Men and women alike are at risk of infection from the HIV virus, yet in many ways women are particularly vulnerable. The chronology of the epidemic in the developed world has lulled many women into a false sense of security, since it emerged historically as a disease of men. Women continued with their daily lives of working, caring for their children, maintaining the home, unaware that in many important ways they were at risk of infection.

This is not true of women in sub-Saharan Africa or parts of Latin America, who can read the chronology of this disease on the faces of their women friends as they waste away and die. They watch men and women die in equal numbers. The modes of transmission of the virus are the same for women as for men: through blood, invasive instruments or sexually. Thus women's susceptibility arises largely from their reproductive role and their place in society.

For men, both homosexual and heterosexual, self-identity is, to a significant extent, bound up with male sexuality, and this places men at particular risk of sexual transmission. Women's self-identity is not based, to the same extent as men, on their sexuality, but there are other factors which put them at risk. One is their social and sexual passivity; in particular, a lack of assertiveness in interpersonal relations. Women, even when they are aware of the risk of transmission, find it difficult to insist on safe or protected sexual intercourse, just as they find it difficult to insist on the act being a pleasurable one for them.

This socialised passivity is linked to a form of conformity by default which arises when women are not taught the skills required for saying no: saying no to experimenting with or taking drugs; saying no to alcohol; saying no to sexual propositions. These are all social situations in which women must now be able to refuse to participate in order to protect themselves. In the 1970s this was acknowledged on a badge which read: "I have just said no and I don't feel guilty." Today, however, for many women, the assertion must be: either a condom or not at all. Bargaining within casual or longer lasting sexual relations is not consonant with the non-assertive or peacemaker roles instilled into women.

Another critical factor, in "Western" societies at least, is the inculcated belief in the myth of romantic love. True love or falling in love are assumed to be beyond the reach of reason. One is caught up and swept along. Orderliness, it is assumed, will happen later on.

Data on prostitutes show how pervasive and how dangerous these myths are. A number of studies show a high level of awareness in prostitutes of the way the disease is transmitted, and they often require clients to use condoms. But in their private lives, prostitutes often do not use condoms, on the grounds that this is a way of distinguishing love relationships from work relationships, that it would not be romantic to use them, and that the husband or sexual partner would not allow it.

Men with multiple sexual partners, whether heterosexual or bisexual, place women at high risk of infection. Often the wives or sexual partners of these men are not aware of the existence of other sexual partners and so are at risk without their knowledge. In these cases, women are vulnerable to infection, not through their own behaviour but through the behaviour of their sexual partners, and without the ability to protect themselves from infection.

There are also socio-economic factors which put women at risk, in particular those factors which force women to work in the sex industry. In many developing countries, for instance, there is an
increasing displacement of women to urban slum areas. There, because of what is considered acceptable or appropriate behaviour for men and women, and because of discrimination in access to education, training and land ownership, many women drift into prostitution and become vulnerable to infection with the virus.

A number of social customs relating to women must now be reconsidered for risk factors. One of these is the use of blades or other instruments in female circumcision. There is no evidence as yet of transmission of the virus by this means, but the practice puts women potentially at risk. Childbirth places midwives and traditional birth attendants at risk in areas of high female infection. In rural areas, these women are called from their fields to attend a birth. Their hands are marked by their work, and usually neither gloves nor other means of protecting themselves are available or routinely used.

Women who are infected or whose partners are infected are at present faced either by a life without any, or any more, children or by the possibility of giving birth to an infected child. Women are still choosing to have children in these circumstances. Studies of wives of infected men with haemophilia indicate that this choice is being made despite a great deal of knowledge about the risk of infection to themselves and to their child. Is it that life without childbirth, childbearing, and children is unacceptable? We must look at the nexus between conception and child raising. Is this link essential or can the desire for children be satisfied by raising children other than one’s own? Is this socially acceptable or normal? Is it legally possible? If this nexus cannot be broken, the choices for women are stark: childlessness or the possibility of death for themselves and their children.

However, there are also ways in which the existence of this terrible disease may even help women, and certainly ways in which women can help to prevent its spread. Communities are being forced to face many issues which previously had been ignored or denied: extramarital sexuality, adolescent sexuality, prostitution, homosexuality and intravenous drug use.

One positive outcome for women may be the need to take a more active role in social and interpersonal relations. Their self-confidence and assurance will be essential to combat this epidemic, not only to prevent sexual transmission but also transmission through intravenous drug use and even through medical treatment. In developing these skills, individual women will be better able to protect themselves and to limit the spread of the virus.

The role of women’s organizations in containing this epidemic will be crucial. Firstly, they have the potential to assume a direct preventive role. This has already occurred in many countries where women have organised themselves, for example, in Mexico and India against rape, in India and Kenya against alcoholism in men.

Secondly, women’s organizations have an important educational role and are a means of reaching not only into each community and village but into each household. The message that must go out about the means of containing the epidemic will strike a chord with women. One common source of distress to women, illiterate or literate, in villages or towns, is the disintegration of relationships between men and women, the growing lack of trust, responsibility and communication. To survive uninfected, particularly from sexual or intravenous transmission, women must learn not only to be assertive but to choose or create relationships based on mutual concern and respect. This in itself should lead to an improvement in the quality of their relationships.