

3rd icH&Hpsy 2017
3rd International Conference on Health and Health Psychology

**PREVENTION OF HIV/AIDS AND OTHER STIs IN WOMEN IN
THE CONTEXT OF RELATIONSHIPS**

Ana Luísa Patrão (a)*

*Corresponding author

(a) Collective Health Institute, Federal University of Bahia, Salvador, Bahia, Brazil, luisa.patrao@ufba.br

Abstract

Women's anatomy and physiology place them at a higher risk of contracting the human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) compared to men. In addition, certain cultural and social issues increase women's vulnerability to STIs. This descriptive literature review analyzed the different problems comprising relationship contexts as factors involved in the promotion of sexual health and the prevention of STIs in women. Data were obtained from classic authors who reported on how gender roles and imbalances in male-female relationships interfere with the prevention of STIs in women. For this, a systematic search was made of databases included in the Biblioteca Científica Online (B-on). Based on the selected articles evaluated, relationship-associated factors such as gender power imbalance, negative attitudes regarding condom use, and poverty and financial inequalities, as well as inadequate communication between partners were found to place women at risk of acquiring STIs. Since factors within relationships may play a significant role in STI prevention in various ways, it is relevant to take relationship characteristics into consideration when designing interventions aimed at promoting sexual health and preventing HIV/AIDS and other STIs in women. STI prevention programs should target both sexes and should focus strongly on increasing women's capacity to negotiate and communicate with their partners.

© 2017 Published by Future Academy www.FutureAcademy.org.UK

Keywords: STI prevention, Women, Relationship Context.



1. Introduction

The human immunodeficiency virus/ acquired immune deficiency syndrome (HIV/AIDS) continues to be one of the most socially stigmatizing chronic diseases (Mugoya & Ernst, 2014) and one in which women's vulnerability is undeniable (UNAIDS, 2006). Currently, approximately 35 million individuals live with HIV/AIDS worldwide and over 50% of infected adults are women (32.1 million adults; 17.7 million women) (UNAIDS, 2013). Women's physiological characteristics and the anatomical differences in their genitalia contribute directly to their increased risk of contracting HIV and other sexually transmitted infections (STIs) compared to men (UNAIDS, 2006). In addition to these factors, cultural and social issues contribute significantly to women's vulnerability insofar as STIs are concerned (UNAIDS 1998). The social role of gender increases vulnerability since gender power imbalance limits access to up-to-date, appropriate information on STIs/HIV/AIDS (Silveira, Béria, Horta & Tomasi, 2002). In such cases, it is very difficult to achieve behavioral changes and to maintain these changes in daily interactions. Therefore, there is an urgent need to increase knowledge and understanding on the psychosocial factors that place women at greater risk than men for STIs/HIV/AIDS (Türmen, 2003). In this scenario, it is important to investigate the role of gender and power imbalances in relationships, as well as the repercussions of inequity on the ability to negotiate and on sexual behavior. Relationship power is understood as the capacity to influence the behavior and attitudes of the other person (Tschann, Adler, Millstein, Gurvey & Ellen, 2002).

The vulnerability of women to HIV and other STIs is strongly defined by how the woman relates to her inner self and her sexuality, which may characteristically result in her subordination to a man's desires (Borba & Clapis, 2006). The rigidity of roles and conduct in gender relationships has been shown to be one of the factors that define vulnerability for STIs/HIV/AIDS (Heise & Elias, 1995). When a woman feels unable to negotiate condom use because she fears losing material support or support for her children, because she believes that a woman should not make sexual demands on a man, or because she fears that her partner will respond with violence, it is legitimate to consider that gender imbalances increase an individual's vulnerability to STIs/HIV/AIDS (Zierler & Krieger, 1997).

2. Problem Statement

Gender power imbalance, resulting in inequality insofar as access to resources is concerned, represents a huge obstacle to women's participation in protecting themselves against HIV/AIDS and other STIs. These constraints are of particular concern among more socioeconomically vulnerable women, since the literature has suggested that such women are particularly vulnerable to gender imbalance and injustices (Romero et al., 2006).

