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Analysis and Comments

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REFLEXIVE ANALISYS ABOUT THE SOCIAL ASPECTS TO HIV/AIDS: FEMINIZATION, DISCRIMINATION AND STIGMA

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ABSTRACT

Aids has always been surrounded by taboos, prejudices and discrimination. Fact influenced by its history and its social construction. Objective: **To investigate influence of factors: discrimination, prejudice and feminization of Hiv, in important social aspects of the individual.** Method: **It was accomplished a historical overview of Hiv, followed by a reflective analysis that addressed the social behavior of the virus carrier, and the society, as well as these factors interfere with their social life.** Discussion: **It was observed that society keeps an exclusionary behavior towards carriers of HIV, which determines a behavior of self-exclusion of these individuals.** Conclusion: **Stigma being a socially constructed attribute, it is necessary to intensify the discussions about the issue, trying to deconstruct the old image of the bearer of HIV, and contribute to the return of people carrying HIV back into society, participating in social relationship.**

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Keywords: **Hiv; Acquired Immunodeficiency Syndrome; Feminization; Prejudice; Health education.**

INTRODUCTION

AIDS has always been a disease covered by taboos, stigma and prejudice, and for many years, it has been associated with homosexuals, prostitutes, hemophiliacs and drug users due to its history that marked it as a disease related to behavior not accepted in the society we live in and regarded as unclean, unhealthy, promiscuous and marginalized.

Thus, we sought to examine reflectively starting from the literature on how feminization, discrimination and stigma are related, influencing important social issues, interfering in the attitudes and lifestyles of both carriers of HIV and the society in general.

To better understand the influence of HIV/AIDS' history in stigmas present in society today, a brief description of AIDS in Brazil and worldwide is featured.

METHOD

This current study is a reflective analysis, from a narrative review of literature, whose source was a series of articles published in indexed journals, theses, dissertations and books available online. The search was initiated in the Virtual Health Library (VHL), focusing on LILACS and SciELO basis. For the selection of texts were used keywords: HIV, AIDS, and feminization, Discrimination. The selected texts have gone through analysis and reflection, using as a basis for thematic content analysis, through which it was possible to make a historical trajectory of HIV/AIDS and the psychological and social aspects related to the virus, the disease, HIV patients, and society at large.

Historical background of the AIDS epidemic

It was in late 70s and early 80s that the first hospitalizations caused by HIV took place. At the time this name did not exist yet and we did not know the causative agent of the infection. It was on this same occasion that occurred the hospitalization of five young adults in a Los Angeles hospital with pneumonia caused by Pneumocystis carinii, a few weeks later there was a record of 26 young people with Kaposi's sarcoma, a vascular neoplasm. That was when we began to notice an increase in the incidence of such cases worldwide, especially in the United States[1].

The healthcare professionals who were watching these people observed that all of them, until then, were male, had homosexual or bisexual behavior, got ill and often died of opportunistic diseases, since the PCP and Kaposi's sarcoma were observed in people who had compromised immunity or some genetic disease, or were transplanted[1].

The incidence of HIV infection increased remarkably. According to the Control Center in Atlanta the incidence of AIDS was doubling every six months, and it was observed that the infected people had the following characteristics: they were homosexual or bisexual men, prostitutes, hemophiliacs or intravenous drug users. At this point begins a race to find a cure for a stigmatized disease, full of prejudices and taboos, labeled as an ill that only people who were promiscuous and marginalized were affected. Then come the so-called risk groups. Kaposi's sarcoma is called the gay cancer[1].

The image of AIDS was built by society along with medicine. For as no one knew what it was, the population followed the evolution of the disease according to medical discoveries, contributing to the promotion of discrimination and prejudice related to the disease and bearers of HIV, since the population had constructed concepts of incurable illness, deadly, that affected promiscuous people and violators of social standards. Therefore, came up the idea that the carriers of HIV/AIDS were themselves to blame for the disease, because this was a consequence of their behavior, which blames and punishes the individual with the virus and disease.

