

Gender Issues and the HIV/AIDS Epidemic: The Kuwaiti Women Experience

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Abstract: In the Middle East, limited research has been conducted on HIV/AIDS. In Kuwait in particular, the number of Kuwaitis with HIV/AIDS is ignored. Little information concerning morbidity and mortality rates of the disease is available, and the perception is, as in most Arab countries, that AIDS is an imported infection that comes mainly from foreigners. A statement issued by the Arabian Gulf University asserts, however, that the Middle East is no longer immune to HIV/AIDS, and health officials admit that they no longer can rely on closing drawbridges. The latest World Health Organization Report estimates that 70% of the cases in the Arab world are sexually transmitted through heterosexual contact. HIV/AIDS is not only a biological condition, but also a social, political, and a cultural problem. Explanations for the rapid increase and vulnerability to HIV/AIDS in women are a complex mix of biological, sociocultural, and economic related factors. The authors examine these recognized factors and use them as a conceptual framework in exploring Kuwaiti women's awareness, knowledge, and, to a certain extent, experience with HIV/AIDS. The theoretical framework on Comprehensive Health Seeking and Coping Paradigm (CHSCP) adopted from Lazarus and Folkman's Stress and Coping Paradigm, and Schlofeldts Health Seeking Model (1984) served as overriding frameworks to identify relevant variables and guide this assessment. An exploratory study was designed and a snowball sampling technique utilized. The authors used the method of interviewing to collect data that would provide examples to illustrate Kuwaiti women's diverse levels of awareness,

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perceptions, and knowledge about HIV/AIDS. Data were analyzed using both qualitative and quantitative methods. Results enlighten levels of understanding of HIV/AIDS among Kuwaiti women, and help in dismissing generalized perceptions and misconceptions of Kuwaiti women as detached from HIV/AIDS issues. Based on the results, designs of scientifically informed policies and development of programmatic gender sensitive strategies for education and prevention are offered.

Key words: HIV/AIDS - Kuwaiti Women - World Health Organization

Introduction

HIV/AIDS Origins, International Statistics, and Cost Scientists have concluded that the virus that sparked the AIDS epidemic first surfaced in people sometime around 1930, probably in Central Africa. The oldest viral sample discovered to date came from the Congo in 1959 (Agence France-Presse, 2000).

Acquired immune deficiency syndrome (AIDS) has been the most dramatic event of the second half of the twentieth century (Global Health Council, 2000). As of December 2003, according to the Joint United Nations Program on HIV/AIDS, the following trends of the worldwide epidemic of HIV/AIDS are evident:

- Today, 42 million people are estimated to be living with HIV/AIDS (CDC Division of HIV/AIDS Prevention, Basic Statistics, December 2003). These figures are believed to be an underestimate due to the ten year incubation of the HIV virus before full-blown AIDS develops, and to problems of accurate reporting of cases (Huntley,1994).

- An estimated five million people acquired HIV in 2003, including 4.2 million adults and 700,000 children under the age of 15.

- During 2003, AIDS caused the deaths of an estimated three million people (CDC Division of HIV/AIDS Prevention, Basic Statistics, December 2003).

- The HIV epidemic is still in its early phase and there could be 68 million HIV related deaths between 2000 and 2020, unless prevention and treatment programs to combat the disease are drastically expanded (NAM Publications 2003c). Such a level of mortality would represent a threefold increase on the 21 million deaths attributed to AIDS in the 20 years before 2000.

The latest World Health Organization Report shows that there is

one death from AIDS related diseases every minute in the Asian Pacific region, with more than half a million people who died of AIDS related diseases in 2003. India has the highest number of people living with HIV/AIDS in Asia, with an estimated 3.8 to 4.6 million people affected (United Nations Development Programme 2004a). The spread of HIV in China, the Far East, and Eastern Europe has prompted UNAIDS to warn that the HIV epidemic is still in an early phase. Reported data included the 70% increase of cases of HIV in China in the first six months of 2001, and the rapid increase of HIV cases in Indonesia, the world's fourth most populous country.

AIDS continues to claim a devastating toll in Africa where some countries have an HIV infection rate of 38.5%. One reason for this high rate is its migrant labor system. Many of the region's peoples have homes in their ancestral homeland but spend most of the year living near their place of work. Many of these workers are men who frequent prostitutes or have girlfriends with high rates of HIV infection. It is estimated that, in Africa alone, at least 12 million children have been orphaned through HIV related diseases (2000), a number projected to double by the year 2010. In poverty stricken Zambia, dependent on its copper mines for 90% of its income, mining companies "train four people for each skilled job in the knowledge that three will die" (of AIDS). As in Mozambique, when a man dies in Zambia, the man's brother looks after the children and will, by tradition, also take the children's mother as a second wife (Family Care Foundation, 2004).

UNAIDS has been warning that theories about HIV leveling off in countries with high prevalence rates have been, and are being, disproved. To object to these leveling off projections, the report on the Global HIV/AIDS epidemic highlights Botswana, with the highest HIV infection rate in the world with almost 39% of all adults now HIV positive, up from less than 36% during the two prior years; and Zimbabwe, where HIV prevalence increased from a quarter of the adult population in 2000 to a third by late 2001. UNAIDS also projects that 50% of South African new mothers could die because of HIV, and that mortality among the 15-34 years old will be 17 times higher because of AIDS. Parts of Africa that previously had low rates of HIV infection are now seeing an accelerated spread of the disease, with explosions of the epidemic noted in Cameroon and predicted for Ethiopia (NIAID, 2002). While educational programs

warn people of the dangers of HIV, and condoms are readily available, tradition, religion, ignorance, and superstition prevail, with many placing their faith in traditional witch doctors or taking fatalistic approaches. Others believe that sex with a virgin is a cure, resulting in babies being raped and infected (Family Care Foundation, 2004).

International comparisons are difficult, however, due to reporting system variations between countries. Limited resources and levels of awareness and knowledge also have a profound effect on the ability to monitor cases (Huntley, 1994).