3. Research Questions

Identifying the psychosocial factors that place women at a greater risk of acquiring STIs/HIV/AIDS is a task of the utmost importance. In this respect, the type of relationship between these women and their partners/companions merits particular attention. It is only by acquiring more in-depth information on the components of this risk within the context of the relationship that effective

intervention programs can be drawn up to prevent STIs/HIV/AIDS in women. There are several relational factors that could contribute to or reduce the risk, namely gender roles and power imbalance, attitudes regarding condom use, economic inequalities and communication between partners.

4. Purpose of the Study

The objective of the present paper was to analyse the different issues involved within relationship contexts as factors affecting the promotion of sexual health and the prevention of sexually transmitted infections (STI) in women.

5. Research Methods

This was a descriptive study involving a literature review. Data were obtained from scientific reports on the vulnerability of women to HIV/AIDS and other STIs in books and papers following consultations in health databases contained in the Biblioteca Científica Online (B-on). The articles collected from the LILACS, MEDLINE, Index Psi and SciELO databases referred to the 1995-2014 period.

The electronic search, conducted using the keywords “inequality in relationships”, “influence” and “preventing HIV and other STIs in women” for all the sources in the title, yielded a total of 235 studies. The papers were then filtered and selected by reading their abstracts and principal findings. Only studies that referred to the influence of the context of the relationship in women’s vulnerability were selected. This step resulted in 46 papers, which were read in their entirety and included in the final study sample. Evaluation of the selected material allowed four principal axes of analysis to be constructed and discussed: 1) gender roles and power imbalance; 2) attitudes regarding condom use; 3) poverty and economic inequalities; and 4) communication between partners. Of the 46 papers, 17 were written in Portuguese, with 8 of these being from Brazil, 5 from Portugal and 4 from Mozambique. The remaining 29 papers were written in English and were predominantly North American. Twelve of the selected papers were used in the first axis of analysis, 19 in the second, 11 in the third and 4 in the fourth. There were cases in which the same scientific paper, report or book was included in different axes of analysis.

6. Findings

6.1. Gender roles and power imbalance

Behavior that increases the risk of infection by HIV and other STIs is not necessarily a consequence of lack of information on how to prevent infection, but of worldviews that are the result of social experiences in which the risk is minimized or over-recognized, as argued by Corossacz (2004). Indeed, in a qualitative study conducted with 32 young Brazilians, that author analyzed the trajectories of 18 females and 14 males in terms of sexuality and identified gender asymmetry as playing a central role in the construction of sexual experiences. The results of that study showed that, even today, women are associated with household chores, with unpaid work in the home, and with the affective and moral domain, whereas it is men who occupy public space and are considered women’s providers and

protectors. Insofar as the sexual sphere is concerned, gender asymmetry is highlighted by the value given to women's virginity and to sexual experience in men (Corossacz, 2004). Therefore, this type of view in which women's autonomy is devalued leaves no room for conscious, considered choices regarding women's sexuality.

Even self-efficacy, a socio-cognitive factor of extreme importance in women's negotiation of safe sex (Leal, & Costa, 2005; O'Leary, & Jemmott, 1995; Wingood, & DiClemente, 2002), also depends on the woman's power within the relationship and on perceived gender roles. A study developed with a sample of 125 migrant women living in the United States showed that gender roles and the power strategies used by these women predict their level of self-efficacy. The results of that study shed further light on the idea that low relationship power and the incorporation of gender roles that diminish women are factors that contribute to women developing beliefs that they have little control over their own motivations, thoughts, emotional states and behavioral patterns regarding safe sex (Bowleg, Belgrave & Reisen, 2000). Another study conducted with 150 Hispanic women with high rates of risky sexual behavior reported the existence of a belief that the locus of control over what happens in their sex life belongs to the man (Loue, Cooper, Traore & Fiedler, 2004). This means that these women believe that everything concerning their own sexual life depends on and must be decided by their partners.

The very way in which the couple and the family are recognized may determine vulnerability for infection by HIV/AIDS and other STIs. The results of a qualitative study conducted with women living in a Brazilian slum indicated that in this setting it is the man who is responsible for the woman's health and she entrusts her health to him. Those authors concluded that, as far as these participants are concerned, the role of protecting the woman's health falls to the man. To a certain extent, this also includes the children's health, since maintaining the balance between health and STIs within the context of the family depends exclusively on male behavior (Praça, & Gualda, 2003). Therefore, women have to hope that their partners will be sufficiently loyal to them that they will tell them about any possible infidelity and whether they have acquired an STI so that the women can take measures to preserve their own health.

