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Gender asymmetry in healthcare-facility attendance of people living with HIV/AIDS in Burkina Faso[☆]

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ABSTRACT

Anthropological research in Burkina Faso indicates that more HIV-positive women than HIV-positive men are attending care facilities for people living with HIV/AIDS (PLWH) and accessing antiretroviral medicine. This article, situated in the field of study of interactions between gender and AIDS, offers a description of this asymmetry and an anthropological analysis of the socio-cultural determinants, through analysis of data from ethnographic research among PLWH and health actors. Examining social representations of femininity and masculinity in Burkinabe society and the organisation of the healthcare system in connection with gender shed light on the decision-making processes of both sexes around therapeutic choices and the itinerary of care. On the one hand, the social values attached to femininity, maternity and the status of wife create conditions for women that favour their attendance at care facilities for PLWH and encourage a widespread practice where wives take the place of their husbands in healthcare queues. Moreover, health policies and the effects of women's empowerment within the healthcare system strengthen women's access to health services.

On the other hand, representations of masculinity are fully implicated in the cultural construction of men's reluctance to attend care facilities for PLWH. The values associated with this masculinity cause men to run great health, economic and social risks, not only for themselves, but also for their wives and children.

By better understanding the interaction between gender, the experience of HIV and the institutional organisation of healthcare, we can identify ways to reduce men's reluctance to attend care facilities for PLWH and improve both prevention and treatment-oriented programmes.

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Introduction

The experience of HIV infection in sub-Saharan Africa, as elsewhere, is gendered, and the effects of gendered systems with regard to this disease mostly disadvantage women. Many studies indicate the multiple vulnerabilities of women to HIV infection on the biological, epidemiological, cultural and social planes. This is an important issue in Africa, where 68% of the world's infected people live, 61% of whom are women (UNAIDS, 2007). Their living conditions put women at greater risk than men of contracting HIV. The cultural representations and practices pertaining to women in diverse African societies; the separation of functions, spaces and activities; and the subsequent economic weakness among women

are factors that can drive their social vulnerability (Bardem & Gobatto, 1995; UNAIDS, 1999; UNAIDS, UNFPA, & UNIFEM, 2004).

In Burkina Faso, this vulnerability hinges on the social representation of women's "dangerousness" as carriers of HIV infection relative to men in explanatory models of the illness. HIV-positive women are also more frequently and more seriously exposed than men to practices of exclusion, discrimination or harm caused by the seropositive status (Le Palec, 1997; Egrot, 2004, 2006; Egrot & Taverne, 2003).

However, we have observed that, once infected, gender may work to the disadvantage of men in terms of obtaining care. When beginning this study, we first noted that the number of HIV-positive women attending care facilities for PLWH was greater than that of HIV-positive men, in proportions that are explained neither by the sex ratio of the population nor HIV-prevalence rates based on sex – as the prevalence of HIV/AIDS in Burkina Faso is almost equal for both men and women (Bila, Egrot, & Desclaux, 2006, 2007). We decided to investigate this inversion of the usual gendered vulnerability, which seems to hinder men in the domain of access

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to care. This paper aims to better understand why women actually seem to have fewer difficulties than men in accessing HIV testing and care once they become HIV positive. This article will describe this observed asymmetry and offer an anthropological analysis focusing on gender and the organisation of the health system in Burkinabe society.

Methods

The results presented here come from the anthropological study entitled “Social networks, search for therapy and experience with treatments among PLWH in Burkina Faso” carried out between 2003 and 2005 and then for a thesis (of B. Bila, with additional funding from IRD and Sidaction) until 2008. During 2003 and 2005, this study was conducted in partnership with CRECSS (Centre de Recherche Cultures, Santé et Sociétés, Aix-en-Provence, France), IRSS (Ouagadougou, Burkina Faso), SHADEI (Sciences Humaines Appliquées au Développement et à l’Evaluation des Interventions, Centre Muraz, Burkina Faso), and IRD; the study was coordinated by M. Egrot and A. Traoré and funded by ANRS (Agence Nationale de Recherche sur le Sida) and Sidaction (Paris, France). The two principal investigators were B. Bila and M. Egrot. This programme combined direct observation, individual interviews and group discussions with 81 PLWH and 40 healthcare actors. Group discussions consisted of a small number of people (6–12) with data collection through note-taking or audio-recording. The 40 healthcare actors included 8 women and 32 men, aged 30–55; these men and women included 18 doctors, 19 associated staff and 3 paramedical workers.

