Socio-Cultural Determinants of HIV and AIDS: the Context of Women in Bangladesh

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Abstract: HIV/AIDS is one of the major threats to economic development. Although the epidemic was first detected among men and was primarily concentrated among men, in many regions, women remain at a much higher risk of HIV infection than men. A significant shift of the epidemic with a higher proportion of new HIV infection among women was noticed in the late 1990s. While both women and men are vulnerable and affected by HIV and AIDS, a multitude of factors increases women's vulnerability to HIV acquisition, such as biological, behavioral, socioeconomic, cultural and structural risks. Most studies and interventions conducted in Bangladesh focus on key affected populations such as female sex workers and people who inject drugs. Rather than focusing on the key affected population only, this article reflects on the role of the socio-cultural determinants those make women more vulnerable to HIV transmission in the context of Bangladesh.

Keywords: HIV/AIDS, Bangladesh, socio-cultural determinants, women

1. Introduction

HIV/AIDS is one of the major threats to development and a primary public health concern despite major efforts and political commitments to eliminate the epidemic by 2015 [1]. According to UNAIDS, nearly 35.3 million people were living with HIV, and there were 2.3 million new HIV infections globally in 2012 [1]. Although the epidemic was first detected among men and was primarily concentrated among men, a gradual but significant shift of the epidemic with higher proportion of new HIV infection among women was noticed in late 1990s [2]. By 2012, majority of the HIV-positive cases were identified among women.

While both women and men are vulnerable and affected by HIV and AIDS, women are especially vulnerable due to biological and socio-cultural determinants [2]. The UNAIDS report on the global epidemic showed that the number of women infected and/or affected by HIV/AIDS is almost double compared to men in low- and middle-income countries [1]. In this article presents an analysis of the role of gender in the socio-cultural context of Bangladesh in making women more vulnerable to HIV transmission.

2. Methods

Scholarly search engines, major databases, digital library and search engines such as PubMed, JSTOR, Web of Science and Google Scholar were used for the literature search. Technical papers, strategic plans and special publications published by national and international organizations were collected. Literature focused on socio-cultural determinants of health, women, HIV and AIDS in Bangladesh were included for the review. Global data on women, HIV and AIDS were collected as well. Based on set inclusion and exclusion criteria, 47 literatures were reviewed, critically examined and analyzed.

3. Women, HIV and AIDS: the Context of Bangladesh

Bangladesh, resource-constrained country of south Asia, experienced the first case of HIV in 1989 and within 20 years, the country experienced a concentrated HIV epidemic among people who inject drugs (PWID) [3-5]. Besides, the prevalence of active syphilis among female sex workers (FSW) were more than 5% across different venues, and highest rate of active syphilis was recorded among street based FSWs in Hili (12.5%) [5]. An extensive review of literature of HIV and AIDS scenario on Bangladesh revealed that women are disproportionately vulnerable to HIV not only because of biological determinant, but also mainly because of gender inequity that pose higher risk of HIV transmission among women [4]. The same findings were later reflected in the national strategic
plan for HIV and AIDS and by ministry of health [6, 7].

3.1 Patriarchy, social status of women, HIV and AIDS

In the patriarchal society of Bangladesh, women have lower social status that can leave them to greater exposure to HIV transmission. Early marriage is a still prevalent in Bangladesh which is reinforced by social norms those places higher status of women who get married early and parents want their daughters to get married at an early age [8, 9]. In this marital context, young women get married to elder males. Women at that age have limited knowledge on sexuality, while the men have more experience of sexuality and are exposed to different sexual networks due to social norms on masculinity that permits promiscuity, premarital and extramarital sexual relationships and more likely to have sexually transmitted infections (STIs) [10-12]. In addition, due to higher social status, men are the ultimate decision makers regarding condom use sexual relations in the marital context or pre or extramarital sexual relations [11, 13-14]. Early marriage of women to elder men in Bangladesh therefore poses greater risk of HIV transmission among women due to their lower social status that affects negotiating condom use, and exposure to wider sexual network through elder and experienced man.

