HIV/AIDS and Gender: Fact Sheet Overview

Gender is an inextricable part of the HIV/AIDS equation.
Young women are disproportionately vulnerable to infection; elderly women and young girls are disproportionately affected by the burden of care-giving in the epidemic's wake.
Gender inequality and poor respect for the human rights of women and girls are key factors in the HIV/AIDS epidemic: both from the point of view of effectiveness and from the call for social justice, HIV/AIDS programming must take account of the gender dimensions of HIV/AIDS and its processes.

This resource pack sets out the latest information on HIV/AIDS and its impacts, and makes recommendations for effective programme and policy options.

The Operational Guide explains how gender inequality is driving the HIV/AIDS pandemic and the need for a rights-based approach both to improve responses to HIV/AIDS and to protect and promote the rights of subordinated groups. It provides a conceptual framework for programme implementation from a rights perspective, and carefully constructed tools and checklists to help development practitioners respond strategically to the gender-HIV/AIDS nexus.

The Fact Sheets aim to provide policy makers with concise information about gender related aspects of the HIV/AIDS pandemic. They deal with core facts and issues in thematic areas and are underpinned by an analysis which clarifies how gender issues are fuelling the crisis. Each theme presents a self-contained set of issues and recommendations and many of the themes are interlinked. All of them are connected by a concern to promote a gender-enlightened and comprehensive response to HIV/AIDS and its impacts.

1. The fact sheet on **HIV/AIDS, Gender and Global and International Commitments** gives an overview of the commitments relevant to gender and HIV/AIDS made by UN member states. It draws attention to the articles which are particularly relevant as advocacy tools and which have direct implications for HIV/AIDS policy and programmes.

2. The **HIV/AIDS, Gender and Human Rights** fact sheet elaborates on how observance of human rights can help to address the gender dimensions of HIV/AIDS and on the international human rights instruments and key documents available to advance this approach. It draws attention to the fact that HIV/AIDS responses should include the promotion of participation and empowerment of women such that they, as citizens, can collectively demand and obtain their rights.

3. The **HIV/AIDS, Gender and Education** fact sheet discusses both how education systems suffer under the impact of HIV/AIDS and how education can play a major role in addressing HIV/AIDS and in impact mitigation. It highlights how gender relations operate, often to the disadvantage of girls, in educational contexts, and how educational initiatives can promote gender equality and HIV/AIDS prevention.

4. The **HIV/AIDS, Gender and Young People** fact sheet draws attention to how the lower social status of young people interacts with gender inequalities to enhance vulnerability to HIV/AIDS amongst young girls. Half of all new adult infections now occur amongst 15-24 year olds. Young people are especially vulnerable, but they are also the key to controlling HIV/AIDS in the future.

5. The fact sheet on **HIV/AIDS, Gender and Male Participation** addresses men's roles in the spread of HIV, including stereotypes of masculinity which encourage sexual aggression and predation and endanger both themselves and their sexual partners. It draws attention to successful initiatives to involve men that emphasise positive aspects of masculinity such as leadership and courage. It calls for interventions to engage men as friends, community members, caring partners and fathers in the response to HIV/AIDS and the challenge to gender relations that it must be based in.

6. Gender-based violence takes a variety of forms and is a major reason why women are more vulnerable to HIV infection than men. The **HIV/AIDS, Gender and Violence Against Women** fact sheet spells out some of these forms and the contexts in which they occur. Violent sex increases HIV transmission because vaginal abrasions facilitate entry of the virus. In addition to this, violence or the threat of violence is often key in maintaining or

exacerbating relationships of power and subordination between men and women which are at the core of HIV spread. Tackling this situation requires a comprehensive approach rooted in community and national action for the promotion of women's rights.

7. Conflict situations expose affected people to additional forms of violence, and to a higher risk of HIV infection. The **HIV/AIDS, Gender and Conflict Situations** fact sheet clarifies the factors behind this increased risk and alerts policy makers to ways in which humanitarian assistance programmes can incorporate HIV/AIDS prevention and mitigation measures such that interventions recognise women's particular vulnerabilities and support their rights.