In Brazil and worldwide the transmission of HIV occurred primarily by sexual contact, being observed that out of the 39,000 cases reported until July 1993, 60% were associated with some type of sexual contact. Moreover, 28.35% of the total, associated with homosexual transmission, and 14.54% were classified as cases of bisexual contact. In June of 1989 began in Rio de Janeiro, with the support of the Ministry of Health, a study on the sexual practices of homosexuals and bisexuals and awareness of

AIDS among men, whose goal was to map out a socio-demographic profile of this group. From this study it was understood the need to create programs containing information about the disease and campaigns encouraging safe sex[3].

In the 90s changes in the epidemiology profile of AIDS were perceived. We started to notice an increase of infection in females with monogamous behavior and a decline in HIV infection in hemophiliacs and injectable drug users[4]. The epidemics of AIDS in Brazil started to draw attention to three main traits: impoverishment, internalization, and feminization[4].

- Impoverishment: Researchers point to the growth of the epidemics among the economically underprivileged social segments[4].

- Internalization: Here, the indicators show the evolution of the epidemic of HIV/AIDS throughout the Brazilian territory. The analysis of the spread of the epidemic, according to the categories of the population of the size of cities, demonstrates that the epidemic started in urban centers, but these same centers hold the lower relative increase in growth[4].

This process is due mainly to the routes of distribution and consumption of drugs amongst cities such as Itajai, Santos and other cities which comprise the so-called "hillbilly route" such as Campinas and Ribeirão Preto (4.5).

- Feminization: Characterized by the increasing incidence of HIV in women. Although women are present in the context of the epidemic since the '80s, through the participation of vulnerable groups like sex workers, from the '90s on female presence has intensified, mainly through sexual transmission, considering that most of these had a steady partner at the time of infection[4].

Reflecting on the feminization of HIV/AIDS

Women have always been present in the context of AIDS, including the participation in the "risk group of prostitutes", but no goal was established by the government to monitor and even reduce the incidence of infection in women. Up until the '90s, the programs to prevent AIDS have always been aimed at men[3.4]. It could be observed that occasionally the female figure would appear in advertisements to encourage condom use.

But why? There was no interest in taking care of prostitutes, after all they were only prostitutes, and "family" women were not included in risk groups. This was a fact that contributed to the increase of HIV/AIDS in women[3].

With the advent of contraception and the pill in particular, in the '60s and '70s, women began to better control their fertility and sought greater social independence. The discovery of the contraceptive pill gave women a little more autonomy over their bodies, their desires, making them more independent. While the pill helps to change the view of female sexuality by women themselves, it is not characterized as a factor for preventing the transmission of HIV and other STDs. The concern of women with regards to the risk of unintended pregnancy declined significantly. However, taking the pill has always been something that depended only on the woman's will to use it or not, but the male condom depends on the willingness of the partner and the issues of STD/AIDS were not clearly discussed. As the campaign for reducing the number of partners, which for women is considered to be ineffective, since they already tend to have a monogamous behavior[6].

Thus, women have gained more autonomy over their body and began to express more freely their wishes. But they became more vulnerable to HIV/AIDS, since they were not considered in a risk behavior for infection without the worry of unwanted pregnancy and believing they are secure in a stable relationship, they did not make use of preventive methods.
In the late 80's statistics showed that most infected women did not fit in the previously mentioned risk behaviors. On the contrary, they were not prostitutes, they were "family" women, between 15 and 40 years of age, mostly with children[3.4].

As a result, the researches show that even being monogamous women are contracting the HIV virus through sexual intercourse. That happens either because they cannot make their partners use condoms, or because they deny the risk of this infection because, by admitting the existence of such a risk, it means confronting fears and painful feelings of betrayal, which can be perceived as unnecessary or inappropriate for their gender[6-8].

