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HIV/aids in Brazil: the feminization of the epidemic under analysis

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Abstract

This article analyzes the feminization of the HIV/aids epidemic in Brazil and the importance of considering this process when planning public health actions. This study is a literature review and also includes the analysis of official data from the Ministry of Health. The results show that effective actions to combat HIV/aids infection among women must take gender differences and the sociocultural conditions of each region into consideration. The need for a broad health education process for both men and women focusing on empowerment, self-care and caring for others can also be highlighted.

Keywords: HIV. Acquired immunodeficiency syndrome. Feminization. Disease prevention. Health promotion. Health planning. Empowerment for health.

Resumo

HIV/aids no Brasil: feminização da epidemia em análise

Este trabalho analisa a feminização da epidemia de HIV/aids no Brasil e a importância de considerar esse processo no planejamento de ações em saúde pública. A pesquisa foi desenvolvida por meio de revisão de literatura e estudo de dados oficiais do Ministério da Saúde. Os resultados mostram que ações eficazes no combate à infecção por HIV/aids entre as mulheres devem contemplar diferenças de gênero e condições socioculturais de cada região. O artigo ainda propõe que é imprescindível um processo amplo de educação em saúde, que abranja simultaneamente homens e mulheres e tenha foco no empoderamento e no cuidado de si e do outro.

Palavras-chave: HIV. Síndrome de imunodeficiência adquirida. Feminização. Prevenção de doenças. Promoção da saúde. Planejamento em saúde. Empoderamento para a saúde.

Resumen

VIH/sida en Brasil: la feminización de la epidemia en análisis

Este artículo analiza el proceso de feminización de la epidemia de HIV/sida en Brasil y su importancia en las acciones de planificación en la salud pública. La investigación parte de una revisión de la literatura y de datos oficiales del Ministerio de Salud de Brasil. Las acciones efectivas para combatir la infección por VIH/sida entre las mujeres deben abordar las diferencias de género y las condiciones socioculturales en cada región. Es esencial un amplio proceso de educación sanitaria, que abarque a las poblaciones masculinas y femeninas, centrándose en el empoderamiento, el autocuidado y el cuidado de los demás dentro de las relaciones establecidas.

Palabras clave: VIH. Síndrome de inmunodeficiencia adquirida. Feminización. Prevención de enfermedades. Promoción de la salud. Planificación en salud. Empoderamiento para la salud.

Research

The authors declare no conflict of interest.

In the early 1980s, a large number of male patients residents of San Francisco and New York, presented a similar clinical picture, characterized by the appearance of Kaposi's sarcoma, *Pneumocystis carinii* pneumonia and compromised immune system. This was a new disease, which appeared to be infectious and communicable. Similar cases were also reported in Haiti and Central Africa, in an apparently restricted group of people, composed of hemophiliacs, homosexuals, injecting drug users and sex workers [1,2].

In 1983, researchers Luc Montagnier and Robert Gallo were able to isolate the HIV-1 virus in blood samples from sick patients, and an international committee recommended the use of the term "human immunodeficiency virus" to name the cause of the new pathology – the acquired immunodeficiency syndrome (aids) [1]. In 1986, a second etiological agent was identified with similar characteristics to HIV-1, which was called HIV-2 [1,2].

Aids is the worsening of HIV infection, marked by great compromise of the patient's immune system, leading to the emergence of opportunistic diseases caused by viruses, bacteria, protozoa, fungi and neoplasms. Due to advances in antiretroviral therapies, patients living with HIV can remain healthy for many years. However, recent studies have shown that HIV infection initiates a more accelerated aging process when compared to healthy people, bringing the degenerative character of the disease into light [3]. A factor that possibly contributes to this process is the cellular response added to the individual's age – which occurs prematurely, in response to stress – and its relationship with comorbidities and antiretroviral therapies [3].

Over the decades, Brazil has advanced in the assessment and monitoring of the disease, reaching the compulsory notification of HIV infection in the Health Surveillance System from 2014 onwards. Currently, aids and HIV infection are included in the National Compulsory Notification List of diseases. However, despite all these efforts, epidemiological bulletins from the Ministry of Health (MS) [4,5] reveal underreporting of cases in the Notifiable Diseases Information System (Sinan) and point out flaws in the registration of information, such as the lack of identification of the individual's sexual orientation and the exclusive focus on sexual partnerships, practices, and affective-sexual relationships and the classification of people as cisgender or transgender (based on agreement, in the cis case, or disagreement, in the trans case, between self-declared gender identity and the anatomical sex designated at birth [6]).