8. The prevention of mother-to-child transmission is an important programme initiative traditionally focussed on the prevention of transmission from HIV-positive pregnant women to their babies. **HIV/AIDS, Gender and the Prevention of Mother-to-Child Transmission** highlights new calls to broaden this area of work to include HIV prevention among HIV-negative pregnant women and young women, the prevention of unintended pregnancies among HIV-positive women, and the treatment and support of HIV-infected women and their families.

9. Commercial sex workers have been the focus of many HIV/AIDS interventions, as evidence shows that preventing transmission amongst those with numerous sexual partners can help prevent spread into the wider community. The **HIV/AIDS, Gender and Sex Work** fact sheet draws on this experience to elaborate how gender relations resonate in sex work contexts, and often mitigate against the ability of sex workers to protect themselves against HIV/AIDS. Successful sex-worker focussed HIV prevention programmes have taken into account the contexts in which sex workers work and comprehensively addressed STI treatment, condom promotion and sex worker empowerment issues.

10. The **HIV/AIDS, Gender and Microbicides** fact sheet highlights that microbicides are promising transmission prevention substances which have significant potential in particular for women's ability to protect themselves. They are as yet underdeveloped in terms of medical research, and the fact sheet calls for further effectiveness trials.

11. The **HIV/AIDS, Gender and Male and Female Condoms** fact sheet explains that both male and female condom use are mediated by gender relations, which must be addressed in condom promotion initiatives. Such initiatives should in particular include work to strengthen negotiation skills for condom use amongst young people and women.

12. Gender affects the world of work because people take their gender identities to work, and the workplace mirrors gender inequalities present in wider society. The **HIV/AIDS, Gender and the World of Work** fact sheet identifies types of work situation and groups of people within them that may have higher risks of HIV infection, and the gender relations which exacerbate risk. It provides specific recommendations for workplace policy on sexual harassment and sex education.

13. Care-giving in HIV/AIDS affected households carries an enormous opportunity cost in terms of time and energy, almost always for women. The **HIV/AIDS, Gender and the Care Economy** fact sheet expresses this also as an 'empowerment' cost, contributing to deepening poverty in HIV/AIDS affected households, and calls for urgent social protection benefits to compensate for carers' loss of income, as well as campaigns to encourage change in gender relations in the household.

14. The **HIV/AIDS, Gender and Food Security** fact sheet exposes how agricultural livelihoods and households are affected, focussing on how HIV/AIDS impacts on the cycle of food and nutrition, health, agricultural labour and food production. Women's roles in food production and in care-giving are critical in this cycle, and the trade-offs they face in HIV affected households are instrumental to the spiral of poverty the disease can fuel.

15. The **HIV/AIDS, Gender and Rural Development** fact sheet chronicles the impacts of the epidemic on rural economies and agricultural production, despite a widespread myth that HIV/AIDS does not affect rural populations. It shows how gender inequalities fuel the epidemic in rural areas, and how the epidemic often exacerbates gender inequalities in workloads, poverty and rights to land. When survival strategies include transactional or commercial sex, an especially vicious cycle of risk and impact is produced. Rural women's empowerment is an essential aspect of HIV/AIDS responses.

16. The final fact sheet, **Gender-Sensitive HIV/AIDS Indicators for Monitoring and Evaluation**, gives examples of gender-sensitive indicators for assessing the inputs, outputs and processes of HIV/AIDS programmes. Without the systematic use of indicators such as these feeding into the programme on a continual basis, programme effects on the gender issues that fuel the epidemic will remain a subject of speculation.

UNAIDS Inter-Agency Task Team on Gender and HIV / AIDS

HIV/AIDS, Gender, and Global and International Commitments

The complex relationship between gender, health, development, and socio-economic status means that gender, and women and men's vulnerabilities to HIV / AIDS must be addressed as cross-cutting issues, not only through the health sector but also through education, the media, and public policy. Although not every United Nations convention, declaration, or programme of action specifically addresses the issues of gender inequity and HIV / AIDS, nearly all of them address some aspect of health, human rights, or women's rights; and all are inextricably related. Listed here in reverse chronology are the United Nations declarations and programmes of action which deal specifically with gender, or gender and HIV / AIDS. Each document is different, and carries with it different legal and policy implications for United Nations Member States.