3.2 Violence against women in Bangladesh: higher risks of HIV transmission

Violence against women increases women’s vulnerability to HIV transmission. It is now a fact that violence, especially sexual violence including forced sex or rape, increases women’s vulnerability to HIV transmission [2, 15-17]. Violence against women, including sexual violence, had been widely reported in both rural and urban settings [18, 19]. Such violence undermines women’s dignity and affects their capability to negotiate, or at least initiate the proposal to use condoms. Violence against women in the social context of Bangladesh increases women’s vulnerability to STI transmission as well as HIV transmission [4, 20]. In addition, perceived risk of violence also limits women’s service uptake like voluntary counseling and testing (VCT) or HIV counseling and testing (HTC). Moreover, the same fear affects HIV-positive women’s health-seeking behavior [4].

3.3 Stigma, discrimination, social exclusion: women, HIV and AIDS

Widespread stigma and discrimination against HIV-positive people had been documented in Bangladesh and women suffer the most because of this stigma [21, 22]. Stigma and discrimination associated to HIV and AIDS often hinders women’s access to VCT and antiretroviral treatment for those who are HIV positive. United Nations General Assembly Special Sessions (UNGASS) monitoring report on Bangladesh shows that in Bangladesh, still now, HIV and AIDS as outcomes of promiscuous and immoral sexual behavior [23]. Like other neighboring patriarchal countries, “chastity” of women is highly valued in Bangladeshi society [24, 25].

Moreover, this stigma is so acute that even service providers and health care workers had expressed their negative attitude towards people living with HIV and AIDS, especially women [21]. A recent study among Bangladeshi doctors and nurses revealed that even with better knowledge and understanding about HIV and AIDS, they tend to stigmatize people living with HIV and AIDS (PLWHA) [26]. Their attitude towards women was worsening, since they “doubly stigmatized” women “both as "women" and as PLWHA”.

As a result, women are less likely to be tested for HIV due to perceived stigma, discrimination and social exclusion associated to HIV and AIDS due to the promiscuous nature of the epidemic. Again, due to the same reason HIV-positive women are more likely to suffer the most due to the delay in health seeking behavior for antiretroviral drugs [27]. Thus, although both HIV positive women and men both face stigma and discrimination the socio-cultural context of Bangladesh, women tend to suffer the most due to prevailing social attitudes and gender norms. Therefore, although Bangladesh has made notable success in reporting and achieving UNGASS indicators, ensuring women’s adherence to VCT and antiretroviral drugs remain as a challenge [4, 28].

3.4 Poverty, education and knowledge: gender inequalities, HIV and AIDS

T. Türmen (2003) in his critical review on gender, HIV and AIDS mentioned, “HIV and poverty are inextricably linked”, which seems to be the case in Bangladesh where poverty, HIV and AIDS reinforces each other [2]. Although Bangladesh had made significant progress in poverty reduction and women’s employment, still around 26 percent people live under the poverty line earning only two US Dollar per day [29]. The situation is worse for women, many of whom are dependent on men for living. Again, poverty is one of the major barriers to education and acquiring appropriate knowledge. A study on the role of media on developing HIV-related knowledge indicates that
Poverty also leads to an inextricable of drug use and unsafe sex act among a few women PWIDs. In a study among female PWIDs of Dhaka district of Bangladesh, Azim, et al. found that many female PWID sell sex to make the money for their living and to purchase injecting drugs [35]. The female PWIDs, who also sell sex, are less likely to negotiate condom use in paid sex due to intoxication and for their extreme poverty.

3.5 Indigenous women, HIV and AIDS

Indigenous population of Bangladesh had been exploited by dominant Bengali community in many ways [36, 37]. Indigenous women, in particular, were reported to be exploited due to their “minority” indigenous status and for being women. In an anthropological assessment among the indigenous population of Bangladesh, it was found that the indigenous populations are vulnerable to HIV transmission due to their culturally embedded practices and due to inter-ethnic interaction with Bengali community. However, the findings of an unpublished study revealed that indigenous women were more vulnerable to STIs and HIV transmission due to sexual abuse, poverty, limited education, and being abused by intoxicated clients, prolonged unsafe sexual intercourse with intoxicated male partners, unwanted sex with guards during cross-border mobility [38]. Moreover, due to limited access to biomedical knowledge and absence of HIV prevention led to a situation where condom had no place in their perception that ultimately made women the most vulnerable to STI and HIV transmission.