Such reporting of deficiencies make it impossible to produce trustable data to understand vulnerabilities to HIV infection and may hinder the continuity of the medication delivery system and, consequently, the definition of more consistent strategies to face the epidemic [4]. Epidemiological data from the MS show that, from 2007 to June 2020, 342,459 cases of HIV infection were reported in Brazil, distributed as follows: 152,029 (44.4%) in the Southeast, 8,385 (20%) in the South, 5,106 (19%) in the Northeast, 30,943 (9%) in the North, and 25,966 (7.6%) in the Midwest. As for aids, from 1980 to June 2020, 1,011,617 cases were identified, with a greater concentration in the Southeast (51%) and South (19.9%), followed by the Northeast (16.2%), North (6.7%) and the Midwest (6.2%). Of the 37,308 aids cases detected in 2019, 48.5% were from the Sinan, 8.2% from the Mortality Information System (SIM) and 43.3% from the Laboratory Examination Information System (Siscel) [4], showing a decrease in the registration of aids cases in the Sinan.

Despite the decline in the number of aids cases in Brazil in recent years, the MS points out that part of this decrease may be due to problems in the information transfer between the Unified Health System's (SUS) databases at all management levels (municipality, state and the Federation). Currently, the reduction in numbers may also result from a slow data reporting in the Sinan databases, due to the mobilization of professionals and services allocated to the covid-19 pandemic [4].

In Brazil, the HIV and aids epidemic is composed of several sub-epidemics related to different realities, resulting from economic profiles, education level of the population and investment capacity in health. Over time, the viral infection has followed different

trends, such as internalization, feminization, impoverishment, and, in recent years, rejuvenation, with a new rise in male populations, noticeable by the increase in infection rates among younger gay and bisexual men [4-8].

Currently, SUS provides resources to combat HIV infection through Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP). The first is indicated for those most at risk of contact with the virus, members of the so-called "key populations": sexually active queer, trans people, sex workers, people who have unprotected sex with partners living with HIV, and patients who have frequent episodes of sexually transmitted infections or make repeated use of PEP. This second form of prophylaxis is aimed at people who, due to sexual violence, unprotected sex, or occupational accidents are at risk of contact with the virus. However, despite its importance for understanding the individual's profile, the previous use of these strategies are not recorded in the notification system [9,10].

Although the feminine category includes diverse women (cis, trans, heterosexual, lesbian, and bisexual), the feminization of HIV/aids has traditionally been treated as an exclusive issue of cisgender and heterosexual women. Trans women – long mistakenly included into the segment of sexually active queer men or men – have always been recognized as a vulnerable population. Lesbian women, on the other hand, tend to be understood as a group excluded from the risk of acquiring the infection. However, heterosexual and bisexual (when in a heteronormative affective-sexual relationships) cis women only became an object of concern for coping with the HIV and aids epidemic after the increase in infection rates in this segment. This fact reveals a high risk of exposure to an injury traditionally associated with "promiscuity" and homoaffective practices.

Despite not delving into the discussion about gender and femininity diversity, this article reflects on the feminization process of the HIV/aids epidemic seeking ways to overcome the different contexts of vulnerability of this group. We infer that the naturalization of the sexist view that cisgender and heterosexual women are monogamous and maintain stable relationships rendered weaknesses invisible, including these women in a territory of false protection. In summary, this article aims to analyze the feminization process of the HIV/aids epidemic in Brazil and discuss health promotion and planning actions geared to this segment.

Method

This is a narrative bibliographic review, method that searches the available scientific production and builds concepts that harmoniously combine diverse knowledge, making the research theme more explicit. We used a search strategy adaptable to the characteristics of the MS website and the databases searched (Latin American and Caribbean Literature in Health Sciences and Scientific Electronic Library Online). The searched keywords – all registered in the Health Science Descriptors – were combined with the Boolean operators *or* and *and*: "HIV," "aids," "feminization," "prevention," "health surveillance" and "health promotion". The bibliographic search, conducted in February 2021 without limitation filters, returned 100 papers. We excluded 38 duplicate studies and proceed to an exploratory reading of the remaining 62; finally, there were 30 papers that met the purpose of this article. These texts and analyzed and discussed below.