Collectively, the documents address such diverse issues as:

- **GENDER** - gender stereotypes; gender-based violence; male involvement; women's empowerment; sexual exploitation; gender mainstreaming.
- **HIV/AIDS** - vulnerability to transmission; HIV testing and counselling; sexual and reproductive health services; treatment; access to and development of barrier methods, drugs and other therapies; people living with HIV / AIDS; behaviour change; prevention strategies; access to information and education; caregiving; mother-to-child transmission; discrimination and stigma; sexuality education.
- **POLITICAL AND SOCIAL CLIMATE** - socio-economic status and poverty; age; ethnicity; political commitments; the economic impact of HIV; emergency and conflict situations; refugee and internally displaced populations; international humanitarian assistance and peacekeeping; policy and decision-making; laws and traditional practices; information and data collection and analysis.

Taken together, these documents represent a comprehensive and powerful articulation of commitment by Member States to addressing and eliminating gender inequity and HIV / AIDS, a commitment which must be honoured and fulfilled. It is essential for policy makers and those seeking to engage in policy advocacy to understand the international and national legal frameworks within which their interventions are structured. The links below provide access to the full text of each of the documents:

UN General Assembly Special Session (UNGASS) on HIV/AIDS Declaration of Commitment

Date: 2001
Who made the commitment: Heads of State of UN Member Countries.
Website: www.unaids.org/UNGASS/index.html

By far the most comprehensive effort to address the HIV / AIDS pandemic, the **Declaration of Commitment** from the UNGASS sets out a number of policy and programmatic resolutions and recommendations – many of which address both gender and women's vulnerability.

Article 14 of the Declaration stresses "…that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV / AIDS".

This and other articles (see articles 4, 6, 23, 37, 47, 53, 54, 59-62, 68, 75, 78, and 94) carry with them significant gender-based implications for policies and programmes which attempt to address this global crisis.

Millennium Declaration and Development Goals

Date: 2000
Who made the commitment: Heads of State of UN Member Countries.
Website: www.un.org/millenniumgoals/index.html

Millennium Development Goal # 3 - Promote Gender Equality and Empower Women
Target - Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015.

Millennium Development Goal # 6 - Combat HIV/AIDS, Malaria and other Diseases
Target - Halt and begin to reverse the spread of HIV/AIDS.

The **Millennium Declaration** also commits states to "promot[ing] gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable".

On more than one occasion (for example, International Women's Day), Secretary General Kofi Annan has stated that Goal #3 is essential for the achievement of all the other Millennium Development Goals (www.un.org/events/women/iwd/2003/sgmessage.html).

World Education Forum

Date: 2000
Who made the commitment: Governments, Organization, Agencies and Groups in Attendance.
Website: www.unesco.org/education/efa/wef_2000/index.shtml

In Article 7, Paragraph ii of the Dakar Programme for Action, the participants in the forum made a commitment to ensure "…that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete, free and compulsory primary education of good quality".

In Article 8, Paragraph vii, participants further committed to "implement as a matter of urgency education programmes and actions to combat the HIV/AIDS pandemic".

Fourth World Conference on Women ("Beijing") Declaration and Platform for Action

Date: 1995
Who made the commitment: State representatives who attended the conference. The declaration and platform were subsequently endorsed by UN Member States during a General Assembly.
Website: www.un.org/womenwatch/daw/beijing/platform/

Strategic objective C.3 - Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.

The Beijing Platform for Action, through Strategic Objective C3, addresses the issue of Gender and HIV/AIDS quite comprehensively, setting out 16 "Actions to be Taken" in order to increase the gender-sensitivity of programmes and projects which address HIV/AIDS.

Beijing +5 (2000) - www.un.org/womenwatch/daw/followup/beijing+5.htm

Article 3 of the Beijing +5 Outcome Document re-states the importance of integrating a gender perspective into the HIV/AIDS response, highlights continuing problems relating to the epidemic, and recommends solutions for states and the international community.

