2. Socio-Cultural Factors

The degree to which men and women are able to control the various aspects of their sexual lives (i.e. their ability to negotiate the timing of sex, conditions under which it takes place, and the use of condoms), plays a critical role in determining their vulnerability to HIV infection.

People’s control over their sexual lives and choices is in turn shaped by gender-related values and norms defining masculinity and femininity. These culturally-defined gender values and norms evolve through a process of socialization starting from an early stage of infancy. They determine and reinforce themselves through traditional practices such as wife sharing, widowhood related rituals, early marriage, female genital mutilation and the condoning of gender-based violence. These cultural practices, values, norms, and traditions have strong influences on the visible aspects of individual behaviors and are important determinants of men’s and women’s vulnerability to HIV.

Personal risk of contracting HIV is determined by numerous social and cultural factors that shape gender and sexuality perceptions, attitudes and behaviors. Gender norms are deeply rooted in the socio-cultural context of each society and enforced by that society’s institutions and practices. Socio-cultural norms build notions of masculinity and femininity which in turn create unequal power relations between men and women. This power imbalance impacts women’s and men’s access to key resources, information, and their sexual interactions. It curtails women’s sexual autonomy and expands men’s sexual freedom and control over sexuality. This results in their different vulnerabilities to HIV infection, as described below.

The gender role prescribed for women, or ‘femininity’, demands a submissive role, passivity in sexual relations, and ignorance about sex. It also restrains women from seeking and receiving information related to HIV prevention. In some cultures motherhood is a key aspect of femininity, so the use of contraceptives such as barrier methods that prevent pregnancy and HIV present difficult and often insurmountable challenges for women and men in balancing their desire for children against HIV prevention. In cultures where virginity is highly prized, young women attempt to preserve their virginity by practicing alternative sexual behaviors, such as anal sex which increases their vulnerability to HIV. In cultures where women are socialized to please men and defer to male authority, particularly in sexual interactions, women sometimes engage in high risk sexual behavior such as vaginal douching (a process of rinsing or cleaning the vagina by forcing water or another solution into the vaginal cavity to flush away vaginal discharge or other contents) which they believe makes sex more pleasurable for their male partners.

‘Masculinity’ requires men to be more dominating, knowledgeable and experienced about sex. This assumption puts many young men at risk of HIV infection as such norms prevent them from seeking information or
admitting their lack of knowledge about sex or methods of protection. These norms also promote promiscuity and reinforce risk-taking behavior. In many societies men are socialized to be self reliant, to conceal their emotions, and to not seek assistance in times of need or stress. This expectation of invulnerability associated with masculinity runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk.

Notions of masculinity that emphasize sexual domination over women or feminized males as a defining characteristic of manhood contribute to homophobia and the stigmatization of MSM. Stigma and fear force MSM to hide their sexual behavior and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners, female and male.

Various social and cultural traditions reinforce vulnerability to HIV. These are examined in the context of the following practices and institutions:

### 2.1 Marriage

Gender inequality in marital relations, especially in sexual decision-making, increases vulnerability to HIV transmission. Trends in current data on new HIV infections suggest that the incidence of HIV is rising among married women and girls worldwide, with unsafe and unprotected heterosexual intercourse being the single most important factor in the transmission of HIV among women. Marriage, which greatly increases women’s sexual exposure, has in itself become a risk factor for women and girls in many countries. The dramatic rise in the frequency of unprotected sex after marriage is driven by the implications of infidelity or distrust associated with certain forms of contraception such as condoms, a strong desire to become pregnant, and an imbalance in gender power relations. This results in women’s increased inability to negotiate safer sex. In spite of having knowledge of their spouse’s extra-marital sexual interactions, women are often unable to protect themselves due to an imbalance of power within relationships created by economic and emotional dependence.

### 2.2 Polygamy

The traditional practice of polygamy, which is legally sanctioned in some parts of the world, allows husbands to have more than one wife. This occurs despite international human rights instruments defining equality in marriage and family life through an equal rights and responsibilities framework, violated in polygamous unions because wives have fewer de facto marital rights and their husbands fewer responsibilities (See Rights Box 1).