Fifty-three PLWH were interviewed (35F/18M). They were aged 20–63 years and were socially diverse. They were followed up in care facilities in Ouagadougou and Zorgho, which included: various associations (Association Laafi La Vîm [ALAVI], Vie Positive [Vie+], Association Africain Solidarité [AAS], Association des Femmes Africaines Face au SIDA [AFAFSI], Union des Routiers du Burkina dans la Lutte contre le Sida [URBLS], and the Réseau Africain des Jeunes Contre le Sida [RAJS]); the Centre de Traitement Ambulatoire (CTA); the health facilities at Lamizana Military Camp, the programme implemented by Médecins Sans Frontières (MSF) of Luxembourg in collaboration with the CMA of Pissy (in the district of Ouagadougou); the medical centre at Zorgho; and two private clinics in Ouagadougou. The CMA, or Centre Médical avec Antenne-chirurgicale – a health centre with a surgical unit – is a healthcare facility at the health district level. Table 1 shows the distribution of subjects according to site of participation.

Contact was established with the PLWH following a pre-defined procedure. Ethics approval was provided by the Ethical Committee for Health Research in Burkina Faso. The PLWH, initially contacted by association members, healthcare providers or other PLWH, decided to participate in this study based on a preliminary information meeting.

Table 1
Distribution of interviewees in Burkina Faso.

Site	Total (N)	Male (N)	Female (N)
ALAVI	7	2	5
Vie+	6	2	4
AAS	5	4	1
URBLS	4	0	4
CTA	4	1	3
Lamizana Military Camp	7	3	4
MSF	6	2	4
AFAFSI	3	0	3
RAJS	3	1	2
Private clinics (two)	2	1	1
CMA & Zorgho	6	2	4
Total	53	18	35

The data were transcribed and then analysed through transverse analysis of content, a method enabling data analysis from individual interviews, group discussions and direct observations. Results related to a specific item were extracted to create thematic files and an open-ended list of pre-established items. In addition, social actors themselves can generate key points to analyse.

This study focused on differences in men’s and women’s attendance at care facilities because specific questions on this gender asymmetry of attendance and the reasons that encourage individuals in or deter individuals from therapeutic options have been included in the survey guides for PLWH and healthcare providers. Group discussions were specifically organised around these questions. At ALAVI, one group was exclusively female (9 women) and the other male only (7 men). The third, co-ed group interviewed at Vie+ was equally divided between men and women – 6 men and 6 women. Focus group participants ranged in age between 30 and 55 years old. These focus group discussions enabled collection of more comprehensive data.

Background

AIDS in Burkina Faso

In 2004, Burkina Faso’s 2006 population was projected at just above 13 million inhabitants (INSD, 2004), composed of some 60 ethnic groups; 48% of the population belong to the Mossi ethnic group. According to the Human Development Index (UNDP, 2007), Burkina Faso is ranked 176 among 177 countries. Nearly half the population lives below the poverty line (approximately 150 USD/year), with poor access to basic social services, notably educational and health services, particularly for women (INSD & ORC Macro, 2004).

The 2003 Burkina Faso DHS (Demographic and Health Survey) found a 1.8% national HIV seroprevalence. Unlike most countries, prevalence among men and women is equal. Nevertheless, HIV seroprevalence varied considerably by region, e.g., in Ouagadougou, prevalence was 4.2% but 0.1% in the Sahel region or 3.7% in the South-West region (INSD & ORC Macro, 2004). The 2006 UNAIDS evaluation estimated the prevalence rate to be 2% (UNAIDS, 2007).

In December 2007, 17,263 patients were undergoing anti-retroviral (ARV) treatment (Sanou et al., 2008). The national healthcare structure for access to ARVs in principle enables any patient whose health status requires it to receive free ARV treatment, averaging 8000 FCFA/month (16 USD) for the ARVs, and biological examinations. This has since decreased to 1500 FCFA/month. In most public facilities, the option of “global care” offered by associations since 1996 (Egrot, 2006; UNDP, 2001) includes medical treatment of the HIV infection in a package of services: psycho-social support, food, care of orphans and vulnerable children and support for socio-economic activities.

In these facilities, including associations or religious organisations, many patients declared as indigent received “completely free” treatment (Desclaux, Bila, Kouanda, & Egrot, 2006).

These crowded facilities, however, make it very difficult to remain unseen by others. AIDS still carries a negative image and is associated with shame and the transgression of cultural values, indeed with a loss in social standing (Egrot & Taverne, 2003; MPDH, 2007; Ouattara, Gruénais, Huygens, & Traoré, 2004; Taverne, 1996, 1999). Nevertheless, people living with HIV/AIDS can still build a social network, a determining factor in access to quality care (Egrot, 2006; Egrot, Bila, & Traoré, 2007).