International Conference on Population and Development Programme of Action

Date: 1994
Who made the commitment: State representatives who attended the conference. The programme was subsequently endorsed by UN Member States during a General Assembly.
Website: www.unfpa.org/icpd/icpd.htm

In Article C of Chapter 7 (on Reproductive Rights and Reproductive Health), the ICPD Programme of Action addresses sexually transmitted diseases and the prevention of HIV from the perspective of women's vulnerability to the epidemic, setting out key recommendations for addressing HIV through reproductive health services.

In article E on Adolescents, the Programme sets out how governments and civil society can work to meet the distinct HIV-prevention needs of adolescents.

ICPD +5 (1999) - www.unfpa.org/icpd5/icpd5.htm

World Conference on Human Rights Declaration and Programme of Action ("Vienna Declaration")

Date: 1993
Who made the commitment: UN Member States.
Website: www.unhchr.ch/html/menu5/wchr.htm

Though the Declaration does not mention either gender equity or HIV/AIDS specifically, it "…recognizes the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span" (Article 41), and makes several other significant statements relating to women's human rights and violence against women.

Vienna +5 (1998) - www.unhchr.ch/html/50th/vdparev.htm

Convention on the Rights of the Child

Date: 1989
Who made the commitment: UN Member States.
Website: www.unicef.org/crc/

Though the Convention does not mention either gender equity or HIV/AIDS specifically, it recognizes "…the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". Furthermore, it commits States Parties to ensuring "…that no child is deprived of his or her right of access to such health care services" (Article 24).

In particular, Section 2(f) of Article 24 commits States Parties to developing "…preventive health care, guidance for parents and family planning education and services", which has broad-reaching implications for the issue of HIV/AIDS.

Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)

Date: 1979
Who made the commitment: UN Member States.
Website: www.un.org/womenwatch/daw/cedaw/conven.htm

Though the Convention does not mention either gender equity or HIV/AIDS specifically, Article 12 of the Convention commits States Parties to "…take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning". Article 12 is also being used by a number of countries to call for HIV/AIDS prevention and care services.

The **CEDAW Committee** has also released a set of *General Recommendations on HIV/AIDS* (1990)
Website: www.un.org/womenwatch/daw/cedaw/recomm.htm

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HIV/AIDS, Gender and Human Rights

How do human rights relate to HIV/AIDS?

A poor respect for human rights increases the prevalence and worsens the impact of HIV/AIDS. For those denied or with only poor access to information, education and health care services, the risk of contracting HIV is increased and the impact of the virus felt more keenly. The ability of any individual to access their human rights outlined in the table below is thus closely linked with the spread of HIV/AIDS and its impact on people and communities around the world. The spread of HIV/AIDS also undermines progress in the realisation of human rights, as the pandemic places strain upon the country's resources, depleting its social capital and undermining attempts to provide a full complement of services as of right to all citizens. The disproportionate incidence of HIV/AIDS among certain groups including in many countries women and girls, those living in poverty, and specific groups such as disabled people illustrates this broad correlation between access to basic rights and risk from sexual abuse and HIV/AIDS.

HIV/AIDS-related human rights include:

the right to life	the right to the highest attainable standard of mental and physical health
the right to liberty and security of the person	the right to freedom of association
the right to non-discrimination, equal protection and equality before the law	the right to freely receive and impart information
the right to equal access to education	the right to marry and found a family
the right to privacy	the right to freedom of movement
the right to freedom of expression and opinion	the right to be free from torture and other cruel, inhuman or degrading treatment or punishment
the right to work	the right to seek and enjoy asylum

Key Issues

The link between human rights, HIV/AIDS and gender

Heterosexual transmission, while being only one aspect of the epidemic, is now the most common mode of HIV transmission globally. In developing countries women are more likely than men to be infected with HIV, with young women outnumbering young men among newly infected 15-24 year olds by two to one (WHO 1995; Weiss et al. 1996).
Women continue to bear the burden of care for family members with HIV/AIDS, and very often assume the responsibility of children orphaned by AIDS. Gender-based discrimination hinders women's ability to know about, access and negotiate use of effective protection methods and to respond to the consequences of HIV infection for themselves and their families. The vulnerability of women and girls to HIV and AIDS is compounded by other human rights issues including lack of adequate access to the information, education and services necessary to ensure sexual health; by sexual violence; by harmful traditional or customary practices affecting the reproductive health of women and children (such as early and forced marriage); and by lack of legal capacity and equality in family matters.