Middle East

Only 208 AIDS cases had been reported by 1989 throughout the Arab world, including countries such as the Sudan, Djibouti, and Somalia. Yet, the cumulative total has been growing to unexpected figures. Several Arab countries for some time refused to report their AIDS cases to international authorities and underreporting or misreporting is still widespread. Egyptian authorities publicly claim that every Egyptian AIDS case has been contracted through contaminated blood transfusions received abroad, although the same authorities admit privately they know otherwise. The North African countries of Morocco, Tunisia, and Algeria have seen the disease appear from the south, and among the many young men who frequently travel back and forth to Europe. However, UNESCO fears that the HIV virus is now not only being imported into Arab countries, but also spreading from within. About 400,000 people in the Middle East now have HIV or AIDS and it is assumed that about a fifth of these contracted the virus in 2000 (Middle East Health, 2001).

The oil rich Gulf States are trying to protect themselves against the HIV/AIDS epidemic proportions in parts of Asia, countries from where most of the region's foreign people come. However, health officials admit that they can no longer rely on closing drawbridges to fight the disease (Murphy, 1992) and the disease is settling in the Middle East where it remains a disease of fear and shame. Strict religious and societal taboos against extramarital sex and homosexuality are probably partly responsible (Amman, 1997) in a region where explicit and outspoken AIDS education campaigns are virtually nonexistent, and where tradition hampers open discussion of sexuality (Information, Inc., 2000).

The WHO called on Arab governments and non-governmental organizations to step in the fight against AIDS by educating the public about the disease and breaking the barrier of silence enshrouding its transmission (Amman, 1997). In response, in Sudan, whose AIDS reported cases are the highest of any Arab country, a billboard warning of the dangers of AIDS confronts travelers driving into Khartoum; in Egypt, the widespread radio, television, and brochure campaign that started recently is thought to be unprecedented (Murphy, 1992).

Kuwait

Accurate numbers of Kuwaitis with HIV/AIDS are ignored, since screening is not compulsory for nationals (Middle East Times, 2001). Foreigners, who make up about two thirds of the 2.2 million Kuwait population, but constitute more than half the 640,000 work force in the private sector and all the 300,000 domestic helpers, are obliged to test for HIV/AIDS as a precondition to work in the Gulf Arab states. Under Kuwaiti and Gulf Cooperation Council rules, foreign workers arriving in the region from Asia must undergo medical tests in their home country and repeat them on arrival. Kuwait deports foreigners who are HIV positive (Agence France-Presse, 2000).

Under Kuwaiti law, nationals found infected must stay in the Emirate's Infectious Diseases facilities for treatment. (Agence France-Presse, 2000). Year two thousand statistics show that, since 1984, 787 cases of HIV have been reported, 50 cases of AIDS have been diagnosed and, more than 20 Kuwaitis have died of AIDS (Information Inc, (2000).

According to the World Health Organization the Arab world in general and Kuwait in particular, has had two factors on its side regarding the relatively low level of AIDS. First, the disease was not introduced into the region until the mid 1980's. For the most part, AIDS seems to have originated in the Persian Gulf region from imported contaminated blood from areas where AIDS was prevalent before blood screening became routine in 1986. Secondly, and further discussed in this paper, the socio-cultural and religious patterns have worked against the spread (Murphy, 1992).

Economic Cost

The economic cost of a disease is generally estimated in two ways:

direct cost (ie, health care) and indirect cost (ie, loss of labor and productivity, and potential income) (Dossier, 1992). Most of those infected by HIV have been in the most productive years of their life, causing a secondary economic impact beyond the cost of caring for them, and creating a cohort of orphans. In 1980, the global cost of treatments for AIDS was between 2.6 and 3.5 billion US dollars. Only 40% of AIDS cases were in the industrialized world, yet, it accounted for 84% of all expenditures. In developing countries, the lifetime cost for treatment and care is estimated at 230 to 250 US dollars, as in Uganda, compared with 102,000 US dollars in the developed world. In the Middle East, treatment for AIDS depends on where one is. Only the oil-rich Persian Gulf states offer costly drugs, and most of the countries of the region treat only AIDS related complications (Amman, 1997).

The total number of deaths and expected deaths from HIV already exceeds the toll in all the major wars of the twentieth century (MMWR, 2001). Its impact is particularly tragic because 95% of the infections occur in developing countries, least equipped to absorb the impact of the health and economic consequences of this epidemic (UNAIDS, 2002). Global disparity is evident, and it has further widened with the introduction of effective means of preventing mother to child transmission in most of the wealthier countries (NAM Publications, 2003). It was in 1996 when the era of highly active antiretroviral therapy began and, over time, HIV/AIDS death sentences began to be commuted to life with a long-term chronic disease (Susman, 2004). A decade ago, a diagnosis of HIV meant a life expectancy of about two years. Now, highly effective drugs are keeping people alive far longer.

Perceptions

Knowledge of the HIV/AIDS epidemic has evolved from the initial misguided belief that the virus was only an affliction of high risk groups to the current recognition that all people are vulnerable. Beyond the staggering numbers, there are aspects of this epidemic that have transformed it from a health problem to a social issue that affects all aspects of human life (Mahithir, 1997; Kremer, 2003; Zorrila, 1999; NACO, 2001).

The behaviors associated with HIV transmission are often not socially approved behaviors, outside the legal and ethical framework of

communities (United Nations Development Programme, 2004b). Acute stigmatization has led to a growth in attitudes that have resulted in AIDS primarily being associated with three main groups: homosexual males, bisexual males, and illegal drug users. The belief that AIDS spread from Africa also "... has great appeal to those who associate the continent with sexual incontinence and primitive behavior," effectively upholding racist values still prevalent in 'advanced politically correct' societies. Schafer (1991) describes this as a 'plague mentality' which "encapsulates a series of attitudes and values: victim blaming, xenophobia, irrationality, and desocialization." These distorted images, which largely result from media sensationalism, can be easily "incorporated into the divine model of retribution for sin" (Schafer, 1991). This view lays the blame upon the individuals that Bassford (1991) identifies as "those who engage in potentially infective activities" (Huntley, 1994).

These attitudes also enforce the view that HIV/AIDS is a disease associated with minority groups and risk behaviors (ie, homosexuality, promiscuity, drug abuse, prostitution), and lead to the belief by the bulk of the population that they are not personally vulnerable (Pitts, 1993).