**RIGHTS BOX 1: HUMAN RIGHTS INSTRUMENTS SUPPORTING EQUALITY IN MARRIAGE**

**Article 16 of Universal Declaration of Human Rights (1948):** Men and women of full age, without any limitation due to race, nationality or religion...are entitled to equal rights as to marriage, during marriage and at its dissolution.

**International Covenant on Civil and Political Rights:** States shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage, and at its dissolution. (Article 23 (4))

**Convention on the Elimination of All Forms of Discrimination of Women:** Polygamous marriage contravenes a woman’s right to equality with men, and can have such serious emotional and financial consequences for her and her dependents that such marriages ought to be discouraged and prohibited. (General Recommendation no. 21)
Polygamy operates to create concurrent sexual networks within marriage between multiple wives and their husband, and in addition to any extra-marital sexual contacts the spouse may have. Direct sexual transmission of HIV can occur in these concurrent sexual networks where the virus is introduced through the spouse’s extra-marital sexual contacts or where a new wife who is already HIV positive enters the polygamous union.

A formal recognition of polygamous unions in various countries amounts to reinforcement of the patriarchal notion that women should passively accept their partners’ sexual decision making. It broadens the scope of masculine sexual freedom. In addition to reinforcing patriarchy, studies have shown that the typically discordant nature (relationships that are characterized by friction and disagreement) of polygamous co-wives and husband-wife relationships also aggravates domestic violence. These strong patriarchal notions increase the risk of HIV transmission by undermining women’s ability to negotiate condom use, to insist on partner fidelity, and to leave high-risk sexual relationships. Negotiating safe sexual practices and insisting on partner fidelity becomes further complicated in polygamous households given that multiple wives are often reliant on one husband for material survival. The economic hardship and lack of emotional attention associated with polygamy can lead women to engage in extramarital sexual relationships.

2.3 Early Marriage

The majority of sexually active girls aged 15-19 in developing countries are married. Child marriage (marriage before age 18) remains a fact of life in South Asia, portions of Latin America, and many sub-Saharan African countries. Eighty-two percent of girls in Niger, seventy-five percent in Bangladesh, sixty-three percent in Nepal, fifty-seven percent in India and fifty percent in Uganda marry before the age of 18. If the present trend continues, over 100 million girls will be married worldwide before the age of 18 years in the next decade.

Early marriage severely increases young girls’ vulnerability to HIV as they are most likely to be forced into having sexual intercourse with their (usually much older) husbands. Young girls have softer vaginal membranes which are more prone to tear, especially on coercion, making them susceptible to HIV and other STIs. Older husbands are more likely to be sexually experienced and HIV infected. The dramatic rise in young married girls’ exposure to unprotected sex is driven by pressure to bear children and their inability to negotiate safe sex. The significant age gap in spouses also further intensifies the power differential between husband and wife, which in turn discourages the open communication required to ensure uptake of voluntary counseling and testing for HIV, sharing test results and planning for safe sexual relations throughout the marriage.

Early marriage also curtails girls’ socio-economic development and results in their social isolation which is increasingly identified as a predisposing factor for HIV risk. This is because it curtails the social contacts and networks that play a vital role in transmitting HIV prevention information and supporting behavior change. Girls who are married at an early age also have low educational attainment and limited or no schooling options, limited control over resources, and little or no power in their new households.

Child marriages must be viewed within a context of force and coercion, involving pressure and emotional blackmail, as children lack the choice or capacity to give their full consent. Child marriage is a violation of human rights as it violates the right to freedom and growth of children. Gender inequality is both a cause and a consequence of child marriage.
2.4 Multiple Sexual Partners

Gender inequality and patriarchy (social structures where men take primary responsibility and dominate in their households) encourage multiple sexual partners for men inside and outside of marriage, while women are required to be faithful and monogamous. Such socio-cultural practices and norms make men and their partners especially vulnerable to HIV. In a study in Zimbabwe, one in eight married men said they had casual sex (more than one sexual partner in the previous twelve months), but only one in one hundred women said they had sex outside marriage. In these circumstances marriage puts women at the greatest risk of HIV infection instead of protecting them.