A study aimed at analyzing the effect of gender power imbalance on women's ability to negotiate condom use and on the response of their partners to this request showed that gender imbalance in a relationship strongly affected women's ability to negotiate safe sex. Women who were much younger than their partners (at least 10 years younger), women with a history of mistreatment, women living in relationships in which communication regarding STIs was poor, and women financially dependent on their partner were those least likely to suggest condom use to their partners. What is more concerning, as argued by the author of that study, is the fact that the partners who had other casual sexual partners were precisely those who were more likely to refuse to use a condom with their regular partner (Langen, 2005).

Even when women believe that they have power within a relationship, it has been found that, insofar as their sexual life is concerned, this power may actually be minimal. A qualitative study conducted with an African-American population of 51 women is good example of this phenomenon. The authors of that study concluded that practically all the women interviewed believed that they had control in the relationship, including during sexual intercourse. Nevertheless, 43% reported not talking to their partner about matters concerning safe sex, fearing that this would have a negative effect on the emotional

dimension of the relationship (Jarama, Belgrave, Bradford, Young, & Honnold, 2007). In other words, women clearly seem to be largely insecure regarding who has control in the sexual sphere. Although they reported feeling in control in the relationship in general, this control tends to dissipate in the sexual sphere, with submissive attitudes being found insofar as sexual behavior is concerned, and the woman avoiding negotiating safe sex for fear of losing her partner's trust or affection.

The high rates of HIV/AIDS infection in women and girls are largely due to basic issues of male power and control and to the way in which society traditionally ignores behavior related to power imbalances and men's controlling behavior over women. For example, in Africa, the area of the planet most affected by STIs/HIV/AIDS, principally among women, the United Nations Population Fund (UNFPA, 2002) reports that it is common for women (particularly victimized women) to stop using contraception or protect themselves sexually in response to their husband's demands. With respect to marriage, within the African context there are still many social and cultural norms that weaken women, rendering them more vulnerable to STIs due to their diminished power to make decisions regarding their relationship and sexual life. According to the United Nations Organization for Education, Science and Culture (UNESCO) and the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) (UNESCO & SAfAIDS, 2001), the position of the African woman in marriage involves much less power than that of the man. This is already clear at the very time the decision is made to marry, since in many settings the man chooses the woman whom he wishes to marry, while the woman is given no opportunity to decide whether that is what she wants. Within the marital relationship, the woman is seen as being inferior to the man and subject to a series of rules, attitudes and values based on a completely patriarchal power. Therefore, the woman has little or no opportunity to decide on her life, particularly with respect to areas as complex as the sexual sphere. Regarding forced marriage, one study showed that this practice continues to be common, particularly in Africa, and that it is one of the principal barriers to girls being able to attend school and remain in education, and one of the factors responsible for the high illiteracy rates among African women (Osório, & Silva, 2009). This finding gives reason for concern, since women's education level is a factor that affects their degree of vulnerability to the risk of infection by HIV/AIDS and other STIs. Situations of forced marriage and, consequently, girls abandoning their education are factors that maintain the constant cycle of dependence and gender imbalance in many African communities.

In summary, according to the scientific literature, the social construction of gender roles and power imbalances in relationships exert a strong effect on women's attitudes and sexual behavior in that they are prevented from making informed and autonomous decisions regarding the preservation of their own health. This occurs specifically, for example, with condom use, as detailed later on in this text. These data suggest that power imbalance, principally in issues related to violence, should be one of the foremost questions to bear in mind when drawing up strategies for preventing STIs in women (Jewkes, Dunkle, Nduna, & Shai, 2010).