Negative attitudes about HIV/AIDS create a climate in which people become more afraid of the stigma and discrimination associated with the disease than of the disease itself. When fear and discrimination prevail, people may choose to ignore the possibility that they may be infected, even if they know they have taken risks. People may also decide not to take measures to protect themselves in fear that, in doing so, they could be associating themselves with the disease (UNAIDS Initiative 2002).

Homosexual Issues

Seventy four percent of the AIDS programs throughout the world admit that they do not operate any prevention or support programs targeted at gay men. The major obstacles to HIV prevention work with homosexual men include the following: lack of support from funders, chiefly from donor agencies in the developed world; difficulty in reaching a population that is invisible to heterosexual public health officials; social taboos and unacceptability of homosexuality; and lack of recognition of the role which sex between men plays in the spread of HIV.

Common features of the attitudes toward homosexual activity in

developing regions are public silence and religious disapproval. In many countries, visible manifestations of homosexuality are criminalized and violently persecuted. The only country in the developing world to afford any rights to lesbians or gay men is South Africa (Aidsmap, 2003). Societies such as Brazil are likely to hold different strata of understanding and discourse about homosexual activities also influenced by class and education (Mardina, 1997).

A survey conducted by the Panos Institute found widespread homosexual activity in developing countries often fitting into complex patterns of social custom and taboo. Along with discomfort about discussing taboo issues, many communities are dealing with high levels of ignorance, denial, fear, and intolerance about the disease itself. As a result, people with HIV have been disowned by their families, and fired from their jobs (Huntley, 1994).

In the Middle East, homosexuality is truly 'the love that dare not speak its name'. The issue of gay rights has not been raised and most gay people live in fear of being discovered for, in a number of states such as Iran and Saudi Arabia, homosexual acts are a capital offence. Well known academicians claim that homosexuality does not exist in Kuwait since, "Ours is a Muslim society and homosexuality is against Islam" (Amman, 1997).

Illegal Drug Connection

HIV/AIDS continues to spread among drug users. Since the mid 1980's, increase among injecting drug users has been seen in China, India, Malaysia, Burma, Pakistan, Thailand, Viet Nam, and most recently in Indonesia and Nepal (United Nations Development Programme 2004a). One of the most powerful drug-related factors governing the spread of HIV in developing countries is the globalization of the heroin and cocaine trade, and the unintentional impact of policies to combat that trade. The major source of heroin in the world is the Golden Triangle region of South East Asia where, until the 1970s, opium was gathered for shipment to Europe to be refined into heroin. This practice ensured that opium was the drug most readily available in South East Asia and minimized the practice of injecting drug use. However, in the late 1970s, heroin factories in Europe began to close down due to law enforcement, and it became safer to refine the drug at the site of production. Cheap

injectable heroin soon became easily available and injecting drug use began to spread along heroin supply routes into Burma, Vietnam, northern India, Thailand, and southern provinces of China, as users developed tolerance to the smoked form of the drug. Heroin also began to spread to African countries, especially Nigeria, as drug trafficking into Europe and North America increasingly used West Africa as a relay point.

In the Russian Federation, Eastern Europe, and South America, injecting drug use has also led to a fast growing HIV epidemic. In Russia, it is estimated that one million people are now injecting opiates. As in South America, intensive policing of cocaine supplies has led to shortages and, subsequently, to price increases. When prices rise, more people are tempted to inject the drug to get maximum value for money. A shortage of disposable syringes resulting in needle exchange adds to the risk (NAM Publications, 2003b).

Middle East/ Muslims

The starting point of any analysis must be the thorough understanding of the structure of the society in which it takes place. The perception in many Arab countries is that AIDS is an imported disease that comes mainly from foreigners. However, the World Health Organization now estimates that 70% of new cases in the Arab world are sexually transmitted, more than half of which are through heterosexual contact (Murphy, 1992).

In a new initiative aimed at preventing the disease from becoming a major health problem in the region, the Bahrain based Arabian Gulf University has been holding a special program funded by the Gulf Cooperation Council (GCC), which unifies Saudi Arabia, Kuwait, Bahrain, Qatar, the United Arab Emirates, and Oman into one group. A statement issued by this University's authorities asserts that the Middle East is no longer immune to the disease. Simultaneously, along with awareness campaigns, the Gulf authorities are expelling each month dozens of foreigners infected with HIV, placing them on a blacklist to make sure that they do not return to the region (Mardini, 1997).

Religious institutions have traditionally played a role in caring for those who are weak and in need of support. Religion can play a major role in fighting the stigma associated with HIV/AIDS, and can encourage

openness and positive living among those who are infected and affected (Department of Health, 2002). Still, the denial and taboos surrounding HIV/AIDS result in people questioning and challenging the legitimacy and purpose of any Muslim organization dealing with HIV/AIDS, not only because of the judgmental attitudes and misguided beliefs that AIDS is a curse from Allah, but also because of the difficulties in convincing the Muslim community that AIDS also affects them.

Islam, like other religious traditions, advocates abstinence from any sexual activity before marriage. The reality is, however, that many Muslims have sex before marriage and engage in extramarital affairs. The belief that the Islamic way of life protects Muslims is, therefore, unrealistic and leads to a false sense of security in the Muslim community. Some Muslims also believe that AIDS is a homosexual disease or a disease that affects only black people, while others ascertain that they have not seen or touched a fellow Muslim living with HIV/AIDS. Due to the secrecy surrounding HIV/AIDS, Muslims are unwilling to reveal their status, and families are afraid to reveal how relatives died (Huntley, 1994).

How does one fight AIDS in a region where homosexuality is not supposed to exist and where one is not supposed to talk about sex? Even more difficult, how does one advise people who engage in sex outside marriage to use condoms when the sheiks of one of the most revered Islamic institutions in the world (Cairo's Al Azhar University) declares that the principles of the Koran are enough to protect people from AIDS (Murphy, 1992)?

Zion, 1991 states that "the enforcement of gender boundaries is part of the conspiracy by which patriarchy extends and defends itself." Muslim women and children, particularly girls, are the most vulnerable in contracting HIV because of their marginalization, also a result of cultural and religious practices (Huntley, 1994).