In many countries, MSM also have sex with women. In a study of MSM in South Asia, thirty-nine percent of respondents who were married stated that their wives knew that they had sex with other men, but claimed that their wives accepted it, or were incapable of doing anything about it as divorce is highly stigmatizing for women and often leads to ostracism. Further, masculinity demands that men be sexual risk-takers. With lack of knowledge of HIV and reluctance to use condoms, these practices put men and their male and female partners at risk of HIV. In this context, the dangers of multiple sexual partners relates to the fact that if one person in a ‘circle’ of partners gets infected with HIV, there is a very high likelihood that all persons involved will become infected.

2.5 Harmful Cultural and Traditional Practices

Harmful cultural practices such as widowhood-related rituals, sexual cleansing and female genital cutting (See Example Box 2) heighten the risk of HIV transmission. These practices are often justified in the name of cultural values and traditions. No doubt cultural values and traditions are important to community identities, but it is important to realize that they cannot be continued at the cost of the right to health of the individual.

Example Box 2: Female Genital Cutting

Between 100 and 140 million women and girls have undergone mutilating operations on their external genitalia, suffering permanent and irreversible health damage. Every year, two million girls are subject to mutilation, which traditional communities call “female circumcision” and the international community terms “female genital mutilation” (FGM), or “female genital cutting” (FGC). According to WHO, FGM/FGC comprises all procedures involving partial or total removal of the external genitalia or injury to the female sexual organs. This could be either for cultural, religious, or other non-therapeutic reasons. FGC is practiced in a large number of countries and cultures.

FGC/FGM places girls and women at increased risk of HIV infection through several routes. Firstly, the use of unsterilized instruments, such as razors or knives, to carry out the procedure among a number of girls risks passing the virus from one girl to the next. Secondly, FGM renders the female genitals more likely to tear during intercourse. In cases of sewing up of the vaginal entrance, penetration is bound to lead to bleeding, which in turn makes sexual transmission of the virus from an HIV positive partner much more likely. Thirdly, difficulties with intercourse may make a woman less likely to welcome the partner’s advances and...
lead him to a more violent approach to sex; or to engage in sexual practices with his wife (such as unprotected anal intercourse) which might place her at increased risk of HIV infection. The perpetuation of this practice is a clear example of gender-based discrimination and a violation of the right to health.

2.6 Gender-based Violence

Gender-based violence has become commonplace in almost all societies. Acts of violence greatly increase vulnerability to HIV, especially for women and marginalized groups such as MSM. Violence has many facets. Within the household this can include battering by an intimate partner, marital rape, dowry-related violence, and sexual abuse. Violence outside the home can include rape, sexual abuse, sexual harassment and assault. Violence against MSM in many societies is often targeted at feminized MSM, who are often the sexually ‘receptive’ partners, not the ‘penetrating’ partners.

Various social, cultural, and religious norms produce and reinforce gender inequality and the stereotypical gender roles that underpin gender-based violence. Gender-based violence is a key factor in increasing risk of contracting HIV. For millions of women, the experience or fear of violence is a daily reality and, increasingly, so is HIV/AIDS. Studies from various countries have shown up to threefold increases in risk of HIV among women who have experienced violence as compared to those who have not. Gender-based violence is a violation of human rights and is identified as such by international human rights treaties (See Rights Box 3).

Violence increases vulnerability to HIV infection in several ways. Sexual violence can result in ‘direct transmission’ of HIV which can be the result of forced or coercive sexual intercourse with an HIV-infected partner. The biological risk of transmission in a violent sexual encounter is determined by the type of sexual exposure (vaginal, anal or oral). Transmission of HIV is higher for anal, followed by vaginal, and then oral sex. Risk of direct transmission in forced and coerced sexual encounters is also dependent upon the degree of trauma, such as vaginal or anal lacerations and abrasions, which occurs when force is used. For example, where sexual violence occurs in girls and young women, risk of transmission is likely to be higher because girls’ vaginal tracts are immature and tear easily during sexual intercourse. Sexual violence can also result in ‘indirect transmission’ of HIV infection among women or men: violence or the threat of violence affects the individual’s power and ability to negotiate the conditions of sexual intercourse, especially condom use.

