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Patriarchy, Poverty and Cultural Norms: The Intersecting Drivers of HIV and Gender-Based Violence a Narrative Review with Particular Attention to Sub-Saharan Africa

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ABSTRACT

HIV and gender-based violence (GBV) are deeply interconnected public-health and human-rights challenges shaped by patriarchy, poverty, and harmful cultural norms. Patriarchal systems often give men greater control over money, mobility, sexuality, and household decisions, reducing the ability of women and gender-diverse people to refuse sex, negotiate condom use, disclose HIV status safely, or leave abusive relationships. Poverty increases dependence, homelessness, food insecurity, migration, and transactional sex, while limiting access to healthcare, justice, and safe shelter. Harmful cultural beliefs may normalize male dominance, victim-blaming, child marriage, sexual entitlement, and silence surrounding sexuality, while expectations of masculinity can promote risky behaviour and discourage HIV testing or treatment. GBV heightens HIV exposure through forced sex, trauma, and reduced preventive power, whereas HIV stigma may trigger violence, abandonment, and economic exclusion. Effective interventions must therefore integrate HIV services, survivor-centred care, economic empowerment, legal protection, gender-transformative education, and institutional accountability to achieve lasting social change.

Keywords: HIV; gender-based violence; patriarchy; poverty; social norms; intimate partner violence; gender inequality; structural determinants

INTRODUCTION

HIV and GBV are often organised into separate policies, funding streams and service systems, yet they intersect in the same lives. GBV includes physical, sexual, psychological and economic harm rooted in gendered power relations. It occurs within intimate relationships and families, but also in schools, workplaces, healthcare settings, conflict, displacement, trafficking and online spaces [1]. HIV vulnerability likewise extends beyond biological exposure: it is shaped by who controls sex, money, mobility, information, healthcare and the consequences of disclosure [2]. The scale of the overlap is substantial. WHO estimates that roughly one in three women worldwide has experienced physical and/or sexual intimate-partner violence or non-partner sexual violence. UNAIDS reports that women and girls accounted for 44% of new HIV infections globally in 2023 [3]; an estimated 210,000 adolescent girls and young women aged 15–24 acquired HIV that year, far above the global target (WHO, 2026; UNAIDS, 2024a). Aggregate figures, however, do not explain causation. The central analytical task is to identify the mechanisms through which social structures produce unequal exposure and unequal capacity to respond [4]. This narrative review draws on global policy evidence and research, with particular attention to sub-Saharan Africa because the documented intersection of HIV, intimate-partner violence and gender inequality is especially pronounced there. Patriarchy, poverty and cultural norms are treated as overlapping systems rather than isolated "risk factors." Culture is not presented as static or inherently harmful: norms are contested, vary within communities and can also support care, solidarity and resistance.

Table 1: A Reinforcing HIV–GBV Cycle

Pathway	Effect on HIV	Effect on GBV
Sexual coercion	Direct exposure; genital injury; inability to use condoms or prophylaxis	Normalises entitlement and repeated abuse
Economic control	Dependency constrains prevention, testing, adherence and safe disclosure	Makes leaving, reporting or obtaining legal help unaffordable
Stigma and disclosure	Fear delays testing and treatment; secrecy interrupts adherence	Diagnosis or disclosure may trigger blame, abandonment or assault
Institutional failure	Discriminatory or unsafe services reduce engagement	Impunity and poor survivor response reinforce perpetration
Trauma and isolation	Mental distress can undermine self-protection and continuity of care	Social isolation reduces support and increases perpetrator control

The relationship is bidirectional. Forced or coerced sex may involve genital injury and removes the possibility of negotiating condoms, HIV testing or pre-exposure prophylaxis. Partner control can restrict clinic attendance and access to medication. A pooled analysis of nationally representative surveys in sub-Saharan Africa found that intimate-partner violence was associated not only with HIV acquisition but also with poorer engagement across the treatment and care cascade [5, 6]. In the opposite direction, HIV testing, status disclosure and visible medication may generate accusations of infidelity, economic abandonment or assault. The same relationship can therefore contain both exposure to infection and punishment for attempting prevention or care [7].

Patriarchy as a System of Unequal Power

Patriarchy functions as a system of unequal power that extends beyond individual attitudes and shapes relationships, institutions, laws, and access to resources. In sexual decision-making, it often grants men authority over when sex occurs, whether contraception is used, and whether women can refuse intimacy. As a result, women may understand HIV prevention yet lack the power to insist on condoms or make choices about fertility and bodily autonomy [8]. Resistance may expose them to violence, abandonment, stigma, or loss of financial support, while marriage is sometimes wrongly treated as permanent consent. Patriarchal control over property, inheritance, employment, and household income can deepen women's economic dependence and make abusive relationships difficult to leave. Legal, health, and justice institutions may reinforce this inequality when police dismiss violence, courts remain inaccessible, health workers violate confidentiality, or services prioritise women only as mothers [9]. Patriarchal expectations also pressure men to prove masculinity through dominance, sexual conquest, multiple partnerships, alcohol use, aggression, and emotional silence. These norms can increase HIV risk and discourage testing or treatment because seeking help is viewed as weakness. Effective HIV and GBV prevention must therefore transform unequal power relations, strengthen women's autonomy, ensure institutional accountability, and promote non-violent, care-centred forms of masculinity [10].