Women's Issues

Gender refers to differences in behavior, in cultural expectations, and in the social roles of men and women within particular social structures. A gender approach to health and illness includes not only the biological aspects of sex, but also the social, psychological, cultural, and economic contexts of being female. It is concerned with understanding

differentials in the impact of disease on women and men within the social, economic, and cultural context (Rathgeber, 1993). Reasons for the rapid increase of HIV among women are, therefore, a complex mix of biological, economic, and social factors (NAM Publications, 2003a).

More than 70% of the HIV infections worldwide are estimated to occur through sexual relations between men and women (UNAIDS, 2000). According to the latest UNAIDS Global Epidemic Report, at the end of 2003, of the estimated 42 million individuals living with HIV, half were women. Everyday, around 5,500 women in the world are newly infected and more than 3,000 die of complications due to AIDS. In Sub-Saharan Africa, 58% of those living with HIV are women (2003), and women ages 15 to 24 are 2.5 times more likely to be infected than are young men (UNAIDS Initiative, 2004).

This female vulnerability is primarily due to inadequate knowledge about HIV/AIDS, insufficient access to prevention services, inability to negotiate safe sex, and lack of female controlled prevention methods (UNAIDS Initiative, 2004). HIV is a medical condition, but is also a political problem due to oppressive gender stereotypes, limited sexual roles, and misogynic practices. Overall remarks about the attitudes toward women affected by HIV are that they are either “passive and good victims of HIV transmission from men, or actively evil transmitters of disease to men.” The ABC approach, (Abstain, Be faithful, and Condomise) assumes that all people have freedom of choice. However, women’s economic and social freedoms are constrained, leading to powerlessness to engage in any preventive behaviors (Gupta & Weiss, 1993; Worth, 1989; Zierler & Kreiger, 1997). In some of the regions worst affected by AIDS, more than half of young women age 15 to 19 have either never heard about AIDS, or have at least one major misconception about how HIV is transmitted (UNAIDS Initiative, 2004).

Biologically, the greater efficiency of male to female viral transmission partially explains the increased vulnerability of women at risk of heterosexual HIV infection (Anderson, & May, 1988; Freidland, & Kline, 1987). At the physiological level, women are more likely to acquire HIV from sex with men than vice versa. Estimates of the efficiency of transmission vary, but it has been suggested that vaginal intercourse with an HIV infected person is between two to 20 times more risky for a woman than for a man. Retrospective epidemiological studies have also

reported shorter survival periods for women and suggest gender differences of delay in diagnosis (Lemp, et al., 1992; Melnick, et al., 1994; Morlat, et al., 1992), and also inferior access to, and poor utilization of health services (Sabo & Carwein, 1994; Lea, 1994; Kremer, et al., 2003; Chaisson, et al., 1995). Adding to these vulnerabilities is the fact that many women begin intercourse young and often younger than their male partners. When the female genital tract is immature, trauma during intercourse is more likely (NAM Publications, 2003a). (UNAIDS Initiative, 2004).

Women who have been infibulated also have a heightened vulnerability as intercourse will inevitably cause bleeding. Since the practice of infibulations is often covert and illegal or carried out within a poorly resourced health care system, the operation itself can create a risk of blood transmission. The United Nations Family and Population Agency estimates that two million women undergo this operation each year. In addition, the use of agents that dry or tighten the vagina is common among women in some countries and this practice causes inflammation, bleeding, and abrasions that also increase the risk of HIV infection (NIAID Division of Aids Science, 2002).

The practice of anal intercourse by women is rarely afforded attention even when surveys suggest that as many as 25% of women have had anal sex as means of contraception, during their menstrual periods because of blood taboos, or for pleasure. This means that more women are having anal sex than men (NAM Publications, 2003a). Another overlooked physiological factor is post menopausal women. No longer fearful of unwanted pregnancy, they are less concerned about having unprotected sexual intercourse (Aberdour, 2004).

Economic dependence and social pressures also limit women's responses (Jejeebhoy & Cook, 1997). Dossier (1992) states that the overriding reason for the rapid spread of HIV has been the high correlation between poverty and vulnerability to the virus. The poorest of the world's poor tend to be women who are also the most disadvantaged by social and cultural notions regarding acceptable behavior. Ninety percent of the HIV positive women live in developing countries (Mahithir, 1997).

An example of the link between poverty and inequalities as a fundamental factor in the spread of HIV/AIDS is inheritance rights. In

many countries, property is usually owned by men while women only have rights through marriage. Women whose male partners die are often left homeless, as the property rights are passed on to her husband's relatives. This practice radically reduces economic security and can lead to women enduring abusive relationships or resorting to sex for economic survival (UNAIDS Initiative, 2004).

Women responses are not limited to financial but to cultural and social reasons, such as when culture patterns of subservience to men are the basis for the relationship (McCaskill, 1988). Women may be coerced into unprotected sex or run the risk of being infected in societies where it is accepted for men to have more than one partner. In fact, most sexually transmitted HIV infections in females occur either inside marriage or in relationships women believe to be monogamous. The typical woman who gets infected with HIV has only one partner, either her husband or steady boyfriend.

Unsafe sex is also linked to emotional dependence on men, since women may find intimacy in a relationship to be more important than protection against HIV (Center for AIDS Prevention Studies, 1998). Beliefs that a woman should be sexually passive and acquiesce to her partner's desires and needs lead women to be dependent on their male partners, and prevents them from asserting themselves in sexual relationships. Fear of partner retribution is also a barrier to discussing fidelity and refusing sex (Vivian et al., 2003).

Violence also increases the danger of HIV infection among women. Coercive sex is a common feature of women's lives in Cameroon, the Caribbean, Peru, and South Africa for example, where between 20 and 48% of young women age 10 to 25 have reported that their first sexual encounter was forced. Fear of violence not only prevents women from accessing HIV/AIDS information, it prevents them from getting tested, disclosing their HIV status, and receiving treatment and counseling even when they know they have been infected. Women infected with HIV often face physical and emotional violence, can be abandoned by their families, and be ostracized by their communities (UNAIDS Initiative, 2004).