What does gender mean in this study?

Gender will be considered within the continuum of various studies (Doyal, 2000; Héritier, 1996; Hurtig, Kail, & Rouch, 2002;

Löwy, 2006; Parini, 2006) as a dynamic social construction of categories, defined with reference to a set of socio-sexual realities. The articulation of this development process within specific changing and historically-determined socio-cultural contexts explains the social, cultural and temporal variability of the categories of gender. Similar to Löwy's (2006, pp. 63–66) analysis, we will consider that it is impossible to envisage one or another of the categories of gender autonomously. On the contrary, they are quite "interdependent," constantly intervening in the determination of social links, trust relationships, hierarchy or domination between existential realities, referring to masculinity or femininity in social discourses and practices.

This study contributes to the vast research exploring the interface between gender and health. This issue is central to what Fassin (1996, pp. 71–72) defines as the political space of health, where illness is an event that "inscribes" social inequalities, particularly gender-related inequalities, "onto bodies." The causes for many differences between men and women with respect to diverse illnesses or access to medical care are found in specific socio-cultural contexts (Annandale & Hunt, 2000; Mastroianni, 1998; Pollard & Hyatt, 1999; Saillant, 1999). The social sciences have also clearly shown that gender is also a cultural factor orienting the discourses and practices of healthcare providers (e.g., Bretin, 2004; Kempner, 2006; Membrado, 2001; Vinel, 2007).

This contribution specifically investigates access to care of PLWH in Burkina Faso and fits into an even more precise field of study: the interactions between gender and AIDS, in which the social sciences have analysed women's vulnerability to HIV infection, the effect of gender on representations, prevention messages and healthcare practices (Farmer, Lindenbaum, & Delvecchio Good, 1993; Rao Gupta & Weiss, 1993; Schoepf, 1991; Ward, 1993).

Being a woman, man and parent in Mossi culture

Among the Mossi, women's social status resides mainly in reproduction, notably their ability to bear and raise children. However, even after their integration as a mother, they are still perceived as potentially dangerous to their husbands' families and the children born into them (Bonnet, 1988, 1996; Egrot, 2001, 2004).

A woman's capacity to "produce human beings" is superimposed upon children's transformation into "social beings" by their fathers when they become full-fledged members of the husband's lineage. Additionally, the patrilineal and virilocal character of the kinship system confers on men, especially fathers, a determining role in the child's integration into the paternal lineage, an essential condition for social recognition (Egrot, 2001).

Consideration of this point is particularly important in understanding the mothers' involvement in retaining a father for their children. In the patrilineal logic structuring the conceptions of family, children belong to their paternal lineage. They therefore do not leave with their mother, even if she should want or need to leave the conjugal home, whether her husband is alive or not (Lallemant, 1977; Vinel, 2005).

In the Mossi culture, men and women do not share the same spaces. Male/female boundaries are strictly observed, and "each sex performs the work incumbent upon it, generally in different spaces" (Egrot, 2001). Any transgression of the gender boundary is therefore seen as inappropriate or incongruous; for example, a man accompanying his wife for her prenatal follow-up or participating in sessions on nutrition.

For the Mossi, it is the husband's duty to regularly provide his wife with the *zeed ligdi*, the Moré term (literally 'sauce money', a term derived from the practice of women who prepare meals regularly receiving grain from heads of family units in rural areas)

for the amount of money required to purchase condiments for meal preparation. The head of a family must prove his ability – *zaksoaba* in Moré – primarily by providing for his family, the minimal obligation of a capable husband (Attané, 2003).¹

Women's status, widowhood and repudiation

The social status of women in Mossi society changes with their marital situation and age. Sisters and daughters on paternal land will diachronically and synchronically become wives then mothers on their marital land.² Women's mobility from paternal to marital land makes the separation of the sexes and the power relationships between women and men particularly complex.

Nevertheless, the marriage ties remain the cohesive factor defining women's social position, all the while favouring their submission to their husband's family (Egrot, 2001, 2004; Vinel, 2005). Equally, certain acts such as witchcraft, adultery or lack of respect toward members of the husband's family can be invoked as reasons for repudiation against women (Egrot, 2001).