6.2. Attitudes regarding condom use

The correct, systematic use of male condoms is the most effective means of preventing STIs. Nevertheless, it is known that there are many gender-associated issues that prevent their use (Guinan &

Leviton, 1995; UNAIDS, 1998). Power asymmetry within sexual relationships determines “why”, “how” and “when” a preventive method such as the condom will be used to protect against STIs, with this decision normally being made by the man. For many women, it is extremely difficult to adopt preventive sexual behavior, since women are not the ones who directly control condom use, and they find it difficult to discuss and negotiate this issue with their partners for various reasons: gender power imbalance within the relationship, cultural expectations regarding the woman’s role, fear of insinuating distrust in the relationship, etc. (Guinan, & Leviton, 1995). The lack of ability to negotiate safe sex is one of the most common reasons why women run the risk of contracting STIs/HIV/AIDS (Alves, Kavács, Stall, & Paiva, 2002), and the reason why campaigns to promote condom use should be accompanied by specific programs to teach women how to negotiate condom use with their partner and how to use condoms correctly (UNAIDS, 1998).

The strategies commonly adopted by the majority of programs for the prevention of AIDS and other STIs highlight three central aspects: reducing the number of partners, promoting condom use, and treating STIs. Nevertheless, these programs are unable to protect the majority of women who are vulnerable to disease, since these women tend to be poor and to have no power within their sexual relationships (Heise, & Elias, 1995).

The association between condom use and distrust, and poor communication between partners with respect to sexual issues are factors that limit women’s ability to practice safe sex (Parker & Camargo, 2000). Condom use can be impossible for many women, since it requires the cooperation of their partner who may not always comply with their wishes. Many women run the risk of emotional and physical abuse if they suggest that their partners use condoms, which the men associate with an accusation of infidelity (UNFPA, 2001). A study conducted with a population of African-American women showed that in a sample of 128 women, 45.3% were found not to use condoms during sexual intercourse, with non-use being strongly associated with the women’s perception that negotiating condom use implied an idea of insinuated infidelity or instability in the relationship (Wingood, & DiClemente, 1998). Along the same lines, another study conducted with a sample of 165 American women found that women who were verbally, emotionally and physically abused are more susceptible to participating in risky sexual behavior insofar as HIV/AIDS is concerned, since they are more fearful of asking their partners to use condoms (Wingood, & DiClemente, 1997). This finding is very important because, as shown previously, power imbalance within a relationship prevents the woman from participating in her own sexual life.

According to the results of a qualitative study conducted with 20 men and women, the woman recognizes that the decision regarding whether or not to use a condom depends exclusively on the male partner’s willingness and she considers this valid. The authors describe a statement made by one of the female participants of the study who said that it is the man who has to decide whether or not to use a condom because he has authority over the woman. In her opinion, this process is correct, since she was brought up to be submissive and loyal to her man (Macia, & Langa, 2004). Another qualitative study developed with 67 couples, in which one of the partners was seropositive, reported on women who live in very stressful life situations because their husbands, despite being infected by HIV/AIDS, do not consider that they have to use condoms. These women also reported that refusing or trying to negotiate tended to end in violence, since the husbands feel that their authority is challenged by their wife attempting to

negotiate safe sex (Bunnell et al., 2005). In both of the aforementioned studies, the way in which a woman, even today, subjects herself to her husband's will and authority on sexual issues is clear, even when she is aware that complying with men's demands may result in very high risk sexual behavior.

One power-related aspect that may affect sexual behavior is associated with the fact that condoms are physically placed and controlled by men, which may contribute to women's perception of lack of power that consequently hampers negotiations for safe sex. One way of combatting this type of constraint is to resort to the use of female condoms. The female condom has proven to be one of the best responses to the marital controversies regarding the male condom, and can prove to be a solution for many of the situations described above. The female condom has received a lot of attention due to its potential to provide women with an option for safe sex (Busza, & Baker, 2004; Mandel & Rutherford, 2006). This is a contraceptive method that allows many women to have more control with respect to their own protection during sexual intercourse (Busza, & Baker, 2004; Dias, Gonçalves & Silva, 2003; UNFPA, 2001).