In a study from South Africa, women who experienced coercive sex were found to be nearly six times more likely to use condoms inconsistently than those who did not experience coercion and, in turn, women with inconsistent condom use were 1.6 times more likely to be HIV infected than those who used condoms consistently.
“My husband hated condom use. He never allowed it. He used to beat me when I refused to sleep with him… He said ‘when we are man and woman married, how can we use a condom?’…It’s a wife’s duty to have sex with her husband because that is the main reason you come together. But he didn’t listen to me. I tried to insist on using a condom but he refused. So I gave in because I really feared [him].”

- Woman from Uganda in Human Rights Watch Report

Violence is also directly and indirectly associated with men’s increased vulnerability to HIV. Several studies highlight that men’s use of violence is linked to their own sexual risk-taking. One study showed that Indian men who had experienced extramarital sex were 6.2 times more likely to report wife abuse than those who remained faithful; and those who reported STI symptoms were 2.4 times more likely to abuse their wives than those who did not. Violence or the fear of violence is also considered to be a barrier to women seeking HIV testing, and for those who seek testing it acts as a barrier to disclosure of their HIV status to their male partners. For example, more than half of the women surveyed in Kenya who knew they were HIV infected said that they did not disclose their HIV status to their partners because they feared violence or abandonment. Many community organizations are working in this area to build awareness on the issue (See Example Box 3).

Example Box 3: Gender-based violence

The Group of Men Against Violence (GMAV), founded in Nicaragua in July 1993, originally began educating male staff of participating NGOs about gender issues and violence. They then organized workshops, courses on masculinity, and support activities for men in various communities. By 1998, GMAV was conducting seven youth groups in the capital city of Managua led by adults who had completed the training. The young male participants were enthusiastic, suggesting their own topics for discussion such as the influence of drugs and alcohol on their sexual behavior. An impact evaluation in late 1997 of one of the participating NGOs courses showed changes in gender norms among the adult men who are important in educating their adolescent counterparts.

Violence is also inflicted on sexual minorities such as transgender people, lesbians, gay men and other MSM in almost all countries. Violence against homosexual men and women is particularly rampant in countries where laws prohibit same sex relationships. In these circumstances violence takes many forms such as high levels of abuse and rape. The social, legal and judicial environment in these countries has a detrimental impact on sexual health interventions, where even staff members of NGO MSM agencies are victimized by law enforcement agencies. In a study of Kenyan MSM, victims of physical, verbal, or other forms of violence were significantly more likely to not use a condom at last receptive anal sex, have unprotected sex at last insertive anal sex, and to never use condoms. This indicates that MSM whose lives are characterized by violence are less able to negotiate condom use than other MSM.

Feminized males who do not perceive themselves, nor are perceived, as “men” within MSM are doubly stigmatized because even though biologically they are males, they express a feminine identity and a sexual practice which is seen as being feminine, i.e. they are penetrated. Their feminization reinforces their stigmatization leading to exclusion, harassment, violence and rape. Feminized males face similar levels of violence as women due to social constructions of masculinity and femininity.

This leads to disempowerment of feminized males and increases the vulnerability of MSM to HIV where violence and the violation of human rights obstruct social justice redress. This creates an atmosphere of fear where implementation of sustained HIV risk reduction programs is very difficult, if not impossible (See Example Box 4).
Example Box 4: Homophobia in Jamaica

“In Jamaica, state-sponsored homophobia and discrimination against homosexual men and women ….and the conflation of HIV/AIDS with homosexuality … are undermining an effective response to HIV/AIDS. Police not only harass and persecute people suspected of homosexual conduct but also interfere with HIV/AIDS outreach to them. Men who have sex with men and people living with HIV/AIDS face serious violence and are often forced to abandon their homes and communities. Many are denied health care and past experiences of discrimination, coupled with the fear that their HIV status or sexual orientation will be disclosed and publicized, keep many people from seeking health care in the first instance”.71