Health policy and gender

Maternal and child health is a priority in Burkina Faso's public health policies (MS, 2000). Their implementation corresponds to and reinforces already existing cultural frameworks related to maternal responsibility in procreation and the children's health and survival (Bonnet, 1988, 1996; Vinel, 2005).

Children are seldom seen in health facilities without their mothers or, conversely, a mother without her child(ren).

Moreover, various activities pertaining to prevention and health education are preferentially addressed to women: prenatal consultations, paediatric follow-up, family planning, vaccinations, campaigns to combat various infectious diseases, hygiene and water supply, etc. (Egrot & Taverne, 2003; MS, 2000).

Results

More women than men attend care facilities

From the beginning of the surveys, whether in the discourses of PLWH and healthcare providers or through direct observation at healthcare sites, an empirical fact stood out for the research team: HIV-positive women are more numerous than HIV-positive men as patients at healthcare facilities for PLWH.

This asymmetry was also seen throughout the study. Among the PLWH encountered, there are always fewer men, notwithstanding various attempts to change this asymmetry through recruitment. In fact, this difference among the interviewed PLWH (18M/35F) is reflected in the healthcare structure for PLWH. Therefore, hypotheses relating to this asymmetry and its socio-cultural determinants have been integrated into the study's problematics.

¹ Urban living conditions often cause failure of partial or total payment of the *zeed ligdi*. Women living in towns thus initiate activities, particularly commercial activities (selling fruits, vegetables, condiments, etc.). Hence they complement and sometimes discreetly provide the entire *zeed ligdi*, while attempting to preserve their husbands' honour so as to not undermine the authority of the *zaksoaba*.

² The status conferred on a young wife by her husband and in-laws is hardly enviable. Conversely, being a man's sister or mother puts women in a dominant position, particularly toward their brothers' and sons' wives as well as the children born into these alliances. For example, the term used in Moré by a wife to designate her husband's sisters is "my husband." This is one of the many examples of the inversion of gender existing in Mossi society placing mothers and sisters in dominant relationships with wives based on marital lineage (even when physically absent from paternal land due to their own matrimonial alliances) and consequently, of the extreme complexity of women's social status in this culture.

Observation confirms the low presence of seropositive men not only in the consultation rooms of physicians, psychologists, social workers, etc., but also in queues for food, medicine or school-supply distribution. Additionally, the few men present participated less than women in healthcare-facility orientations for PLWH, discussion groups, meeting organisation, etc.

Information concerning this asymmetry was collected from: 4 associations (Vie+, AAS, ALAVI, URBLS), the CTA, the Pissy MSF/CMA service and Burkinavi clinical research project (a joint project of the World Bank, Centre Muraz, Ouagadougou and Bobo-Dioulasso University Hospitals, and the Hôpital Tenon in Paris). The recorded numbers and calculated sex ratio confirm the observed asymmetry and make it possible to evaluate its extent. The male:female sex ratio of PLWH followed up in these facilities in 2005 and 2006 is between 1:1.5 and 1:2.6, or approximately 2 men for 3–5 women. Among the PLWH treated with ARV, the asymmetry is between 1:1.7 and 1:3.1, that is, approximately 2 men for 3–6 women (see Table 2 for sex ratios across the study sites).

The M:F sex ratio (15–49 years) for the prevalence of HIV infection in Burkina Faso was 1:1.1 in 2003 (INSD & ORC Macro, 2004). The 2003 DHS only calculated the prevalence of HIV infection for the 15–49 age group: 1.9% for women and 1.8% for men. This difference is considerably less than that observed for care-facility attendance among PLWH.

The anthropological analysis presented here clarifies the decision-making processes at various levels for seropositive women and men in their recourse to care, processes that appear to be explanatory factors of this asymmetry.

Reasons evoked for the male–female asymmetry at care sites

The asymmetry of the number of seropositive men and women is generally explained in the interviews by:

- High attendance by women;
- Low attendance by men; and
- Finally, even when seropositive men consent to follow-up, it is widespread practice for women to stand in for their husbands in queues. When it is the wife's turn, she alerts her husband, who has stood apart –even at another place – if his presence is essential (e.g., consultations, taking of blood, etc.) or at the final step, especially in cases of drug, food or other aid distribution.

These three behaviours converge to explain a very high presence of women at the care facilities for PLWH in comparison with men.

Table 2
Sex ratio of PLWH followed up in 7 treatment sites/institutions.