Nevertheless, acceptability of the female condom remains low in some settings. For example, many women in Uganda and in Zambia consider it less acceptable compared to other contraceptive methods because it is voluminous and makes a noise during intercourse (UNFPA, 2001). In addition, several studies have reported a negative impression of female condoms among African-American women (Timpson, Williams, Ross, & Keel, 2005). Another problem is that although this method is easily accessible in industrialized nations, in poorer countries such as many of those in the African continent, access remains difficult. In Brazil, the results of three sequential studies show that the great majority of sexually active women are aware of or have at least heard of the female condom, with an information level of around 90% in the three studies. Although the percentage of women interviewed who reported having tried it at least once is low, this percentage is increasing gradually: from around 4% in 2005-2006 to 9% in 2008. Despite this substantial increase, these figures suggest that the female condom is a resource that, although already well known, is still seldom used (NEPO, ABIA & UNFPA, 2011). In fact, although the female condom has been available for over ten years, the truth is that this means of protection is still perceived as being less accessible. Further studies on its acceptability and the accessibility of vulnerable women to this method are required (Mandel & Rutherford, 2006).

In conclusion, women's attitudes regarding condom use and the perception that suggesting or asking the man to use a condom may imply that they believe their partner to be unfaithful or untrustworthy tend to diminish their motivation to use the method, which, in turn, places them at risk of acquiring HIV/AIDS or other STIs. Poverty and financial dependence are factors that increase the woman's fragility when negotiating safe sex, as will be discussed next.

6.3. Poverty and economic inequalities

Economic power is another form of gender imbalance that may increase sexual risks. A woman who depends financially on her partner is more likely to comply with his demands and sexual desires without discussion or negotiation for fear of emotional or financial abandonment (Jarama et al., 2007). Under these circumstances, asking him to use a condom may be risky, with those women being more likely to fear relationship conflict and their partner's anger and violence (Wingood, & DiClemente, 1998).

For condoms to be used there must be equality in sexual relationships and the myth of the security offered by marriage or by romantic love that exposes many women to the risk of contracting HIV/AIDS and other STIs must be confronted. The literature has suggested that what makes it difficult for a woman to take a firm position within a marital relationship, a position that is necessary to enable her to negotiate safe sex, is often associated with her financial dependence on her partner (Alves, Kavács, Stall, & Paiva, 2002; Martingo, 2002; Zierler & Krieger, 1997). This means that financial dependence may determine a power imbalance in the relationship, including negotiating safe sex.

The results of a study conducted with African American women showed that those in a precarious situation in financial or employment-related terms and who received benefits from a government aid program (Aid to Families with Dependent Children) were three times more likely to report not having used condoms in the preceding three months compared to women who were employed and who depended less on their partners financially (Wingood, & DiClemente, 1998). Another study conducted with 71 sexually active women to evaluate the extent to which women's empowerment affects the prevention of AIDS showed that having negotiating skills and being economically independent from their partner were the factors most strongly related to condom use. The two factors "negotiating skills" and "financial independence" were also found to be strongly correlated with each other (Greig, & Koopman, 2003). The literature has suggested that depending financially on a partner to maintain the household and the family is associated with less condom use compared to women who are not financially dependent (Zierler, & Krieger, 1997).

Unemployment or precarious employment may result in women entering a state of poverty, which affects their risk of acquiring STIs. In a situation of employment vulnerability, financial dependence is greater and places women in unfavorable conditions when deciding when and with whom to have sexual intercourse, as well as for negotiating condom use or refusing to have unprotected sex (Martingo, 2002). In this situation, many women feel obliged to accept the risk as a means of survival (Mabala, 2006). Poverty, more visible in women than in men, also hampers access to healthcare and education, elements that are vital in the combat against STIs.

Within the scientific community, there is no doubt that inequality between men and women in terms of material and financial resources has contributed towards accentuating gender power imbalance (Floriano, 2006), which, in turn, contributes directly and indirectly to a woman's vulnerability to STIs.