- Human Rights Watch Report

“Police always harass me. . . . They stop you and hear you talk a bit feminine [and] they ask you personal questions like are you top or bottom and like that. . . . The last time this happened . . . two police came over and said ‘Battyman mus dead. You should be under the ground. You should not be living in Jamaica.’ … Some police officers say it is not legal so you should curtail your behavior. But most of them, once they hear you talk feminish they begin to [verbally abuse] you and a crowd comes around.”72

- A gay man in Jamaica, Human Rights Watch Report
2.7 Stigma and Taboos

Cultural stigma and taboos (social bans), especially related to sex and sexual activities, increase men’s and women’s vulnerability to HIV. The taboos associated with sex and knowledge of sex act as barriers to seeking knowledge of HIV prevention and to providing the treatment care and support needed by those infected and affected by HIV.

HIV-related stigma (See Definition Box 2) is triggered by many forces such as a lack of understanding of HIV, myths about how it is transmitted, prejudice, lack of treatment, irresponsible media reporting, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs and injecting drug use. HIV and AIDS possess all the characteristics associated with stigmatized diseases. AIDS is incurable, degenerative and fatal. HIV infection has come to be associated with socially condemned sexual behaviors and drug use for which individuals are often considered responsible.73 Besides the stigma arising out of connotations of immorality associated with HIV and AIDS, ignorance about the disease also generates stigma.

Definition Box 2: HIV-related stigma

HIV-related stigma can be described as a “process of devaluation” of people either living with or associated with HIV and AIDS. The stigma often stems from the underlying stigmatization of sex and intravenous drug use - two of the primary routes of HIV infection.74

“It [HIV] might be transmitted through breathing, we do not know. So being careful is necessary: avoiding eating food, coming from patient’s home, not sharing clothes and not drinking with the glass that the patient used. This is what I think.”

- Man from Ethiopia76

“I asked, “Please give me a cup of sugar cane drink” and the vendor said: “If you drink in the cup, other persons will see you drink from that cup and they won’t dare to use it. So take the drink in a [plastic] bag.”

- A man living with HIV/AIDS, Vietnam78
HIV- and AIDS-related stigma and discrimination can take the form of anger and negative feelings towards people living with HIV (PLHIV), avoidance and ostracism, expressions of blame and shame (belief that they are responsible for their infection and deserve their illness), loss of livelihood, loss of housing, physical and emotional abuses, and disruption of family relationships.\(^7\)

Studies have shown that gender clearly plays a role in the nexus between HIV and AIDS and related stigma.\(^7\) Women are much more stigmatized than men when they are infected. This is because there is close association in many cultures between HIV and sex and hence moral impropriety, and women in most cultures are expected to uphold and preserve the moral values of their communities. In these circumstances, HIV is regarded as evidence that they have failed to fulfill their social duties.

The stigma and discrimination based on HIV status, in combination with deeply rooted stigmatizing attitudes and discriminatory practices towards women and girls, gay men and other MSM, transgender people, sex workers, and drug users, among others, creates conditions for HIV to flourish. For example, fear of stigma and discrimination prevents people vulnerable to HIV from seeking testing. Ignorance about one's HIV status increases the person's and their intimate partners' vulnerability to HIV infection. Fear of stigma and discrimination also adversely affects people's ability and willingness to disclose their positive test results to others. Stigma is also linked to power and domination throughout society as a whole. Ultimately stigma creates and is reinforced by social inequality.\(^7\) It causes some groups to be devalued and ashamed, and others to feel they are superior.\(^8\)

Due to the stigma associated with HIV and the discrimination that often follows, the rights of people living with HIV and their families are often violated (See Rights Box 4). Freedom from discrimination is a fundamental human right. Various international and regional human rights instruments prohibit discrimination based on race, color, sex, language, nationality and other statuses. The United Nations Commission on Human Rights has declared that the term “other status” in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV and AIDS (resolution 1999/49). It states “discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing human rights standards” (resolution 2001/51).