Power is also a barrier in maintaining safer sex practices with a primary partner. It is a belief among men, especially in Africa, that women have no rights when it comes to dictating sexual behavior. There is even the suggestion that women who do not agree to have sex with

their male partners are being abusive (Clarke, 2003). For women to protect themselves, they must not only rely on their own skills, attitudes, and behaviors regarding condom use, but also on their ability to convince their partner to use a condom (Center for AIDS Prevention Studies, 1998). At the launch of the Global Coalition on Women and AIDS it was affirmed that, too often, HIV prevention is failing women and girls. Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS UNAIDS says, “because of their lack of social and economic power, many women and girls are unable to negotiate relationships based on abstinence, faithfulness, and use of condoms.”

Several other factors such as stress and poor nutrition exist in the susceptibility to the virus (Seigal, 1988). Treatments are also limited, and authorities cannot afford to provide the comprehensive health care facilities needed to ensure disease prevention, detection, education, and care (Clarke, 2003).

Social construction theory views women as reproducers (Corea, 1985; Overall, 1991), thus the risks from HIV/AIDS have wider implications for humanity. The WHO predicts that wherever female infection rates are high, child mortality could be as much as 30% greater. Early reports state that the risk of HIV infection passing from mother to child is between 20 to 35 percent, varying with the length of the parental infection and progression (Richardson, 1990).

In summary, gender gaps are embedded in the social structure, in contextual situations, in a sexual partner’s relationship, and in society as a global system of social relations. Women’s vulnerability differs from culture to culture and within cultures (UNAIDS, 2000). While biological factors contribute to the behavioral differences between men and women in every society, men’s conduct is determined, at least in part, by expectations about how men should behave, expectations often shared by women as much as men. Disproportionately poor, women may have little choice other than to barter sex for survival. Women, more vulnerable to violence in patriarchal, patrilocal, and patrilineal societies (Bhatti, 1990), subordinate their economic and social position in subservience to their husbands (Mahajan, 1990). Gender inequities are perpetuated by social norms that enable powerlessness and are continued by inheritance, property, and divorce laws that favor men, who also continue to govern the economic, social, and sexual realms within the household (Jejeebhoy, 1998).

Methodology

Health knowledge, attitudes and perceptions are rooted in values, traditions, beliefs, and practices. The theoretical framework on Comprehensive Health Seeking and Coping Paradigm (CHSCP) adopted from Lazarus and Folkman's Stress and Coping Paradigm, and Schlofeldts Health Seeking Model (1984) served as the overriding framework to identify relevant variables and guide this assessment. Variables explored include sociological factors such as stigma, social support from friends and family, risk behaviors, cognitive and psychological factors, and biological factors.

An exploratory study was designed, and the universe were Kuwaiti women above 18 years of age. A snowball sampling techniques was utilized and 360 women were interviewed. The authors used the method of interviewing to collect data that would provide examples to illustrate Kuwaiti women's diverse levels of awareness, perceptions, and of knowledge about HIV/AIDS. The data collection instrument was developed by the researchers and contained 18 qualitative open ended questions in an interview schedule. Quantitative demographic variables on the governate of living, age, marital status, and level of education were also included in the tool. These demographic variables were explored to assess their effect on the women's level of knowledge, perceptions, and awareness about HIV/AIDS.

Twenty social work students from Kuwait University were trained by one of the researchers to interview the sample and gather the data. It took four months for the data to be collected. Incomplete interviews were excluded. Ten interviews were discarded because of missing data. Three hundred and fifty interviews were retained for the analysis.

Findings

Demographics

Forty seven percent of the sample consisted of women between the ages of 18 to 25; 19% between 26 to 30; 11% between 31 to 35; seven percent between 36 to 40; six percent between 41 to 45. The group of 46 to 50 years of age comprised six percent of the sample, and the remainder four percent were 51 years old and above. Most of the Kuwaiti women in the sample came from urbanized areas with two thirds of the sample

coming from areas near Kuwait City, the capital of the country. This distribution according to governate reflects the actual distribution of the Kuwaiti population where most people live in the urbanized suburban areas of Kuwait city. The distribution of categories of marital status reflected as follows: married women (63%); single (32%); divorced (3%); and (1%) separated. One percent of the women were widowed.

The majority of the women held a bachelor's degree (42%); thirty five percent held a high school degree; and women with a two-year college degree comprised 10% of the sample. One percent had a master's or doctoral degree. Those with eight years of schooling comprised seven percent of the sample, and those with only elementary education or no education comprised the remaining five percent.

Qualitative

To the first of the open ended questions, "Have you heard about HIV/AIDS?", the total sample replied in the affirmative. The second question, "Do you think Kuwaiti women have knowledge about HIV/AIDS?", also received an affirmative answer from the majority (79%). About 18% believe that Kuwaiti women have very little knowledge about the disease, and only three percent believe that the Kuwaiti women have no knowledge about the disease. To the third question, addressing knowledge about how HIV/AIDS is transmitted, most of the sample stated that the disease is transmitted through sexual contact and through blood transfusion. One third of the sample believes that the disease could be transmitted through saliva, and two percent expect that the disease could be transmitted by kissing. In addition, two percent believe that the disease could be acquired by going to a beauty salon. Some women (10%) reported that by using personal items, equipment, and tools of a person with HIV/AIDS one could also acquire the disease. Two women believe that the disease could be transmitted through breathing. One woman reported that the disease could be acquired in swimming pools, and another one stated that the disease could be transmitted from sweat or by touching an infected person.

The fourth question, regarding who could get infected with AIDS, received responses very similar to those offered to the third question. In addition, 28% mentioned that "bad actions" would result in HIV/AIDS. Bad actions were defined as committing adultery and/or having sexual relationships outside marriage, including both married and non-married

people. This is consistent with the Islam religion and Muslim belief that people must not have sexual relationships out of marriage.

To the fifth question, “Do you know how to protect yourself from getting infected with HIV?”, more than half of the sample (80%) said yes and 20% said no. Those who said yes provided the same responses given to question number three, emphasizing sexual relationships and blood transfusions as the main source of transmission. One woman stated that staying away from public toilets would prevent people from getting infected with HIV/AIDS, and nine women affirmed that “keeping clean” would prevent people from getting infected.