	PLWH receiving follow-up			PLWH on ARVs		
	M	F	Ratio M:F	M	F	Ratio M:F
ALAVI, Dec. 05	160	640		44	86	
Vie+, Sept. 05	312	605		91	146	
AAS, Jan. 06	608	1247		146	258	
URBLS, Dec. 05 ^a	78	68		Unavailable		
Total associations	1158	2560	1:2.21	281	490	1:1.74
CTA, Apr. 06	1159	1783	1:1.53	237	524	1:2.21
MSF, Dec. 05	971	2496	1:2.57	337	683	1:2.02
Burkinavi, May 06 ^b				49	154	1:3.14
Total	3288	6839	1:2.07	904	1851 ^c	1:2.04

^a URBLS, a truckers' associations (predominantly men), also cares for truckers' partners and all PLWH who contact them. The number of people on ARVs in 2005 and 2006 is unavailable.

^b Anyone included in the Burkinavi cohort is receiving ARVs.

^c Total number of PLWH on ARVs: 2755 or approximately one-third of the 8168 individuals placed on ARVs in Burkina Faso in 2005 (CMLS, 2005–2007).

The data provide different reasons for women's greater motivation to regularly visit these facilities. Conversely, their possible reticence to do so is, according to the testimonies, either non-existent or secondary and negligible in comparison with their concern for themselves, their children or their husbands. Finally, several interviews broach the reasons why women frequent facilities for PLWH more easily and offer or agree to replace men in the queues and conduct activities in their place.

Concern for children as motivation for women

Numerous testimonies refer to the mothers' concern for their children to explain a greater presence of women at care facilities.

The willingness, and moreover a feeling of obligation, to be in good health so as to be able to care for children predominates. Access to care and medicine thus appears necessary in maintaining a physical condition that enables women to cope with the vital domestic and economic activities that support children's well-being and education: "If you go to the association, you get medicines that make you healthy. With good health, you can still get out and find something for your children to eat" (widow, approximately 50 years old, small trade).

According to the women, food donations to association "beneficiaries" offer another motivation for their regular presence. One explains: "What you want now is that God helps caregivers with medicines so they can save your life and help you with food so that you'll have the strength to care for your children so they succeed in life" (widow, approximately 30 years old, activity unidentified).

One man summarized women's concerns about satisfying their children's needs, particularly regarding food: "Being with children means there are things they cannot bear. Thus, a woman will disregard all her principles to go and find something for the children to eat" (approximately 40 years old, association coordinator).

Therefore, women's motivation to attend care facilities is constructed around two converging logics linked to children. The first is long term: to stay "in shape" and to be able to "run", "walk" and "take care of the children" for as long as possible. The other is situated in the immediate present: to find the resources necessary to feed and clothe children and send them to school.

Women's need for a new social-networking space

Women place high importance on attending healthcare sites. The following two extracts are emblematic of all of the discourses. Speaking about her association, this woman said: "[There] you receive help counsel, food, while your family gives nothing for the children and even less for you, their mother" (widow, approximately 50 years old, small trade). Another explains: "If you hide at home, who'll know about your problems? You'll end up dying one day and abandoning your children. But if you get out and share your problems with people from the associations, with the caregivers, [...] you'll improve your health and fortitude" (widow, approximately 30 years old, activity unidentified). The intense contrast between the families' indifference, abandonment, spoliation and the quality of social relationships in associations (Desclaux et al., 2006; Egrot, 2006; Ouattara et al., 2004) prompts many women to strengthen their habit to regularly visit care facilities. Some of the widows who visit associations have been subjected to diverse accusations about the disease or the death of their husband (imputation of responsibility, stigmatisation of risky behaviour, accusations of witchcraft) that are used to justify all kinds of harm (four cases attributing the husband's death to women were noted in this study).

Apart from access to care, women also mention exchanges with others and the conviviality of the sites as motives explaining their presence. These experiences are all the more valuable for these

women because for most, their in-laws fail to respond to their hopes for support, especially when their seropositivity is suspected or known.

Women feel less shame

Many interviewees explain that for women, the issue of shame, particularly in connection with accepting material assistance from outside the family, does not arise or appears to be secondary compared to the issue of economic and social survival for her and her children. One points out that, “Women are not ashamed of queuing up because of the children” (widow, approximately 30 years old, activity unidentified). Another woman goes further: “Because of the children, you will not hide.” A third woman explains: “They help us with the medicines. So, we women won’t be ashamed. Your husband has died and you’re alone. If you don’t go to the association because of shame, what’ll happen to you? Don’t the children count on you?” (widow, approximately 30 years old, activity unidentified). For one man: “Even if they fear disgrace, women must give in because they are anxious about their children” (approximately 30 years old, construction worker).