### RIGHTS BOX 4: ELIMINATING STIGMA AND DISCRIMINATION

**United Nations Declaration of Commitment on HIV/AIDS**

Stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations. (Paragraph 13)

By 2003, [nations should] enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups... and develop strategies to combat stigma and social exclusion connected with the epidemic. (Paragraph 58)

**Guideline 9 of the International Guidelines on HIV/AIDS and Human Rights** says that states should promote the wide and ongoing distribution of creative education, training and media programs explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

### 2.8 Religion

Religion and religious beliefs are the foundations of community life in a majority of societies. Religion prescribes ethical guidelines for many aspects of daily life and also navigates belief systems and norms surrounding sexuality. The majority of religiously tailored belief systems condemn premarital sex, contraception including condom use, and homosexuality. Some religions also advocate a submissive role for women, foster gender inequality in marital relations, and promote women's ignorance in sexual matters as a symbol of purity. The sexuality and gender stereotypes constructed by religion can inhibit prevention efforts and increase vulnerability to HIV infection.
HIV vulnerability caused by religious beliefs and practices is the result of religious institutions’ denunciation of HIV infection as sinful. Such religious judgments play a significant role in generating HIV- and AIDS-related stigma which increases vulnerability.

The religious construction of sexuality, with its emphasis on virginity, has led women to engage in anal sex in an attempt to preserve their virginity, which also increases their vulnerability to HIV. Research has shown that religion also influences men’s and women’s exposure to HIV prevention messages, knowledge and perception of risks, and the practice of prevention. Women have been found to be disadvantaged in seeking information about HIV/AIDS due to their religious beliefs. Religions advocating against condom use pose a serious challenge to preventing the spread of HIV in the communities where they operate. Similarly, religions that denounce homosexuality tend to fuel stigma against those who engage in same sex behavior, thus indirectly increasing their vulnerability to HIV (as noted in section 2.7).

Religion, in spite of being a social determinant of vulnerability, has great potential for preventing HIV and reducing HIV- and AIDS-related stigma. Because of the influence religious leaders have on the community, they can play a significant role in behavior change interventions, including the promotion of condom use, to reduce HIV transmission and de-stigmatize HIV and AIDS (See Example Box 5).

Example Box 5: Role of Religious Leaders in the HIV Response in Senegal

Senegal is a country with two predominant religions; Islam and Christianity. The associations affiliated with these religions are involved in diverse social institutions such as schools, health facilities and youth movements that affect every aspect of people’s lives. Recognizing the importance of involving religious leaders in HIV prevention efforts, Senegal’s National AIDS Control Programme (NACP) planned, supported and pursued strategies for establishing policy dialogues on HIV/AIDS with Senegalese religious leaders.

The objectives of the policy dialogue were to increase awareness and understanding of Senegalese religious leaders about HIV prevention strategies, and to build support among them for an effective comprehensive HIV prevention program.

The program drew messages from religious texts to mobilize religious leaders in HIV prevention. The participation of religious leaders legitimized HIV and AIDS interventions at the community level. NGO’s and local organizations’ involved in information, education and communication activities added a religious element to their HIV related messages. These efforts contributed to an increase in the level of knowledge of HIV/AIDS and an increase in the use of condoms as a means of protection against HIV.

2.9 Recommendations:

- HIV programs must address the root causes of gender-based vulnerability to HIV.
- HIV programs must focus on greater sensitization and education of men and women on the traditions and cultural practices that increase the risk of HIV infection.
- Governments must adopt policies and enact legislation against harmful traditional practices that increase vulnerability to HIV.
- Governments must take stronger measures to prevent the rising incidences of violence against women and sexual minorities.
- Measures must be taken to introduce sex education curriculum in schools, and boys and girls should be provided with information on HIV prevention.
- Outreach programs must involve the use of positive role models (male and female) in the media that break existing stereotypical images and beliefs of HIV.
- Opinion leaders and religious leaders must be engaged in behavior change interventions such as promoting condom use.