To the question about what makes you uncomfortable if or when you talk about AIDS, the responses fell into two categories: things that make them feel comfortable and things that make them feel uncomfortable. The responses are summarized in the following table.

Levels of Comfort in Talking About HIV/AIDS

What makes you feel uncomfortable when you talk about AIDS?	What makes you feel comfortable when you talk about AIDS?
Not knowing how to prevent myself from getting HIV/AIDS The limited public awareness that there is no cure for the disease Fear of the future of HIV/AIDS victims The increasing number of children infected with HIV/AIDS The increasing number of infected people in the Gulf area (GCC) The fear of blood transfusions The increasing number of youth being infected That most of the people can be considered victims (meaning they were not responsible for, or guilty of getting infected)	Having HIV/AIDS knowledge The government’s interest in the health care of the people The government’s teaching people the relationship between religious values and being infected with HIV/AIDS Being in an Islamic country

The seventh question dealt with cognizance of someone infected with HIV/AIDS, and also explored whether or not the women would talk to people suffering from the disease. The majority of the women responded “no” to this question; only two women responded in the affirmative. Those who responded “yes” said that they know people who are infected, but do not talk to those with HIV/AIDS.

The eighth question posed to the women inquired if they had talked to their physicians about HIV/AIDS or if any physician had spoken to

them about the disease. Only four women said that their doctors had talked to them about the disease. Those doctors were female doctors who were responsible for their pregnancies and deliveries. Out of those four women who had spoken with their physician about the subject, two mentioned it happened when they wanted to donate blood.

To the ninth question, asking if AIDS is a problem in Kuwait, and if so why, most of the women agree that AIDS is a problem in Kuwait (46%); 37% think that AIDS is not a problem in Kuwait; 11% are not sure if AIDS is a problem. Only .05% are not sure whether AIDS is a problem or not in Kuwait. Not being religious, traveling a lot, “shortage” of health awareness, immigrant workers, bad influences of peer groups, drugs, illegitimate sexual relationships, and ignorance were reasons offered for viewing AIDS as a problem in Kuwait. Those who expressed that AIDS was not a problem in Kuwait justified their responses in terms of Kuwait being a conservative country where such a disease would not happen. Those who are not sure if AIDS is a problem mentioned that the government might be hiding the real numbers about people infected with the disease. To the question, asking if AIDS is a problem in Kuwait, and if so, what the causes are, women reiterated the responses offered to the previous question (9).

To inquiries about where the disease comes from, the majority said that the disease came for the western world (26%). Sixteen percent stated that the disease came from Africa, and 20% stated that the disease came from southeast Asian countries (e.g. Thailand). The group that stated that the disease came from monkeys was equal in percentage to those who said that the disease came from “doing bad things” (illegitimate sex and using drugs) (14%). Those who stated that they did not know where the disease came from comprised 10% of the sample. Thirteen women stated that the disease came from having sex with animals, and two women stated that the disease came from an insect (in Africa).

The twelfth question, regarding belief that there is a relationship between AIDS and religion and, and if so, what sort of relationship, received an affirmative response by the majority (87%). Only .06% denied a relationship between AIDS and religion. Eleven women (.03%) did not know if there was a relationship between AIDS and religion, and the same number (.03%) thought that, to a certain point, there was a relationship, but not a strong one. Those who thought that there was a

relationship between religion and AIDS believe that the stronger the religious faith, the less possibility of getting infected with HIV. Those women who stated that there was no relationship mentioned that people could be infected through blood transfusion and pregnancy, and from their sexual partner. This later group also stated that the “channels” of becoming infected with the virus have no relationship with religion or religiosity.

When asked what you believe the government is doing in addressing the AIDS epidemic, most of the sample replied that government activities such as having public broadcasting programs that talk about the disease, places available for a medical checkup for HIV/AIDS, an international day of HIV/AIDS, a committee to fight HIV/AIDS, and a school curriculum that includes knowledge about HIV/AIDS were in place to address the problem. Only 16% stated that the government “was not doing much” about HIV/AIDS. This last group of women added that there were little efforts directed toward empowering women with awareness and knowledge about the disease. They also expressed that newly married people should be forced to be tested for HIV/AIDS. Fourteen percent did not know if the government was doing something about AIDS, and 04% said the government was “doing very little”.

To the question about health care facilities available for those infected with HIV/AIDS, more than half the sample responded positively (59%), asserting that good health care was available in Kuwait. Only one percent responded in the negative, and a small number (13) expressed that there were bad health care and health care facilities for HIV/AIDS patients in Kuwait. The rest (27%) alleged not knowing about the availability of health care services for HIV/AIDS patients in Kuwait.

When questioned about aspects of the Kuwaiti tradition and culture that affect the levels of knowledge and awareness about HIV/AIDS, the response of one woman can be used to summarize the answers to this question.

Islam religion and the Arabic customs and traditions protect people from getting infected with the AIDS virus. Islam religion and Arabic customs and traditions discourage women from being with strange men. Islam likes women to be separated from men. This process protects both men and women from getting infected with AIDS. Islam religion and Arabic tradition encourage women to marry at a younger age.

Some women complained about Arabic and Kuwaiti traditions that inhibit people from talking about AIDS, especially in front of children. They explained that “social stigmas” about sex prohibit people from talking freely about the disease and about people with AIDS. They are concerned that “shyness” and “feeling ashamed” also influence addressing the subject. This last group also mentioned that the schools’ curriculum lacks information about HIV/AIDS. Some women (14%) stated that they did not know about a relationship between Kuwaiti culture and tradition regarding knowledge and awareness about HIV/AIDS.

If they would ask a future husband to be tested for the AIDS virus was a question posed to the non-married women. The majority answered “yes”, 26% said “no”. Those who said “yes” think that testing future husbands for the virus would protect them from getting infected. They also stated that this procedure would remove doubts about their future husbands’ health. Only a small minority of the sample (.04% or eleven women) said that they “did not know” if they would ask a future husband to be tested. Women who answered “no” to the question about customs and traditions prohibiting them from asking their future husbands to get tested for AIDS, think that future husbands “might run away” and “change their minds”. As some stated: “Kuwaiti men do not like assertive women.”