Conversely, the feeling of shame appears to be very significant to men. One expressed this forcefully by saying “some men would die before putting their dignity in question. A man doesn’t bargain over his dignity like a woman. For him, it’s natural. Here, we say ‘kuum sao yande’ [death rather than shame].” The contrast is sometimes underscored: “What men consider to be shameful doesn’t embarrass women at all” (male, age 49, farmer).

The same man explained the importance of this aspect in men’s reluctance or refusal to go to care facilities: “Many sick men (with AIDS) do not dare go to care facilities,” particularly because of the transgression of gender boundaries drawn by the culture: “To queue up with women is difficult. I’m not accustomed to being with women in groups. Of course, I chat with my wives in my courtyard. But that is different from being in a group of women. And what’s more, when you don’t see any other men, you feel uneasy”. Another man says that “it’s difficult with this system that mixes everyone and tells them to queue up” (age 36, unemployed welder).

An association official clearly expressed the importance of cultural norms in men’s experiences and practices: “It is a reality in the field: Women are more numerous and more active than men in the associations and discussion groups...The men prefer to hide...A man says he’s a man; he’s ashamed of queuing up to receive medicine or food.”

Women’s involvement in the care of their husband

Of the 35 women interviewed, 16 are widows, 8 are married, 4 separated (three because of their being HIV positive) and 7 single (six have or had sexual partners, and five have children). Nearly all spoke about men’s difficulties in admitting, or even refusing to admit, the possibility of their own seropositivity, at least for a period of time (the refusal to admit being HIV positive does not always mean refusal to be tested; according to several reports, some men had already been tested, were aware of the positive result, but continued to refuse their HIV status, particularly to their wives). They also underscored men’s reluctance or opposition to visiting care facilities for PLWH, even when they are already sick and their wives already receive follow-up there. A married woman, age 39, explains her HIV-positive husband’s attitude toward the care facility: “He doesn’t go to avoid seeing anyone who knows him. During his only visit to his zone’s association for treatment, he left to take a walk outside and then returned. He said that if he’d met someone he knew, he would have told him he had come to accompany me and that I was the one who had AIDS.”

In this context, numerous women replace their husbands in queues for medical consultations, the delivery of medicine or the distribution of food. According to them, if men ask for something, obedience is the rule: “The moment her husband sends her, a woman will put aside the work she’s doing to go in his place. That’s how it is. Since birth, we found³ our mothers obeying our fathers. The woman must obey; if not, where will she go? She won’t find a house to sleep in”⁴ (married woman, approximately 25 years old, housewife).

Women also say they have often decided spontaneously to replace their husbands to prevent or conceal his shame and to avoid widowhood. Hence, one woman stated: “If the man must decide alone, he can easily not go for treatments, waiting for the inevitable, (death). If he dies, what will become of her and her children? At least if the man is present, it’s much better” (married woman, approximately 30 years old, association employee).

The results show that women’s involvement in the treatment program of their seropositive husbands accentuates the lack of men’s presence in care facilities.

Discussion

Taking into account how gender relationships interact within the healthcare system provides understanding on the impact of gender in determining care itineraries.

The surveys were conducted in a society that is greatly influenced by the culture and social organisation of the Mossi. The power of assimilation of the Mossi political system, demonstrated by Izard (1985), still functions, particularly in the central part of the country where the study took place. The influence of this cultural system (Izard, 1985; Skinner, 1964) is even stronger in social relationships and power relationships between men and women.

Gender and its implications in the face of HIV infection

Status as wife, fear of repudiation and widowhood

The status of wife makes women dependant on both their husbands and in-laws. Rejection and being turned away from their homes continues to be one of the major fears among women in contemporary society.

Women in an urban situation and in the context of AIDS need their husbands more than ever to preserve their own social status and as a father to ensure their children’s optimal socialisation. These concerns explain their commitment to their husbands, particularly when husbands ask that they replace them in queues at care facilities.

A maternal responsibility that requires the involvement of women

One reason given in the interviews to explain the asymmetry in the numbers of men and women at the care facilities is women’s pronounced willingness to take care of themselves and improve their socio-economic situation—for themselves but also and above all, for their children. In fact, society demands a total commitment from them in the care of children. Any incident is liable to be interpreted at least as negligence, and at worst, intention to do harm (Egrot, 2001, 2004).

Similarly, maternal responsibility can also be used by women. “Women are not ashamed of queuing up because of the children.” The collected narratives show how this notion of maternal

³ The Moré word for tradition is *rogemmiki*, literally meaning “found at birth”, in other words, “we were born and we found that things were like that.”