There is the hypothesis that the risk in relation to AIDS may get started when the relationship of intimacy and trust is established. Since then, people become more vulnerable and the dimensions of social practices can give evidence that this way of thinking will affect the prevention strategies of this

group. Trust influences relationships, for individuals in stable relationships tend not to take any effective measure to prevent AIDS, they usually do not use condoms and do not know their HIV status nor the partner's. These preventive measures do not come under discussion in the relationship. The relationship based on trust, therefore, leads individuals to the risk of contagion, since it establishes certain vulnerability, and this will affect the strategies for the prevention of disease, especially when it comes to gender[8.9].

Women not only present themselves as vulnerable as a matter of gender, as discussed above, but they also may be from the country area and/or poor, which would place them in the group at a higher risk for HIV infection. This is because it is believed that the cultural and socioeconomic conditions influence in decisions over which conditions, how and when to have sex, which interferes directly in the power of decision-taking of women. These women are therefore considered more vulnerable. On the other hand, the women with higher cultural and socioeconomic level, have more knowledge of prevention and contamination of Hiv/Aids thus being more likely to protect themselves[10].

In 30 years of the epidemics there are 608,230 AIDS cases accumulated between 1980 and June 2011. Of the total, 397,662 (65.4%) cases were reported in men and 210,538 (34.6%) cases were reported in women[11]. In 1984, the ratio was 122 men infected with the HIV virus to one woman; in 1994 ware 5 men to 1 woman; In 2005, this ratio became 1.6:1. Sex ratio has been decreasing over the years. In 1985, for every 26 cases among men, there was one case amongst women. In 2010, this ratio was 1.7 males for every case of women[10]. The estimated average number of new diagnosed cases of AIDS in Brazil each year is 33.000[3.11].

Government programs aimed at women's health had their origins in the struggle of feminist groups and of women's health. One of them is the Program of Integral Assistance to Women's Health (IAWH), which was elaborated by feminist activists and Pro-Women's Health in 1983[3]. In 1997, health services were incorporated within prenatal routine the offer of serological testing for HIV, understanding that along with the increase of AIDS cases in women in childbearing age there is the possibility of vertical transmission. This program was changed in 2004, and began to bring, in addition to a greater emphasis on women with HIV, health issues of women hitherto neglected, such as prisoners and

lesbians.

Discrimination and stigma: social aspects that remain in the world of AIDS

AIDS was a stigmatized disease since its appearance. Certainly, the profile of the first carriers contributed to the construction of the taboos and prejudices that surround it until today[3.12].

The Ministry of Health brings the campaign "Be Aware" which aims to encourage people to do the HIV test so that carriers of the virus are identified, guided and sensitized to adhere to the treatment and use of condoms during sexual intercourse, seeking to reduce transmission and prevent complications of the disease. We believe that many people do not do diagnostic testing because they fear the result, they fear to be judged and rejected by the family, society and many fear losing their jobs.

A study conducted in 2005 with the aim of identifying the predominance of discriminatory attitudes in two moments of Brazilian epidemic of HIV/AIDS, as well as possible occurred changes, conducted researches in 1998 and 2005 in the same Brazilian regions with the same questionnaire. We interviewed 3324 people. It was observed that despite having been identified a significant reduction in the proportion of people between 1998 and 2005 surveys who answered yes to mandatory HIV testing for: admission for employment, before marriage, entry into the military forces, drug users, foreigners entering the country, sex workers and all people, there is still a significant discrimination against the carriers of HIV virus. As an example, the 2005 survey showed that 57.3% think that HIV testing should be done on admission examinations, 75.5% also think that persons entering into the military forces should be screened, 92.9% believe that testing for HIV should be mandatory for drug users, 63.2% would not let their children be in the company of a person with HIV, and 21.9% agreed that pregnant women with HIV should have an abortion[4].

This study has also showed that having less education, being female, being over 45 years of age and reside in the North/Northeast region are factors associated with a higher level of discriminating intention. In relation to those living in the South or São Paulo it was 46% higher and in the Center-West/Southeast that chance was 39% higher[12].