6.4. Communication between partners

According to the literature, women's diminished power within relationships and their sexual vulnerability may be associated with the characteristics of communication. A study conducted with a heterosexual population (n=508) and that focused on analyzing the association between relative power in relationships, communication, protective measures against STIs and condom use found that condom use was greater in relationships in which the level of power of the two partners was equal, as characterized by open communication. This finding led the authors to conclude that it is very important to incorporate these components (e.g. competency in communication) in programs aimed at preventing HIV/AIDS and other STIs (Bruhin, 2003). Likewise, another study conducted with 6,649 young people of both sexes to evaluate the rate of condom use in the 12 months preceding the study showed that the rate of use was low,

with less than one-third (28.6%) reporting having used condoms consistently over that time. The principal predictor of condom use, particularly among the female participants, was found to be the ability to talk to their partner about it (Moyo, Levandowski, MacPhail, Rees, & Pettifor, 2008). These results suggest that the level and quality of communication between the partners are essential factors for constructing a plan of healthy sexual activity. Another study conducted with a population of 173 sexually vulnerable women also showed the importance of communication between the partners in determining sexual protection. The results of that study showed that women who talk to their partner about STIs are better protected, as shown by their greater likelihood to practice safe sex, higher rates of condom use and higher levels of self-efficacy in using condoms (Patrão, 2012).

In addition to verbal communication, non-verbal communication can also serve as an important weapon in assuring safe sex, i.e. in suggesting condom use (Moyo et al., 2008). With respect to the importance of communication, another study showed that, in terms of negotiation, verbal strategies, i.e. direct conversations regarding condom use, constitute the most common method used by couples to decide whether or not to use a condom. Nevertheless, indirect, non-verbal communication such as, for example, leaving a condom where the partner can see it and reflect on its use, appears to represent a strategy that is equally effective in promoting condom use. The same study also found that women are more likely than men to use indirect, non-verbal communication in issues related to sexuality, namely condom use (Lam, Mak, Lindsay, & Russell, 2004).

In summary, with respect to the characteristics of the relationship that affect women's protection against HIV/AIDS, these data show that the type of communication established between partners is of paramount importance. Therefore, it is reasonable to conclude that intervention programs aimed at protecting women should focus strongly on improving the ability of partners or couples to communicate with each other.

7. Conclusion

Following analysis of the different aspects that make up the relationship contexts as factors that affect a woman's risk of acquiring STIs/HIV/AIDS and the constraints to promoting sexual health in women, it is reasonable to conclude that gender roles and power imbalance, attitudes regarding condom use, economic inequalities and communication between partners are essentially the aspects that determine a woman's sexual protection or risk. Consequently, responses to this epidemic should be based on knowledge of expectations and needs with regard to gender and relationships. The strategy used by most STI prevention programs that fail to take the characteristics of the relationship into consideration is inadequate in that it fails to protect most of the women who are vulnerable to disease, since these women often lack power in their sexual encounters, particularly in relation to condom use. Among other aspects, women's struggle against STIs/HIV/AIDS has to first pass through empowerment of the woman's status within the relationship. In other words, to combat STIs/HIV/AIDS in women, many social constructs of gender inequality have to change, with women's empowerment being the cornerstone to reverse the epidemic of HIV/AIDS and other STIs. Combatting gender and power imbalance within relationships is one of the keys to combatting STIs because it is the gender power imbalance in relationships that facilitates the dissemination of these diseases in heterosexual relationships.

Therefore, based on the results of this and other studies, intervention programs aimed at promoting sexual health and preventing STIs/HIV/AIDS in women should focus strongly on increasing women's capacity to negotiate and communicate with their partners. In addition, both sexes should be integrated into these programs, since for protection to be effective and efficacious both partners must be involved rather than one alone. It is hoped that this study, which aims to strengthen the importance of analyzing the relational context within the field of sexual protection, will provide an important contribution to the prevention of STIs/HIV/AIDS and to the promotion of women's health.

Acknowledgments

This work was developed at the University of Minho (Portugal), supported by a grant (SFRH/BD/37909/2007) from the Portuguese Foundation of Science and Technology..