Stigma and discrimination associated with HIV/AIDS reinforces prejudices, discrimination and inequalities related to gender, poverty, sexuality, disability and ethnicity. This contributes to the vulnerability to infection of minority or otherwise weaker groups, as those members at risk or affected by HIV and AIDS may be reluctant to contact health

and social services. The result is that those most in need of information, education and counselling will not benefit even where these services are available.

How can observance of human rights help to address the gender dimensions of HIV/AIDS?

International human rights law guarantees the right to equal protection before the law and freedom from discrimination on grounds including sex, race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status. States' obligations in relation to equality and non-discrimination - and to the promotion and protection of all human rights - are defined in a series of international treaties. These treaties provide the overarching legal framework for a rights-based approach in relation to HIV/AIDS. Equality and non-discrimination are not only cornerstone principles of international human rights law; they are also vital to HIV/AIDS prevention and to ensuring equitable access to care, treatment and support for those infected and affected by HIV/AIDS. Some countries have succeeded in slowing the spread of HIV/AIDS by combating gender inequalities and promoting access to information and services as of right regardless of sexuality, marital status or gender.

The UN General Assembly *Declaration of Commitment on HIV/AIDS* of June 2001 places human rights at the heart of the international response to the epidemic and sets goals and targets based on human rights law in a number of key areas. It calls on states to take measures to eliminate discrimination against people living with HIV/AIDS as well as members of vulnerable groups. Empowering women is essential for reducing vulnerability, and strategies, policies or programmes that recognise the importance of family in reducing vulnerability should be strengthened or developed. Strategies are needed for educating and guiding children and young people which take into account cultural, religious and ethical factors, and which reduce their vulnerability by ensuring access for both girls and boys to primary and secondary education; by ensuring safe and secure environments especially for young girls; and by expanding good quality youth-friendly information and sexual health services.

National strategies that lead to the empowerment of women and increase the capacity of women and girls to protect themselves from the risk of HIV infection need to be complemented by increased understanding of male vulnerability and responsibility for changing the status quo. Regional and national courts, and national human rights institutions are important tools for ensuring the application of these rights. The UN human rights mechanisms (including the human rights treaty bodies and special rapporteurs, special representatives and independent experts) provide additional sources for monitoring and reporting on their implementation.

KEY INTERNATIONAL HUMAN RIGHTS INSTRUMENTS

International Covenant on Economic, Social and Cultural Rights
International Covenant on Civil and Political Rights
Convention on the Elimination of All Forms of Discrimination against Women
Convention on the Rights of the Child

OTHER IMPORTANT DOCUMENTS

General Assembly Declaration of Commitment on HIV/AIDS
General Assembly Declaration on Violence against Women
Committee on the Elimination of Discrimination against Women, General Recommendation No 24, 'Women and Health'
Committee on Economic, Social and Cultural Rights, General Comment No 14 on 'The right to the highest attainable standard of health'
Committee on the Rights of the Child, General Comment No 3, 'HIV/AIDS and the rights of the child'
International Guidelines on HIV/AIDS and Human Rights

Key Actions Required

What should a gender-sensitive human rights strategy against HIV/AIDS include?

HIV/AIDS responses should include strategies for ensuring equal access of men and women to their full rights as citizens. They must address equality and non-discrimination in areas such as education, political rights, marriage and family, property, employment, health and protection from violence. They should promote participation, the empowerment of women and other weaker groups and the networking of organisations such that citizens can collectively demand and obtain their rights.

