GENDER EMPOWERMENT IN THE CONTEXT OF THE HIV/AIDS EPIDEMIC

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Background

Gender inequality continues to fuel the 30-year-old HIV/AIDS epidemic in many countries (Piot, 2001). Worldwide, UNAIDS reports that men and women are almost equally affected by the epidemic. Yet in sub-Saharan Africa prevalence figures for the numbers of men and women infected with HIV in 2005 are 9.2 million and 13.2 million, respectively (UNAIDS, 2006). In addition, women are becoming infected with HIV/AIDS and dying at younger ages than men (UNICEF, 2000). Estimates for southern Africa suggest that 50% of children age 15 will die of HIV/AIDS and that three times as many girls as boys in the age group 15–29 are already infected with the virus (UNDP, 2000). However, there are still no effective strategies for prevention available to women, and governments and non-governmental organizations are struggling to develop appropriate counseling and treatment options (Susser, 2002).

From over twenty years of research on women's roles in development, we know that women have less access over and control of productive resources than men—resources such as income, land, credit, and education. While the extent of this difference varies considerably from one culture to the next, it almost always persists (Buvinic, 1995; Sivard et al., 1995). The power imbalance that defines gender relations and sexual interactions in most cultures increases women's vulnerability and affects women's access to and use of services and treatments. For this reason, since the late 1980s, women's empowerment has been the focus of much work on HIV/AIDS. Particularly, health educators and community activists have concentrated on women for education about prevention, at the beginning promoting narrow messages such as 'ask the man to use a condom' and 'love faithfully' (Gupta, 1996) and, more recently, promoting the use of the female condom (Gollub, 2000). This approach disregards the possibility that, in the

context of the AIDS pandemic, gender relations might evolve and thus that individual strategies of prevention might expand beyond the narrow range offered by family planning methods. Little attention has also been given to the interaction between perceptions of individual autonomy and perceptions of individual HIV risk, and their impact on AIDS-related behaviors. Yet it has been shown that men and women develop strategies of behavior on the basis of their perception of infection risks (Anglewicz and Kohler, 2005), and that they often tend to overestimate their risk, especially married women (Smith and Watkins, 2004; Bignami et al., 2006).

To better understand the changing meaning of gender empowerment in the context of the AIDS epidemic, in this paper we evaluate the relationship between perceptions of individual autonomy, perceptions of individual risk, and AIDS-related behaviors in a longitudinal perspective. We use data from the three most recent waves of the Malawi Diffusion and Ideational Change Project, a longitudinal survey on the role of social networks in changing attitudes and behavior regarding HIV/AIDS, family size, and family planning in rural Malawi.

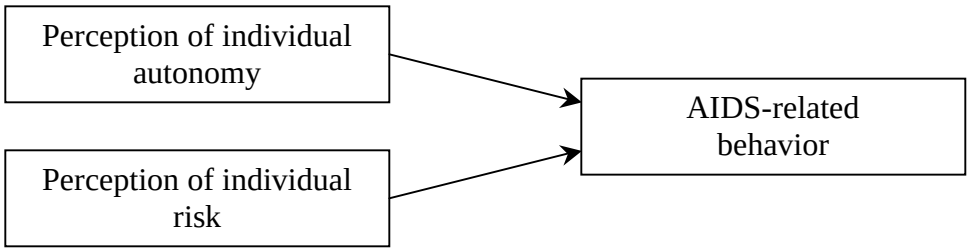
Data and methods

Since 1998, the Malawi Diffusion and Ideational Change Project (MDICP) has collected longitudinal data for a population-based sample of approximately 3000 respondents age 15 or older to examine the role of social networks in changing attitudes and behavior regarding HIV/AIDS, family size, and family planning in rural Malawi. The MDICP is conducted in rural areas of three Malawian districts, one in each of the three regions of the country (North, Center, and South). A comparison of the characteristics of the 1998 MDICP sample with those of the rural population surveyed in the 2000 Malawi Demographic and Health Survey indicates that, at the baseline, the MDICP sample was representative of the national rural population (more details on sampling and fieldwork procedures, as well as the survey data, are available from the project's website: http://malawi.pop.upenn.edu).

The MDICP has completed four survey waves have been completed in 1998, 2001, 2004 and 2006. In this paper, we use longitudinal data from the three most recent waves to ensure questions' comparability. Attrition and nonresponse were quite low

(Bignami-Van Assche et al., 2003), so we are confident that these sources of bias do not significantly affect our results.

Our conceptual framework is illustrated below. Our main goal is to evaluate the extent to which the independent effect of perceptions of individual autonomy and HIV risk on AIDS-related behavior changes for the MDICP female respondents between 1998 and 2004.



We measure the perception of individual autonomy for our sample from a set of ten questions. The first eight questions capture women's attitudes towards divorce in relation to different dimensions such as sexual behavior, faithfulness, and sexually transmitted infections (HIV/AIDS and other STDs). These questions are: "Do you think it is proper for a wife to leave her husband if: A) He does not support her and the children financially? B) He beats her frequently? C) He is sexually unfaithful? D) She thinks he might be infected with AIDS? E) He does not allow her to use family planning? F) She thinks he might have an STD? G) He cannot provide her with children? H) He doesn't sexually satisfy her?" The last two questions capture the acceptability of using condoms with one's spouse, in general and specifically when the husband is suspected to have HIV/AIDS.

We measure perceptions of individual HIV risk for the MDICP female respondents on the basis of their answers to the question: "In your opinion, what is the likelihood that you are currently infected with HIV?"

Finally, we use two sets of questions to measure AIDS-related behavior in relation to the three 'classic' protective strategies against HIV infection: abstinence, faithfulness, and condom use. The first set of questions asks the respondent whether she has made any changes in her sexual behavior to avoid getting HIV/AIDS, and then asks her to specify what these changes were (such as abstaining from sexual intercourse, being faithful to her

husband, using condoms, being more selective about sexual partners, or ending risky sexual relationships). The second set of questions asks the respondent about whether she used condoms with up to three of her most recent sexual partners, and the reasons for not using them. We also use the detailed marital histories collected by the MDICP in each wave to measure marital disruption due to divorce when the suspicion of infidelity or HIV infection where the primary reasons given by the respondent for ending the relationship. This is because it has been argued that, in this setting, divorce has become an important protective strategy against HIV/AIDS (Reniers, 2003).

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