A similar question addressed to the married women was if they would ask their present husbands to be tested for the AIDS virus. Explanations offered were the same as those from the non-married women (question number 16).

To the last question, “If you were suspicious of your husband’s relationships with other women, would you ask him to be tested for the AIDS virus and why?”, more than half of the sample said yes (57%); fifty women said no (14%). One woman said that she did not know. Those women who said yes think that this measure would protect them from becoming infected. Those who said “no” thought that there was no law to enforce the husbands to take the test, that such a thing would cause problems between the wife and husband, that it might lead to divorce, that they trusted their husbands, and that the test would not prove if he had affairs.

Discussion

The Kuwait society is a conservative, religious society. Kuwaiti women's knowledge, perceptions, and awareness about HIV/AIDS was not as limited as expected by the researchers. However, Kuwaiti women still feel threatened by culture and tradition when addressing the issue, and cannot ask their partners to be tested for HIV. Most women still fear punishment and divorce.

Kuwaiti women responded differently about HIV/AIDS nature, causes, and effects. The area of residence (near the capital/ inner city or outer city) and the level of education played a significant role in women's knowledge and awareness about the disease. Those who live closer to the capital have more knowledge and awareness of the disease than those who live in further areas (outside governates). This factor relates to the level of education, since those who live closer to the capital were more educated than those who live in outside governates. Age was another influencing factor. Women who were younger were more knowledgeable and aware about HIV/AIDS than older women. Marital status showed no effect on levels of knowledge and awareness. Generally speaking, Kuwaiti women's knowledge and awareness about HIV/AIDS disease is limited.

The majority of Kuwaiti women blamed the government and the Ministry of Communications for their ignorance and limitations about the disease. They thought that the media was mostly controlled by the government; thus, it was the responsibility of the government to educate people about the disease. They thought the media (TV, radio, newspapers, cinema, etc.) could play a bigger role in educating people about the disease, and women in specific.

Media values and principles, which are part of and reflection of people's values and principles, emphasize the tradition and culture of the society, tradition and culture that see sex as a taboo. Talking freely about sex is considered shameful. Women do not talk about HIV/AIDS since it is related to sex. Kuwaiti society is considered a conservative, religious, and traditional society, and women feel uncomfortable talking about issues related to sex, especially in front of men. For example, although women adamantly to ask their future husband to test for HIV/AIDS as a protection for their health, they feel hesitant because of the taboos. They

will be looked at by society as liberals and radicals, and that is a threat to their future, especially their marriage.

The International Guidelines on HIV/AIDS and Human Rights, issued in 1998 by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Program on HIV/AIDS, expressly point out that “there is no public health rationale for restricting liberty of movement or choice of residence on the ground of HIV status. Policy and practice must take into account the potential contribution, both monetary and non-monetary, that each individual immigrant can make, since not all immigrants will place a burden on health and society” (International Federation of Social Workers, 2000).

Countries that prohibit people living with HIV/AIDS from long term residency due to concerns about economic cost, should not single out HIV/AIDS as opposed to comparable conditions.

UNDP (1990) stresses the need for minimization of HIV/AIDS adverse socioeconomic consequences, but also for the reallocation of resources to aid in developing holistic, sustainable programs focusing on preventive measures. Empowerment of the people to protect themselves will combat the effects and spread of HIV/AIDS, but ideology on sexuality is based on majority values, and this approach has to be free from imposed moralistic and judgmental values. Much confusion is apparent in the literature as to place blame on minority groups or on high risk behaviors, yet contemporary forms of oppression, socio-economic deprivation, and injustice have a marked effect on these groups. In Britain, for example, government health campaigns targeting high risk groups aided the stigmatization and false belief that only minority groups and those who engage in socially deviant behavior are at risk, enforcing prejudice and labeling (Huntley, 1994).

Education is imperative for giving guidance on protection and alternatives, but also for liberating from oppressive, discriminating, moralistic, and homophobic attitudes in lay beliefs. HIV/AIDS is a global, societal problem to which everyone can be equally at risk. Unfortunately, once stigmatization becomes common belief, these attitudes are difficult to change. Prevention strategies must target both women and men, and address gender norms, particularly in sexual decision making (Center for AIDS Prevention Studies, 1998).

Prevention / Education Experiences

The socio-cultural context shapes the ways communities respond to an epidemic, while the epidemic itself influences local practices and perceptions (Gupta & Weiss, 1993; Worth, 1989; Zierler & Kreiger, 1997). The task of saving lives is directly dependent upon the ability to educate effectively and to help promote prevention (United Synagogue of Conservative Judaism, 2001-2004). Understanding the social context of HIV/AIDS risk behavior remains critical to the development of preventive strategies and interventions (Amaro, 1995; Carmona Vargas et. al., 1999; Miller, 1999; Skurnick et al., 1998). HIV/AIDS has caused more human, economic, and social destruction than any other disease in human history. The problems that feed the HIV/AIDS epidemic, including poverty, gender inequities, sexual violence, and exploitation have historically been best overcome by expanding access to education. An effective long term approach to HIV/AIDS prevention should focus on keeping children and young people in school, which provides the best mechanism for providing the skills they need to protect themselves. However, the education systems must also provide knowledge that can reach outside the traditional confines of schooling. At the UN General Assembly Special Session on Children, South Asia leaders joined those from every other regions of the world in endorsing the commitment that by 2005, at least 90 percent of young people would have access to the information and education they need to protect themselves. However, according to the World Bank, more than 95% of the 15 to 19 years old in Bangladesh, for example, still do not know a single method of HIV/AIDS prevention.

Australia was the first country to adopt a national HIV/AIDS strategy and is recognized as a leading nation in the overall management and prevention of HIV transmission. Due to the relatively small numbers of HIV positive people in Australia, the development and application of a strategic approach to this problem now entails a managed response rather than a reactive one (Aberdour, 2004). Sharing personal experiences and educational activities in Africa has helped in uncovering the myths and beliefs surrounding early sex. These myths include a belief that a build up of sperm could lead to madness, that "wet dreams" signaled the time when a boy should indulge in his first sexual encounter, and that HIV/AIDS is solely a woman's disease (Clarke, 2003). The

South African government HIV awareness campaigns reports increased rates of safer sex. A survey conducted by an organization with boys aged 9 to 16 at 20 schools in KwaZulu-Natal shows that the age of initiation of sexual activity is moving from 14 and 15 years to older groups, a change in behavior linked to specific prevention education interventions in school settings.