Poverty as Constraint, Exposure and Consequence

Poverty operates in the relationship between HIV and gender-based violence not as a direct or inevitable cause, but as a constraint that narrows the range of realistic choices available to individuals. People without independent income, secure housing, food, transport, childcare or support may find it difficult to refuse unsafe sex, leave abusive relationships, seek confidential health care or report violence [11]. Economic dependence also makes threats to withdraw rent, school fees, food or support for children more effective, while supposedly free services may require unaffordable travel, waiting time and lost wages. Severe deprivation can further push people towards survival strategies such as transactional sex, age-disparate relationships, migration or insecure employment and housing [12]. The central issue is not moral failure, but unequal bargaining power, because need weakens a person's ability to negotiate condom use, payment, timing, safety or freedom from violence. Migrants, domestic workers, sex workers and displaced people may face perpetrators who control wages, documents, transport or access to authorities, and criminalisation or policing can intensify this exposure [13]. At the same time, HIV and gender-based violence can deepen poverty through injury, trauma, caregiving, missed work, interrupted schooling, property loss, stigma and medical or legal expenses. This creates a damaging feedback loop in which poverty increases vulnerability, while violence and illness further reduce economic security. Effective policy must therefore protect livelihoods, housing, social rights and access to justice alongside individual risk-reduction education [14].

Cultural and Social Norms

Cultural and social norms strongly influence how violence, sexuality, and HIV-related risks are understood and addressed within communities. When male jealousy, dominance, or control is interpreted as proof of love, and wife beating is accepted as discipline, abuse becomes normalised rather than condemned. Bridewealth may also be wrongly treated as ownership, while sexual coercion is dismissed as a private family issue [15]. These beliefs encourage perpetrators to expect tolerance and make survivors fear blame, shame, social rejection, or damage to family unity. As a result, many cases go unreported, survivors receive little support, and urgent medical services,

including post-exposure prophylaxis after sexual assault, may be delayed. Taboos surrounding adolescent sexuality can further restrict access to comprehensive sexuality education, contraception, condoms, HIV testing, and confidential care [16]. Women who request safer sex may be accused of infidelity, while HIV infection is often treated as evidence of immorality. LGBTQ+ people and sex workers face additional risks from stigma, criminalisation, violence, and exclusion from health services. Harmful practices such as child marriage, forced marriage, and restrictions on widows deepen inequality. However, communities also possess values of dignity, mutual care, justice, and non-violence that can support locally led social change through education, dialogue, advocacy, and accountability [17].

Intersectionality and Unequal Burden

Gender does not operate alone. Age, disability, sexuality, gender identity, race or ethnicity, migration status, occupation, incarceration and conflict can compound exposure and limit remedies. Adolescent girls may face adult sexual authority while lacking income and confidential services. Women with disabilities can depend on perpetrators for daily support and encounter inaccessible reporting systems. Sex workers and transgender women may face partner violence alongside client violence, police abuse and healthcare discrimination [18]. Women living with HIV may experience reproductive coercion, involuntary disclosure or denial of services. A universal programme that ignores these differences can widen inequity even when average coverage improves.

Implications for Policy and Programming

Policy and programming responses should integrate HIV services with survivor-centred gender-based violence care so that clients can access confidential enquiry, first-line support, post-rape care, HIV testing, post-exposure prophylaxis, STI treatment, emergency contraception, mental-health support, safety planning, and referrals without being forced to disclose violence. Programmes must protect safe disclosure and continuity of treatment by assessing the risk of violence before partner notification or couple testing, offering discreet medication and communication options, and avoiding pressure on clients to reveal their status [19]. Women's economic empowerment should combine cash transfers or livelihood support with gender-transformative education, childcare, housing, legal aid, and safeguards over financial control, since economic assistance alone may provoke backlash. Prevention efforts should also challenge harmful gender norms through sustained engagement with women, men, adolescents, leaders, schools, and media, while measuring behavioural and institutional change. Stronger laws, trained institutions, and independent monitoring are essential for addressing sexual violence, intimate-partner violence, child marriage, discrimination, and economic abuse [19]. Services should be co-designed with priority populations and combined with condoms, PrEP, PEP, testing, and treatment. Frameworks such as RESPECT Women demonstrate that lasting change requires coordinated interventions addressing relationships, poverty, services, safety, abuse prevention, and social norms, while maintaining confidentiality, consent, survivor safety, and the principle of doing no harm [20].

Critical Considerations and Evidence Gaps

First, association should not be mistaken for a single causal pathway. Poverty, violence and HIV may share upstream determinants, and cross-sectional data cannot always establish sequence. Second, "culture" can become an imprecise explanation that obscures law, political economy and institutional responsibility. Third, women's empowerment is sometimes reduced to income generation; without attention to control over earnings and partner backlash, programmes may fail or cause harm [21]. Fourth, most evidence focuses on cisgender women in heterosexual partnerships, leaving gaps for men experiencing violence, transgender people, non-binary people and diverse relationships. Finally, short project cycles are poorly suited to norm and institutional change. Research should test long-term, locally adapted combinations and examine unintended consequences [22].

CONCLUSION

Patriarchy, poverty and cultural norms exacerbate HIV and GBV because they shape power before any individual sexual or clinical decision occurs. Patriarchy determines whose choices carry authority; poverty determines who can survive the costs of resistance; and norms determine which inequalities appear ordinary, private or deserved. Their interaction increases exposure to coerced sex and unsafe relationships, weakens access to prevention and treatment, protects perpetrators and punishes disclosure. HIV and GBV then reproduce the same inequalities through illness, stigma, trauma and economic loss. Effective action must therefore connect biomedical HIV tools and high-quality survivor services with redistribution of resources, transformation of gender relations and accountable institutions. The decisive question is not only whether people know how to protect themselves, but whether they possess the power, safety and material means to do so.

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