⁴ In Burkina Faso, notably among the Mossi, residence is patrilineal; in cases of repudiation, a woman cannot in principle return to her paternal land.

responsibility is at work more than ever and is sometimes called upon to deny, reject, efface or alleviate any shame they might feel.

A maternal responsibility that effaces AIDS stigma and women's very different relationship to shame

The interviews showed that the “dishonour” leading to feelings of shame in the context of AIDS has two causes. Shame is linked with the fact of being seropositive. Most PLWH feel shame because of the negative moral values ascribed in social representations to the seropositive status (Egrot, 2006; Ouattara et al., 2004; Taverne, 1996, 1999). However for women, their commitment to their children, even at the price of disclosing their seropositivity, contributes to restoring a positive image that was potentially socially devaluing and relativizes or attenuates the risks of stigmatisation linked with seropositivity [sharing experiences with other PLWH also alleviates the magnitude of the risk in revealing the secret (Egrot, 2006)]. Conversely, the potential to raise their standing or the motivation to visit healthcare facilities affects men far less.

Requesting or accepting donations might also entail a feeling of shame among men, particularly when it concerns food for the family. Nevertheless, numerous testimonies stress the fact that it is not shameful for women to seek or accept donations of food or for school and therapeutic purposes. The cultural context thus authorises women to ask for, or receive assistance and gifts from extremely diverse places and persons, without constituting disgrace for them in any way. Conversely for men, the feeling of distress arising from the fear of dishonour is a central concern: to be seen at care facilities for PLWH, and worse yet in the queues for various services, is an eventuality that is difficult or impossible to envisage, so great is the shame that could follow.

For example, the ability to provide the *zeed ligdi* is one of the main pillars upon which the social representation of masculinity among the Mossi is constructed. Not providing it already appears dishonourable and represents shame in the cultural context of Burkina Faso. But, to beg for medical aid or, far worse, for food at care facilities appears to be the height of disgrace for a *zaksoba*.

Gender and access to care in the health system

Health policy as a factor in mobilizing women with respect to biomedical healthcare facilities

Women's attendance in biomedical healthcare facilities is much greater, often affording them greater proximity to healthcare actors. For men, conversely, the onset of illness in their own lives appears as the main opportunity for contact with health services (Desclaux & Desgrées du Loû, 2006). Otherwise, they are only involved in the health of their wives and children in emergencies or in very serious cases, frequently without physical involvement but only through financing treatments and prescriptions, a role conferred on them through their status as head of the family.

Health policies and long-standing habits in the use of health services thus reinforce practices that are already anchored in the culture and provide one of the explanations for the much higher propensity among women to ask for care for themselves, and above all, for their children.

The tendency to visit health services is less evident for men, for whom treatment programs are often more complex and convoluted; healthcare providers describe their itineraries as “therapeutic wandering.” In fact, consultations with traditional therapists or diviners follow rules about spatial separation in society and power distribution within the family. A woman who consults a traditional therapist or diviner often appears as a potential threat, using sorcery or malevolence against her in-laws. This division of spaces and recourses in the health system also explains women's early and privileged orientations toward biomedical healthcare

services, whether public or connected with associations (Egrot, 2001).

“Global care” of PLWH promotes women's involvement in the recourse to care

In healthcare facilities, “global care” appears to be a powerful motivational factor for numerous women who must face the family's nutritional and health requirements daily. It often constitutes the last resort, both therapeutically and economically. In fact, nutritional support and aid for children appeared to be at least as important in the women's discourses as access to medical follow-up, treatment and medicines.

Indeed, numerous women arrive at the associations deprived of everything, unable to ensure feeding themselves or their children, and even less able to support their children's education. While the medicines that are provided are certainly important for their health and that of their children if they are sick, the small amount of free food and assistance with school supplies appear to be equally important.

Healthcare system and women's empowerment

Men's presence at care facilities is often limited to curative consultations for themselves and emergency situations or hospitalisation of family members. Conversely, women benefit from preventive consultations and situations that are particularly favourable to exchanges with healthcare providers. Moreover, attendance at maternal and infant health centres accustoms women to regularly turning to care services in general (Desclaux & Desgrées du Loû, 2006).