Women in Brazilian society

Gender inequalities, which place women in a cultural situation of inferiority in relation to men, are part of the historical formation of Brazil [10,11]. Analyzing the role of Brazilian women in the early 20th century, Biasoli-Alves [11] points out that submission to men (fathers, brothers and husbands) was seen as desirable. But, as the woman started attending school and entering the world of work, traditional values that characterized the "respectable young woman" – obedience, delicate disposition, manual skills, and purity – began to be rejected. Such values, however, did not cease to exist; they only began to manifest themselves in other ways.

Gender inequality makes women vulnerable to the power of men in different situations: domestic and sexual violence, violation of human rights, socioeconomic inequalities, among others [12-14]. These asymmetrical relationships promote a double sexual morality: women are expected to be modest and faithful to their partners, while men are seen as a sexual predator, even when in a stable affective relationship [13,15].

This pattern of behavior, when normalized, becomes a form of oppression. In our society, the naturalization of female monogamous behavior linked to affection still persists, despite all the advances represented by the contraceptive pill in the second half of the 20th century and other contraceptive methods that gave women greater freedom in sexual experiences and the search for pleasure, dissociating the sexual act from reproduction.

HIV/aids and women in Brazil

From 2007 to June 2020, Brazil accounted for 104,824 cases of HIV infection in women, which corresponds to 30.6% of the cases recorded in the period, with a ratio of 2.6 in 2019 (26 men for every 10 women). Among these women, 86.6% were infected in heterosexual relationships. From 1980 to June 2020, 346,791 aids cases were recorded in women (34.3% of the total), with 87.8% of infections via heterosexual relationships. The gender ratio has changed over the years, from 15 men to 10 women between 2002 and 2009, with a gradual increase afterwards, which has been maintained since 2017 at 23 men to 10 women [4].

The stigma that the epidemic would affect only one "risk group" (gay men, transvestites and trans women) put heterosexual cisgender women in a vulnerable situation. It was generally believed that only sex workers – i.e., those who were known to have multiple partners – would be exposed to the infection. But what we saw was the feminization of the epidemic in stable heterosexual relationships.

The naturalization of male sexual desire as continuous and inexhaustible, a symbol of virility, makes men put themselves at risk and extend this situation to their fixed partners. In this context, every opportunity for sexual intercourse, even if extramarital, should be taken advantage of, even if at the moment there are no condoms available for the practice of safe sex [15].

For the hegemonic model of male experience, the use of condoms is only justified for contraception, or when the partner is an "easy woman," i.e., offers some type of health risk. It is common for men to use the barrier method only at the beginning of relationships, switching to unprotected sex when they believe their partner to be faithful (even though they themselves have extramarital relationships) [15-17].

On the other hand, from a woman's perspective, love is often seen as selflessness, and the trust put in their partners harms the perception of infection risks by HIV and other sexually transmissible diseases [18]. Such excessive trust in one's partner and the fear of being misinterpreted – since that could cause the relationship to end – leaves women more vulnerable, impairing the negotiation with their partner about the use of preservatives during sexual relations [12,17-21].

Carvalho and Piccinini [22] state that the highest rate of HIV infection is found among women who have become attached to the false belief that married women do not contract the virus, only the "promiscuous ones." These women submit to their husbands, delegating to them the role of protection and care. As they are faithful in their relationships, they believe their spouses to also be faithful, and in this context there is no room to negotiate the use of condoms [23]. Thus, safe sex is only required during short periods: at the beginning of the relationship or when there is suspicion of cheating [16,18].

Among younger women the reality is no different. In a survey with adolescents between 12 to 21 years old, Sampaio and collaborators [24] found reports on the difficulty in negotiating condom use with partners. Nogueira, Saavedra and Costa [25] draw attention to the fact that among young people, especially females, there is a dangerous tendency to believe that the risk of HIV infection is small. Among those in stable relationships, the fixed partnership and "trust in the partner" are justifications for dispensing with the use of condoms [26]. Such situation is aggravated when women are already sterilized and do not need to protect themselves from unwanted pregnancies [27].