Attributed to education is how the HIV/AIDS prevalence among pregnant women in South Africa leveled off at 25 percent, with statisticians noting a slight fall in new HIV detected cases. Zambia has also managed to reduce HIV prevalence among women in both urban and rural areas through education, and Poland, unlike much of Eastern Europe, has succeeded in curtailing the HIV epidemic among injecting drug users and in preventing it from spreading to the sexually active population. Uganda has been Africa's greatest success story, where at the end of 2001, adult HIV prevalence had fallen from 8.3 percent in 1999 to five percent (NAM Publications 2003c).

A critical element in HIV/AIDS prevention, however, is political leadership. In every part of the world, leadership at the highest levels of government has emerged as one of the most important factors in successful HIV/AIDS prevention (Bellamy, & Piot, 2003). The Five Year Strategic Plan for South Africa (2000), a collaboration of all key stakeholders including the faith-based sector, is a broad national strategic plan designed to guide the country's response to HIV/AIDS in four priority areas: (1) prevention; (2) treatment, care, and support; (3) research, monitoring, and surveillance; and (4) human rights.

In the Middle East, there is an absence of programs that take into account religious and cultural sensitivities, as well as of activities to educate and empower women to be able to negotiate their sexuality within the dominant culture. By educating existing women's groups, for example, the women could avoid drawing attention to themselves and being labeled (Ahmed & Noordien, 2001) when engaging in HIV/AIDS education.

Since much of the stigmatization of people living with AIDS and their families has come from religious quarters, religious involvement is crucial in sending the message that HIV/AIDS is not a punishment (United Synagogue of Conservative Judaism, 2001-2004).

There are many examples of how the faith sector is responding, or

can respond, to this challenge. Regarding education, resources and models for prevention education can be identified; HIV/AIDS prevention through family enrichment can be strengthened; HIV/AIDS prevention through youth programs can be enhanced by building a solid foundation concerning sexuality, responsible adulthood, and marriage; and by breaking taboos about sex. Working with governments, the faith sector can advocate campaigns against taboos and discrimination; appropriate levels of cost-effective health care, especially home based care; means to protect the interests of women and children; and establishment of an annual National Day of Prayer and Healing for all persons affected by the epidemic (Department of Health 2002).

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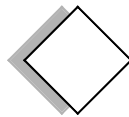
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قضايا الجنس (Gender) ومرض نقص المناعة المكتسبة: تجربة المرأة الكويتية

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ملخص: قد أجريت في الشرق الأوسط بعض الأبحاث - المحدودة - لمرض نقص المناعة المكتسبة، وفي الكويت - على وجه الخصوص - يتجاهل عدد المصابين الكويتيين؛ إذ إن هناك القليل من المعلومات المتوافرة عن معدلات المرض وحالات الوفاة، وهناك تصور - كما في البلاد العربية الأخرى - هو أن مرض نقص المناعة المكتسبة من الأمراض المستوردة ويأتي من الأجانب. وأكد تصريح صدر مؤخراً من جامعة الخليج العربي أن الشرق الأوسط لم يعد محصناً ضد مرض نقص المناعة المكتسبة، كما يعترف مسؤولو الصحة أنهم لا يستطيعون إغلاق الجسور بينهم وبين العالم الخارجي. ويقدر آخر تقرير صدر عن منظمة الصحة العالمية أن 70% من الحالات في العالم العربي منقولة جنسياً من خلال الاتصال الجنسي. إن مرض نقص المناعة المكتسبة هو حالة بيولوجية ولكنها أيضاً مشكلة وخليط معقد من العوامل الاجتماعية والسياسية والثقافية. ويتفحص الباحثون هذه العوامل المعروفة ويستعملونها إطاراً مبدئياً للكشف عن وعي المرأة الكويتية ومعرفة حول مرض نقص المناعة المكتسبة. وتشير النتائج إلى مستويات التفهم للمرض ضمن النساء الكويتيات، وهو ما يساعد على تصحيح بعض المفاهيم الخاطئة لديهن نتيجة بعدهن عن قضايا مرض نقص المناعة المكتسبة. وطبقاً للنتائج، توفر تصاميم لسياسات تعريفية علمياً وتطور استراتيجيات موجهة للجنسين للتعليم والوقاية. إن البعد النظري لنموذج طلب الصحة التفصيلي والتكيف (comprehensive Health Seeking and Coping Paradigm (CHSCP) الذي اقتبس من (Lazarus and Folkman) في نموذج الضغط والتكيف Stress and Coping Paradigm، ونموذج سكولفيلدس لطلب الصحة (Schofeldts Health Seeking Model) (1984) ذات العلاقة وفي توجيه هذا النموذج. وقد صممت الدراسة الاستكشافية عن طريق الاستفادة من تقنية عينة كرة الثلج. وقام الباحثان باستخدام منهج المقابلة لجمع المعلومات، التي تسهم في تعرف مختلف درجات الوعي، الإدراكات، والمعرفة المتعلقة بمرض الأيدز AIDS كأمثلة. ولقد تم تحليل المعلومات باستخدام كل من المنهج الكيفي والمنهج الكمي. وأشارت النتائج إلى اختلاف درجات الفهم والوعي بين النساء الكويتيات لمرض الأيدز AIDS وهو ما ساعد على تجاهل الفهم أو سوء الفهم العام للمرأة الكويتية حول موضوع منفصل عن مرض الأيدز AIDS. وبالاستناد إلى هذه النتائج يمكن تصميم سياسات علمية وجوهرية وكذلك تطوير برامج لاستراتيجيات حساسة للنوع Gender، وبالأخص في مجال التعليم والوقاية.

المصطلحات الأساسية: مرض نقص المناعة المكتسبة - المرأة الكويتية - منظمة الصحة العالمية.

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