A research conducted in 2004 and 2005 shows a recent result of HIV seropositive women who show fear of losing friends, family, sons and daughters. They recognize bias and pinpoint attitudes of discrimination of other people's experiences and those who experienced it. In the statements, discrimination is perceived by the distancing, indicating that there are people who walk away when they know they have the disease. They feel they are badly treated, that children exposed to HIV are removed from playing with their friends on the street or outings with their family[13]. Another study conducted from December 2004 to March 2005, interviewed ten women diagnosed as HIV positive, which presented the following categories: "Frailty related to the discovery of the disease," "Hiding the diagnosis," "Living with the disease" and " imminence of death", and also, HIV/AIDS poses to women other threats, such as the risk of transmitting the infection to her baby during any period of pregnancy and the responsibility of caring for everyone in the house, which culturally is a feminine function; in addition to these factors, if they develop the disease, they have to take care of themselves[14].

The stigma associated with AIDS appears in the testimonies of women as a disease that marks people forever, remind us of the image of Cazuza, a Brazilian popular music singer, who died in 1990, and was carrier of HIV with difficulty to walk, had no hair, was thin and with sunken eyes. This is the image society in general has of AIDS. But there is a mistake, because everyone thinks that the person with AIDS is "dry" and thin, but nowadays with drugs that cause fewer side effects and medical advances many people with HIV look healthy[4].

In another study related to women with HIV and their struggle with difficulties encountered by them at work, researchers interviewed 10 women with positive serology for HIV. All of them reported sexual route as a means of infection; 06 of them had complete high school; 03 had incomplete elementary level and 01 had completed elementary level. This research resulted in a general category "Women, HIV/AIDS and Work," and it was divided into subcategories: "The work itself" - in which women attributed the meaning to work, independence, money and conditions for a good treatment; and they talk about the importance of socialization to coping with the disease; the second subcategory "Work organization and social exclusion" brings the fear of prejudice and discrimination, a participant resigned for shame and fear of her co-workers discovering her serological status. Because of discrimination, many people tend to move away from social contact for protection, because they think they will not be accepted and they also often condemned and do not accepted themselves. The fact

that they resign, move away from friends and relatives may be a defense mechanism, as if they were protecting themselves from prejudice and judgments[15].

The stigmatization process may begin with the needs of antiretroviral treatment, which requires many consultations, absences and delays at work. Currently, such needs are more common than in the first decade of the epidemic, when the disease quickly resulted in death. These situations force the disclosure of diagnosis and the stigma associated with AIDS, followed by discrimination. Women with Hiv, besides suffering prejudice of being carriers of the virus, are labeled as sluts, promiscuous, due to the history of HIV/AIDS[15].

Work is an important object of socialization, including the carriers of HIV, for besides performing an activity and earning a salary, not only are they members of a society, but also they feel part of it[16]. Therefore, it cannot be a source of discomfort and embarrassment among people with HIV.

FINAL THOUGHTS

No doubt AIDS is a disease covered by taboos, stigma and prejudice posed by its history, its transmission is a reason for judgments, its symbolism is the image of a feeble person, with sunken eyes, who has no force to keep standing, even with the progress of treatment of the disease that allowed huge changes in virus carriers.

A woman with HIV in addition to being a carrier of a virus full of stigma is discriminated and judged, for only her HIV status is enough to be simply labeled as a prostitute, promiscuous and worthy of such punishment. Therefore, women with positive serology for HIV suffer double prejudice.

Prejudice and stigmatization bring important social issues that must be constantly under discussion and in government projects aimed at reducing the result of a social, psychological and economic impact.

Stigma is a social process that plays an important role in increasing inequality and legitimizes the violation of human rights, because the International Law of Human Rights establishes the right to health and non-discrimination. Human rights are translated into the rights and freedoms that are common to all human beings, with no distinction and therefore, with no discrimination and prejudice.

Even by acknowledging stigma as a marker of individual and social differences, it is not a fixed attribute, but a social and cultural construction, hence historical and changeable, establishing relationships that depreciate others. Therefore, it fits in socially constructed contexts and processes, turning it possible to review these attitudes and concepts, contributing to the reduction of discriminatory acts, changes in stigma and shift in paradigm.

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