Most institutions involved in the fight against AIDS and associations for the care of PLWH⁵ are engaged in activities to promote women's empowerment, seen as “a process of helping people to assert control over the factors which affect their lives” (Gibson, 1991). This willingness to change power relationships generally occurs in the field through certain activities, particularly training sessions organised for women, who are considered more vulnerable than men. These activities are sometimes linked to a political, collective or ecological (e.g., using recycled materials) goal that strengthens their legitimacy (e.g., weaving sacks, making decorative items, dyeing workshops, soap production, etc.). According to interviewees, women have greater access to credit than men to finance income generating activities in associations because of the low amounts they generally request.

These actions for empowerment contribute favourably to reducing women's vulnerability to HIV infection. However, in the cultural context of gender relationships, the positive effects of this empowerment are limited by the men's reluctance and its consequences on access to prevention and care, not only for themselves but also for their wives.

Conclusion

Since the publication of articles by Taverne (1996, 1999) on prevention messages, gender and AIDS, the relationship between men and women and AIDS in Burkina Faso continues to be discussed. Particular attention is paid to the links between gender, negative moral values and HIV infection, the stigmatisation of women as carriers of HIV transmission and the representations of men as victims (Egrot & Taverne, 2003). This study presents

⁵ This is especially the case for the Burkina chapter of the Society for Women Against AIDS (SWAA), which defends and promotes the interests of HIV-infected women. This is just one example among many in Burkina Faso, where the need to promote women's empowerment is so widespread and applied.

another reality concerning therapeutic recourses and the care itinerary of PLWH (Bila et al., 2006, 2007).

On one hand, the social values attached to femininity create conditions that favour women's attendance at care facilities for PLWH. The high cultural value placed on maternity; the social representation of the role of women in children's survival, upbringing and education; and finally, the status of wife in the husband's lineage are aspects that induce women to go to care facilities. Moreover, health policy and the promotion of women's empowerment within the care apparatus for PLWH add to the preceding cultural factors in maintaining and strengthening women's facilitated and privileged access.

On the other hand, social representations of masculinity—notably ideas surrounding *zaksoaba*, a husband's capabilities and the fear of shame—are wholly involved in the cultural construction of men's reluctance to visit care facilities for PLWH. Thus, most HIV-positive men, when they do not occupy a position of responsibility in an organisation fighting the disease, appear to be handicapped in accessing care facilities—and thus, treatment—by the fear of being seen by others and social judgement, engendered by aspects of masculinity that are culturally valued in the society.

This analysis makes it possible to deduce that isolated treatment of either sex is not the solution. In effect, it does not solve the problem of women's vulnerability to HIV infection in particular or the social vulnerability of men in accessing care. Certainly, more regular attendance at care facilities for PLWH provides many benefits to women (e.g., early access to treatment and quality global care, psychological and economic support, quicker restitution of social network, etc.). But, because of their various forms of reluctance or refusal, men are subjected to harm and find themselves in vulnerable situations (e.g., difficulties and late screening, late recognition of seropositivity, delayed medical care, aggravation of stigmatising symptoms, reinforcement of social isolation, economic depletion due to various therapeutic recourses, etc.). Nevertheless, the observed advantages for women are frequently curtailed and must therefore be relativized. Men's increased vulnerability has a direct impact on the situation of women (e.g., economic depletion of the family, inability to pay for the husband's prescriptions and medical care, sharing of ARV treatments, stigmatisation of women as carriers of the disease, accusations of witchcraft, widowhood, repudiation, robbing of widow's property, etc.). In fact, the men's difficulties cause, perpetuate or accentuate various forms of women's vulnerability before and after infection. These questions are not simply theoretical: If men refuse to acknowledge their serological status and deny themselves access to care and treatments, they endanger not only their own health but also their wives', as well as jeopardising the family's social and economic survival.

Certain recommendations can diminish men's reluctance and thus improve women's access to treatment. Queues could be avoided both by men and women in several ways: increased and better organised staff providing various services, training for healthcare actors in the importance of gender relationships in effective action, drug or food pick-up through presentation of vouchers, drug and food distribution in places other than those known for treating PLWH. Other measures urging men to participate are conceivable: Training programmes and activities could integrate components related to the importance of awareness raising among men based on valuing their social responsibility and not on accusations of dominating or neglecting women. Finally, discourses and training should focus more on the possibilities for a social life based on the experiences of PLWH without exclusively focusing on the risks of stigmatisation, exclusion and discrimination. This orientation would reduce the fear and/or shame of being HIV positive and would decrease reluctance to attend healthcare facilities.

To understand and reduce men's reluctance in visiting care facilities for PLWH appears to be an objective that would make it possible to improve the quality of care of PLWH and reduce women's vulnerability and strengthen their commitment to maintaining the well-being of their children.

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