References

- Alves, R. N., Kavács, M. J., Stall, R., & Paiva, V. (2002). [Psychosocial aspects of HIV infection among women in Brazil]. *Revista de Saúde Pública* 36, 32-39.
- Borba, K. P., & Clapis, M. J. (2006). [Women sex workers and the vulnerability to HIV/AIDS]. *Jornal Brasileiro de Doenças Sexualmente Transmissíveis* 18, 254-258.
- Bowleg, L., Belgrave, F. Z., & Reisen, C. A. (2000). Gender roles, power strategies, and precautionary sexual self-efficacy: implications for black and Latina women's HIV/AIDS protective behaviors. *Sex Roles* 42, 613-635.
- Bruhin, E. (2003). Power communication and condom use: patterns of HIV-relevant sexual risk management in heterosexual relationships. *Brasileiro de Doenças Sexualmente Transmissíveis* 18, 254-258.
- Bunnell, R. E., Nassozi, J., Marum, E., Mubangizi, J., Malamba, S., Dillon, B., Kalule, J., Bahizi, J., Musoke, N., & Mermin, J. H. (2005). Living with discordance: knowledge, challenges, and prevention strategies of HIV-discordant couples in Uganda. *AIDS Care* 17, 999-1012.
- Busza, J., & Baker, S. (2004). Protection and participation: an interactive programme introducing the female condom to migrant sex workers in Cambodia. *AIDS Care* 16, 507-518.
- Corossacz, V. R. (2004). Qual Prevenção? AIDS, sexualidade e gênero em uma favela carioca. *Cadernos Pagu* 22, 353-356.
- Dias, S., Gonçalves, A., & Silva, M. (2003). Gênero e VIH: a vulnerabilidade da mulher nos países em desenvolvimento. Retrieved April 11, 2009 from http://www.aidscongress.com/article.php?id_comunicacao=179.
- Florianio, A. P. (2006). As crianças e o VIH/SIDA na África Sub-Sahariana – o caso de Moçambique. Retrieved March 17, 2010 from http://www.aidscongress.net/article.php?id_comunicacao=283.
- Greig, F. E., & Koopman, C. (2003). Multilevel analysis of women's empowerment and HIV prevention: quantitative survey results from a preliminary study in Botswana. *AIDS and Behavior* 7, 195-208.
- Guinan, M. E., & Leviton, L. (1995). Prevention of HIV infection in women: overcoming barriers. *Journal of the American Medical Women's Association* 50, 74-77.
- Heise, L. L., & Elias, C. (1995). Transforming AIDS prevention to meet women's needs: a focus on developing countries. *Social Science & Medicine* 40, 931-943.
- Jarama, S. L., Belgrave, F. Z., Bradford, J., Young, M., & Honnold, J. A. (2007). Family, cultural and gender role aspects in the context of HIV risk among African American women of unidentified HIV status: an exploratory qualitative study. *AIDS Care* 19, 307-317.
- Jewkes, R. K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet* 376, 41-48.