The *International Guidelines on HIV/AIDS and Human Rights* provides a framework for a rights-based response to the HIV/AIDS epidemic by outlining how human rights standards apply in the context of HIV/AIDS and suggesting legislative and other practical measures to be undertaken at the national level. Guideline 8 suggests that '*States should, in collaboration with and through the community, promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.'*

In line with the *Guidelines*, a gender-sensitive human rights strategy against HIV/AIDS should include:

- **Combating stigma and discrimination** in relation to gender, poverty and HIV/AIDS. Laws, policies, strategies and practice should address all forms of discrimination that increase the impact of HIV/AIDS. This includes the promotion of education and training programmes designed to counter discrimination and stigma associated with gender and with HIV/AIDS.

- Devoting attention to **promoting the human rights of women** including equal right to legal rights and status within the family, in particular in areas such as inheritance, divorce, child custody, ownership of property and employment rights.

- **Combating sexual and economic exploitation of women and girls**, including through the development and implementation of laws, policies, strategies and practices.

- Promoting the **right of everyone to the enjoyment of the highest attainable standard of mental and physical health**, including by:
    - ensuring access to appropriate information related to HIV/AIDS prevention and treatment;
    - empowering women to make decisions in relation to their sexual and reproductive health, free of coercion, violence and discrimination;
    - promoting access to HIV/AIDS-related treatment, care and support, including the provision of essential drugs;
    - ensuring accessibility of voluntary and confidential HIV-counselling and testing services;
    - implementing strategies to prevent HIV infection among pregnant women; to prevent HIV transmission from HIV-infected women to their infants; and to provide care, treatment and support to HIV-infected women, their infants and families.

HIV/AIDS, Gender and Human Rights

Resources and References

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HIV/AIDS, Gender and Education

HIV and AIDS are increasingly challenging the achievement of the global education goals such as the elimination of gender disparities in primary and secondary education by 2005, achieving gender equality in education by 2015 and achieving a 50 percent improvement in levels of adult literacy by 2015, especially for women. At the same time as the HIV pandemic is severely affecting school children and teachers, it is also important to note that education, whether it be formal, non-formal or informal is a "social vaccine" that could contribute to the prevention of further spread of the pandemic. Both the impact of HIV and AIDS on education and the role of education in prevention must be viewed systematically through a gender lens if appropriate responses are to be made in national policies and programmes. This fact sheet aims to identify the main issues and the facts as we currently understand them.

Key Issues

HIV/AIDS affects education in several ways:

HIV/AIDS undermines the supply of education: HIV and AIDS primarily affect the supply of education through their effects on teacher morbidity and mortality. For example in Zambia, 1967 and 2000 teachers died of HIV/AIDS in 2001 and 2002 respectively while teacher colleges are producing fewer than a thousand graduates a year. In parts of Malawi, HIV-positive status amongst teachers is estimated to be over 30 percent. At present it is unclear how this is affecting the gender balance in teaching cadres as data is unavailable.

HIV/AIDS undermines the demand for education: HIV and AIDS affect the demand for education primarily through their effects on children and the households in which they live. Both biological and social factors contribute to adolescent girls having higher rates of infection. By 2001, 13.4 million children under fifteen years of age in developing countries had lost their mother, father or both parents to AIDS and 82 percent of these were in sub-Saharan Africa. Much of the burden of caring with people living with HIV/AIDS and orphans falls on women and girls. Girls are often the first to leave school to take on these roles.

HIV/AIDS affects the quality of education: HIV/AIDS impacts on the processes, contents and organisational aspects of education by putting learners, educators and education providers under great stress. Trauma, crises, suffering, tension, despair enter the classroom and need to be dealt with in positive ways that ensure a conducive learning environment. However, in circumstances marked by the deterioration or absence of support systems, this can not be guaranteed and will have a negative impact on the quality of education. Existing gender inequalities in educational processes and content due, for example, to poverty or stereotypical views of women's learning abilities and needs, are worsened. The fact that girls are often withdrawn early from school to care for others reinforces attitudes that girls are more likely than boys to fail to complete, especially at secondary level. This belief can have long-term damaging effects on the selection chances of girl students at secondary level.

Key Actions Required

Gender-responsive education can help to address HIV/AIDS through the following actions:

- Promoting access to education for all: formal, non-formal and informal education have a major role to play in changing attitudes and behaviours that are sustaining the gender inequalities that contribute to the spread of HIV. Schools, literacy classes, workplaces, health centres, media and all other places of learning have the potential to address the spread of HIV/AIDS by promoting gender equality and working against the stigmatisation of people affected by and infected with HIV.

