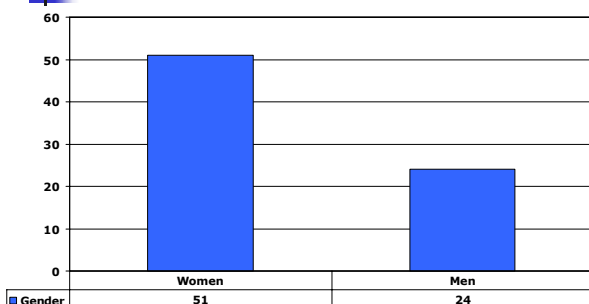
Women's Ability to Negotiate Safer Sex: STI Symptoms



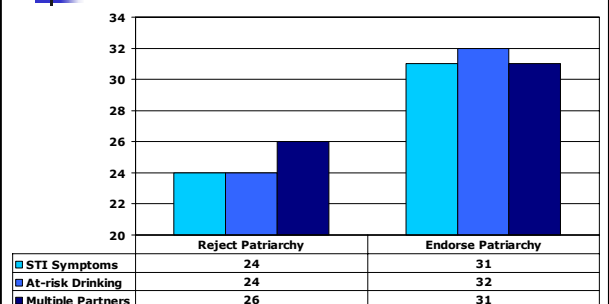
Patriarchal Beliefs Rejected

- Wives should do what their husbands tell them to do.
- Men should always be in control of the things around them.
- Men should be in charge of women.

Patriarchal Beliefs Rejected : Gender



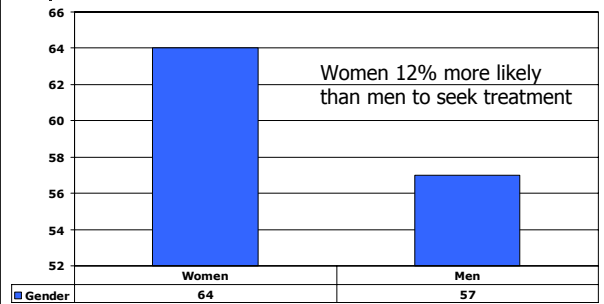
Patriarchal Beliefs Rejected : Risk Indicators



Gendered Treatment Seeking

- Symptoms of TB and STIs
- Access to medical care

Gendered Treatment Seeking : Gender



2005 Summary

- Men (and women) hold gendered paradigms
- Those with gendered paradigms report:
 - Increased sexual risk behaviour
 - Increased risky alcohol use
 - Symptoms of STIs

Discussion

- Women show less risk behaviour.
- Women show less self-protection.
- Men show more patriarchy.
- Men show less treatment seeking.
- Men show less belief in women's rights to self-regulate sex in marriage.
- Gender-based dynamics associated with increase HIV risk.

Discussion

- Men evidence **sexually aggressive** and **self-serving** attitudes and behaviours:
 - Higher sexual risk
 - Higher self-protection
 - Less belief in women's rights to self-protection.
 - Beliefs that women are subordinate to men.
 - Less belief that HIV is a real threat to their well-being.

Discussion

- These men believe they have power.
- They are more likely to act on this belief.
- Especially men with a history of STIs.
- This makes women vulnerable to sexually aggressive men.



Discussion

- Women evidence **less risk**, but also **less self-protection**:
 - A fifth of women do report risky sex.
 - Only about half of these report condom use.
 - A quarter do not believe in women's rights to self-regulate sex in marriage.
 - Half did not reject patriarchal beliefs.



Discussion

- Women become **collaborators** in a patriarchal and gendered paradigm:
 - Endorsing patriarchal beliefs
 - Denying the right of women to protect themselves.
 - Not exercising safer sex practices to protect themselves.



Recommendations

- 1) Target women with self-protection messages & skills.
- 2) Equip men with better knowledge of HIV and safer sex.
- 3) Raise men's perceived threat.
- 4) Reduce men's actual risk behaviour.
- 5) Reduce men's and women's patriarchal beliefs.



Conclusion

- Gender is central to HIV prevention
- In the military, we have a unique opportunity to work with the drivers of the HIV epidemic – men