4. Discussion: gender analysis of HIV, AIDS and STIs among women in Bangladesh

World Health Organization (WHO) developed gender analysis tools to identify how sex and biological differences between women and men to focus on several socio-cultural indicators and determinants in relation to HIV and AIDS [39, 40]. Based on this tool, an attempt has been made to explore these indicators and socio-cultural determinants in the context of Bangladesh as outlined by WHO. Comparisons had been made with other countries, where data is available.

Vulnerability: It is now scientifically established that HIV infection is higher in women than men due to biological reasons [41]. In addition, Studies conducted in other countries show that due to biological reasons “transmission of HIV’ from a man to a woman is 2 to eight times more efficient than from a woman to a man [42].” Moreover, high risk of HIV and STI transmission during unprotected anal
intercourse is “estimated to be 18 times higher than the rate during vaginal intercourse and the risk of acquiring HIV during an act of unprotected anal intercourse is estimated to be 1.4 percent [43, 44].” The pathogens (e.g. HIV) are more likely to be transmitted during male-to-female (vaginal and anal) sex where mucous membranes are more easily broken. Different gender roles and activities of men and women affect women the most. The underlying reasons for this are women confront multiple health risks and women mostly play passive/receptive role in sex acts. Access to and control over resources of Bangladeshi women is a key factor that increases their vulnerability. For example, poverty and gender inequality may lead to different exposure to STI and HIV for women and men. For example, high client turnover and lower level of condom use among FSW mostly because of structural and environmental factors like poverty and masculine notions related to the sex act among men. Moreover, due to sociocultural norms and customary laws, sometimes women have limited access to services.

Health seeking behaviour: Women’s greater involvement in household activities and limited mobility affects their health seeking behaviour. Besides, existing gender norms and values, and control over resources affect women’s access to healthcare services is constrained due to their relative disadvantage to most men in socio-economic status and promiscuous nature of STI, HIV and AIDS. These can be critical factors in accessing healthcare facilities available for treatment for STI.

Ability to access health services: Economic marginalization affects women’s access to health services. Societal oppression due to stigma attached to sex sell, drug use, etc. make women especially vulnerable to HIV and STI infection and transmission.

Experience with health services and health providers: Health facilities sensitive to women, especially people living with HIV and AIDS (PLWHA), are yet to be strengthened in Bangladesh. Medical doctors and nurses often perceive negative attitudes towards women who are HIV positive.

Preventive and treatment options, responses to treatment or rehabilitation: Studies in other countries show that due to asymptomatic nature of STIs among women, it is difficult to treat some STIs among women; and presence of STIs make an individual more vulnerable to HIV transmission [45, 46]. In addition, due to perceived stigma and discrimination, women are less likely to be willing to seek voluntary testing and counselling (VCT) and care from existing healthcare facilities.

Outcome of health problem: Stigmatization of HIV and AIDS, along with the societal expectation that women will be less knowledgeable on sexuality are significant barriers for women to negotiate condom use in marital framework. Diverse socio-cultural factors, alongside poverty, make FSW negotiating condom use with clients. The outcome of HIV and is worse in case of women as once infected they are much more stigmatized, face many negative consequences including social exclusions.

5. Conclusion and Ways Forward

Bangladesh is still a low HIV prevalent country, especially among the general population [4]. Early responses to HIV and AIDS along with circumcision are considered as key factors for this success [3, 4]. However, these are common in several African contexts where HIV is an epidemic among the general population. Unless women’s needs and vulnerabilities are addressed, Bangladesh may face a similar scenario. To address this, structural intervention (inclusive of gender issues) to HIV prevention is required along with continued research on gender inequalities, HIV and AIDS [47]. A successful response to HIV and AIDS in the sociocultural context can only be achieved by addressing women’s needs and bringing men on board.

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