- Lam, A. G., Mak, A., Lindsay, P. D., & Russell, S. T. (2004). What really works? An exploratory study of condom negotiation strategies. *AIDS Education and Prevention* 16, 160-171.
- Langen, T. T. (2005). Gender power imbalance on women's capacity to negotiate self-protection against HIV/AIDS in Botswana and South Africa. *African Health Sciences* 5, 188-197.
- Leal, I. P. & Costa E. I. (2005). Dimensões sócio-cognitivas na adesão das mulheres à contracepção. *Análise Psicológica* 23, 247-260.
- Loue, S., Cooper, M., Traore, F., & Fiedler, J. (2004). Locus of control and HIV risk among a sample of Mexican and Puerto Rican women. *Journal of Immigrant Health* 6, 155-165.
- Mabala, R. (2006). From HIV prevention to HIV protection: addressing the vulnerability of girls and young women in urban areas. *Environment & Urbanization* 18, 407-432.
- Macia, M., & Langa, P. V. (2004, September). Masculinidade, sexualidade e VIH/SIDA em Moçambique. Paper presented at the 8º Congresso Luso-Afro-Brasileiro de Ciências Sociais, Coimbra, Portugal.
- Mandel, J. S., & Rutherford, G. W. (2006). AIDS prevention research in low and middle-income countries: increasing the dissemination of study results in the scientific literature. *AIDS and Behavior* 10(4 Suppl): S1-S4.
- Martingo, C. (2002). A mulher e a infecção pelo VIH/SIDA. Retrieved April 28, 2009 from <http://www.aidscongress.net/pdf/171.pdf>.
- Moyo, W., Levandowski, B. A., MacPhail, C., Rees, H., & Pettifor, A. (2008). Consistent condom use in South African youth's most recent sexual relationship. *AIDS and Behavior* 12, 431-440.
- Mugoya, G. C., & Ernst, K. (2014). Gender differences in HIV-related stigma in Kenya. *AIDS Care*, 26, 206-213.
- NEPO, ABIA, & UNFPA (2011). Preservativo Feminino – das políticas globais à realidade brasileira. Campinas: UNFPA.
- O'Leary, A., & Jemmott, L. S. (1995). Future Directions. In A. O'Leary (Ed.), *Women at Risk: Issues in the Primary Prevention of AIDS* (pp. 257-259). New York, NY: Plenum Press.
- Osório, C., & Silva, T. C. (2009). Género e governação local: estudo de caso na província de Manica, distritos de Tambara e Machaze. Maputo: WLSA Moçambique.
- Parker, R., & Camargo, K. R., Jr. (2000). [Poverty and HIV/AIDS: anthropological and sociological aspects]. *Cadernos de Saude Publica* 16(Suppl 1): 89-102.
- Patrão, A. L. (2012). Prevenção da SIDA e promoção da saúde em mulheres moçambicanas: estudo de preditores de comportamentos de risco e teste da eficácia de uma intervenção psicossocial. (Tese de doutorado, Universidade do Minho, Braga).
- Praça, N. S., & Gualda, D. M. (2003). [The risk of HIV infection: perception of women living in a slum about their participation in the virus transmission chain]. *Revista Latino-Americana de Enfermagem* 11, 14-20.
- Romero, L., Wallerstein, N., Lucero, J., Fredine, H. G., Keefe, J., & O'Connell, J. (2006). Woman to woman: coming together for positive change – using empowerment and popular education to prevent HIV in women. *AIDS Education and Prevention* 18, 390-405.
- Silveira, M. F., Béria, J., Horta, B. L., & Tomasi, E. (2002). [Self-assessment of STD/AIDS vulnerability among women]. *Revista de Saúde Pública* 36, 670-677.
- Timpson, S. C., Williams, M. L., Ross, M. W., & Keel, K. B. (2005). African-American crack users' attitudes and beliefs about male and female condoms. *Journal of Substance Use* 10, 207-213.
- Tschann, J. M., Adler, N. E., Millstein, S. G., Gurvey, J. E., & Ellen, J. M. (2002). Relative power between sexual partners and condom use among adolescents. *Journal of Adolescent Health* 31, 17-25.
- Türmen, T. (2003). Gender and HIV/AIDS. *International Journal of Gynaecology and Obstetrics* 82, 411-418.
- UNAIDS. (1998). Género e VIH/SIDA. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS. (2006). A global view of HIV infection: 2006 global report prevalence map. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS. (2013). Global report: UNAIDS report on the global epidemic 2013. Geneva: United Nations, Joint United Nations Programme on HIV/AIDS.

- UNESCO & SAFAIDS. (2001). Gender & HIV/AIDS – A report of the international workshop on the development of empowering educational HIV/AIDS prevention strategies and gender sensitive materials. Retrieved November 16, 2010 from <http://www.unesco.org/education/uie/pdf/nairobi.pdf>.
- UNFPA. (2001). Prevenção do HIV/AIDS em locais com poucos recursos. *Out Look 19*, 1-10.
- UNFPA. (2002). Violência contra as mulheres: efeitos sobre a saúde reprodutiva. *Out Look 20*, 1-8.
- Wingood, G. M., & DiClemente, R. J. (1997). The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. *American Journal of Public Health 87*, 1016-1018.
- Wingood, G. M., & DiClemente, R. J. (1998). Partner influence and gender-related factors associated with non-condom use among young adult African-American women. *American Journal of Community Psychology 26*, 29-51.
- Wingood, G. M., & DiClemente, R. J. (2002). The theory of gender and power: a social structural theory for guiding public health interventions. In R. J. DiClemente, R. A. Crosby, & M. C. Kegler (Eds.), *Emerging theories in health promotion practice and research: strategies for improving public health* (pp. 313-346). San Francisco: Jossey Bass.
- Zierler, S., & Krieger, N. (1997). Reframing women's risk: social inequalities and HIV infection. *Annual Review of Public Health 18*, 401-436.