MS's prevention campaigns focus on the practice of safe sex – "use condoms" – and the consequences of exposing yourself to risk. However, judging by the spread of the epidemic, especially among the female cisgender population, such campaigns have not been successful [28]. Means of intervention should produce transformations, but for that one must get to know the sexual beliefs and practices of the place where one wants to intervene [29].

Understanding the increase in HIV infection in women is not an easy task, since aids carries the stigma of being a shameful disease, strongly associated with morally devalued behaviors. The social condition of women makes this task even more difficult, mainly because the prevention of aids is linked to the control of sexual behavior, which is related to reproduction and gender roles [30].

Published by the MS in March 2007 and updated in later editions, the Integrated Plan to Combat the Feminization of the Aids and Other STD Epidemic discusses scenarios in which women are more vulnerable and proposes 12 strategies to reduce the number of cases among women. Thus, the plan both identifies the causes of women's vulnerability and suggests important intervention activities to achieve the proposed goals [31].

After more than three decades of coping with HIV/aids, the epidemic remains an important and current issue, considering that human sexuality is one of its fundamental aspects [29]. As for the vulnerability of women, there are many factors that define it, such as age group and education level, that cannot be neglected if we want to adopt effective measures to fight the disease [32-34].

Results and discussion

Women's social role is changing. Initially educated to remain in the domestic sphere and to be housewives, more recently women have been entering the labor market. However, in the affective field, we can observe the permanence of this place of the feminine, forged in the late 19th century, of dependence and submission to men, which is one of the vulnerability factors for HIV infection [11,15,21,21]. The appreciation of the stable relationship and the belief that fidelity guarantees protection blinds people to the possibility that the spouse will have sexual relations with other people, including other men, something common in a society that encourages dual sexual behavior, which separates the husband/partner/boyfriend from the man who is always available for sexual experiences outside the affective or family context [12,13,15,17,20,21,23].

The fear of losing the social status that the stable relationship promotes – be it dating or marriage – or the fear of losing the partner's trust induce people to leave aside the discussion about adopting safe sexual practices, such as the use of condoms. On the other hand, when it comes to contraception, interlocution is more accepted [17,20]. This is due to the beliefs and moral values that Western society credits to marriage (and to stable relationships in general) attributes such as love, respect, fidelity, complicity, and trust [26].

Idealizing love can lead to the abandonment of protected sexual practices and the false belief that, in a stable relationship, there is no risk of infection by HIV (or by another sexually transmitted infection) [26]. Thus, it is not surprising that Barroso, Miranda and Pinheiro [27] found a common point among women infected by their partners: all were faithful to their partners and, because they believed in the reciprocity of feelings, contracted HIV.

Even among the adolescent population, the prevailing thought is that men are responsible for carrying condoms and take the initiative to use it, delegating to the woman a passive and dependent role in the relationship, with little influence on decisions made in the sexual sphere [24,25]. Youth is another important factor of vulnerability, as it combines biopsychosocial immaturity, economic dependence, ignorance of rights and less access to health services. In addition, it is common for young women to have relationships with older partners and, in many cases, to experience sexual violence [32,33].

In our society, women are still daily subjected to patriarchal domination, subordination, and violence. Social normativity determines that they must be feminine, delicate, affectionate, sensitive and submissive, while men are expected to externalize their masculinity by being dominant, active, aggressive, masculine [29,30]. In this sense, it is possible that older women, having been

educated in a context where the wife owes obedience to her husband, have a lower level of openness to talk about sexual life, which makes them even more vulnerable [12,19].

Another significant aspect is the association between condoms and discomfort or decreased pleasure, which reduces their use and increases the risk of infection [18,24,29]. The concern with safe sex seems to be restricted to the beginning of the relationship, a period of mutual evaluation to validate a "phase change" marked by the dismissal of the use of condoms. This happens even in extramarital relationships, which increases the risk of infection for all participants in the relationship [16,18].

When they suspect betrayal, some women demand that their partners start using condoms in marital relationships, but this requirement usually lasts for a short time [16,18]. Even if a laboratory test is done to rule out the possibility of infection, the negative result may be false, as antibodies are only detected in the blood after the so-called "immunological window" (for the rapid test, 30 days after exposure to HIV) [35]. In addition, testing only reflects the subject's serological status until the time of the exam. If unprotected sex continues to occur, the risk of infection will remain.

In Brazil, campaigns to prevent HIV infection focus on the use of condoms and are widespread only during the carnival season. Such campaigns are unable to contain the epidemic and disregard the power relations between men and women and different socioeconomic, cultural, and religious realities [14,21,22,28,36].

Through the Integrated Plan to Combat the Feminization of the aids Epidemic and Other STDs, the MS and the Special Secretariat for Policies for Women call on organized civil society, managers and participants in social movements to *develop, monitor and evaluate programs, actions and equitable and comprehensive strategies to promote universal access to prevent, diagnose, treat, and support people living with HIV and aids* [37]. As a way to expand access to health, we identify the integration of the plan into the Family Health Strategy and the Health and Prevention in Schools Project, at the municipal, state and federal levels, among other actions [31].

The continuous growth in the number of infected people, with about 40 thousand new cases of aids per year [4], reveals that the coping actions are still incipient. The current political situation makes the situation even more critical. Areas of education and health (including the Family Health Strategy) have been weakened by resource cuts, and a conservative wave seeks to erase issues such as the HIV epidemic from spaces for debate and structuring of public policies.

In the midst of all these difficulties, especially the female self-protection in the Brazilian sociocultural context, national epidemiological data reveal that the incidence of infections among men who have sex with men is on the rise [4]. Considering the fact that these men also maintain heterosexual relationships, it is possible that the number of infected women will continue to increase in the years to come. Thus, it is necessary to pay more attention to this fact and implement measures that protect the female population.

As feminist bioethics proposes, it is necessary to *change social relations that are characterized by human domination and subordination and that hinder the exercise of freedom* [38]. We must look critically at the established power structures and their damaging potential on the most vulnerable to seek reparation mechanisms [39].

Final considerations

This study showed that, given the complexity of relationships and gender inequality, HIV prevention campaigns focused on the use of male condoms have been ineffective in containing the epidemic, especially with regard to part of the female population: women infected in heterosexual relationships. Containing the spread of the virus among women requires more effective actions, which include several issues, such as knowing socioeconomic and cultural conditions in each region of the country, as well as power relations between men and women, which are more unequal in certain contexts.

It is essential to clarify the population about the importance of dialogue between partners and the need to self-care when experiencing sexual pleasure, including in stable relationships.

Emphasis should be placed on responsibility towards others and the duty to ensure the health and well-being of the partner we interact with, which favors negotiating the use of condoms not only as a contraceptive method, but also as a protective measure.

Primary care teams, especially the Family Health Strategy, should play a relevant role in this educational work. The link with the registered population facilitates a more frank dialogue between users and health professionals. Sex is still surrounded by taboos, and this closer relationship allows the subject to be addressed more directly, with the necessary depth. Moments of joint reflection, with the participation of health users (women and men) and professional staff, can also favor methods – such as case study and problematization – that expand the ability to reflect on the theme and empower the individual to adopt safe and conscious behavior.

Activities aimed at health promotion and disease prevention can even prepare women to be multipliers of educational information in their homes, with their children and other family members. In this way, looking at their own health needs is broadened and starts to transform the community. That is the reason why we must invest in female empowerment, a valuable tool for social transformation in a context that calls for changes in behaviors and to deconstruct the hegemonic pattern of domination of women by men.

Health education can also gain more strength with partnerships between health teams, schools and religious institutions belonging to the community where they operate. It is necessary to discuss the power relations established in our society and show that gender inequality harms women's lives. Managers and health professionals must be aware of the epidemiological peculiarities of each region in Brazil, working together with the population and seeking to know the behavior of people in the area where they work. Thus, investment in health can be directed to measures that can actually achieve the desired objective: to reduce cases of HIV infection in Brazil.

The ability to deal with issues of gender and sexuality – with a look at the other that sometimes confronts one's own beliefs and values – needs to be worked on right from the training period. Thus, the transversal inclusion of bioethics in the curricula of undergraduate health courses promotes a critical and reflective practice, aimed at developing moral competences that enable students to act in a fair and respectful way, free of prejudices and oppressive fundamentalisms. Continuing education is an ally in the task of fostering discussions about ethical action in health and human rights, seeking to break with the patriarchal and sexist logic, helping women to clearly perceive the risks of unsafe sexual practices and enabling them to self-care.

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