- Reaching the excluded: non-formal education approaches often used in literacy and basic education programmes have an essential role to play in this respect, especially in reaching those who are not in schools, such as

marginalised injectable drug users or the 862 million adult illiterates in the world, two-thirds of whom are women, and the high proportion of children with disabilities who are excluded from education.

- Making policy and strategies coherent by integrating educational strategies to reduce the spread of HIV/AIDS and mitigate its impact into HIV/AIDS national action plans, Education for All National Plans, and national agendas promoting gender equality and empowerment.

- Mainstreaming gender in the education system. This is key to promoting gender equality, which is a critical factor in reducing vulnerability to HIV, discouraging high-risk behaviour, and mitigating the impact of AIDS. Mainstreaming gender means considering the impact of gender norms on a given issue and dealing with these in an integrated and inclusive way. Gender affects education in terms of who accesses education (women, girls and special needs groups e.g. blind students are often denied access); who delivers it (the extent of a patriarchal leadership model within the school structures); and how it brings about change in the learner's life (girls who leave education early to motherhood or marriage are often denied the value added accruing to education by virtue of applying knowledge acquired).

- Ensuring that education policies and programmes address gender-based discrimination, exploitation and violence, including in the school itself. Schools and education establishments are workplaces that need to ensure the safety of their staff, learners and patrons, be they male or female. Unfortunately, this is not always the case. Available data show that one in 200 South African women aged 15-49 has been raped by a school teacher before the age of fifteen. Of the schoolgirls covered by the South African Medical Council survey in 2000, half reported being forced to have sex against their will, one third of them by their teachers. In Zimbabwe, research points to widespread abuse of girls in co-educational schools taking the form of aggressive sexual behavior, intimidation and physical assault by older boys. In addition, there were instances of male teachers making unwarranted and aggressive sexual advances to both male and female students.

- Developing workplace policies for education within Ministries of Education which are compliant with the ILO's Code of Practice on HIV/AIDS and the World of Work.

Gender can be mainstreamed in the educational system so that it effectively addresses HIV/AIDs issues by the following actions:

- Ensuring the curriculum promotes health-seeking behaviour and is inclusive, gender-responsive and 'young people friendly'. Both content and process are important and there is a need to provide updated and relevant information in ways that are sensitive to the learning environment where gender stereotypes and attitudes within the establishment may mitigate against challenging gender norms. HIV/AIDS and sexual and reproductive health should be an integral part of the curriculum.
- Training teachers, teacher trainers, curriculum developers and educational managers in gender issues and HIV/AIDS.
- Conducting thorough gender-sensitive situational analyses prior to developing educational strategies, and understanding the gender dynamics that are at play in any given environment before attempting to work within this specific context.
- Training educators, teachers, educational administrators, planners and facilitators in gender issues and their links to HIV/AIDS. Educators, teachers, school administrators and parents often find it useful to participate in group discussions about these issues. Before teachers feel comfortable discussing these issues with students, they often require training in participatory and learner-centred approaches, which allow them to discuss their own knowledge, feelings and beliefs about these issues.

- Revising or developing educational content so that educational messages are customised to meet local needs. They should be designed to be non-sexist and address sexist practices, to take account of cultural differences and be meaningful to the targeted age group. A promising approach in this area is to address gender issues as cross-cutting themes in learning and teaching materials, whether for non-formal literacy training or formal academic subjects.

Key issues for effective gender-responsive education programmes:

- The nature of the infection, myths and misconceptions that weigh on women and men;
- Gender biases influencing sexual behaviours and increasing vulnerability to HIV/AIDS;
- Behaviours women and men should respectively avoid or adopt in order to reduce risk;
- The promotion of respect for women's and men's human rights and dignity;
- The nature and dynamics of gender relations, including taboos and gender stereotypes affecting these dynamics;
- Stigmatisation and discrimination faced by affected/infected children, young adults, adults and their families;
- Skills for putting into practice understanding, compassion and knowledge.

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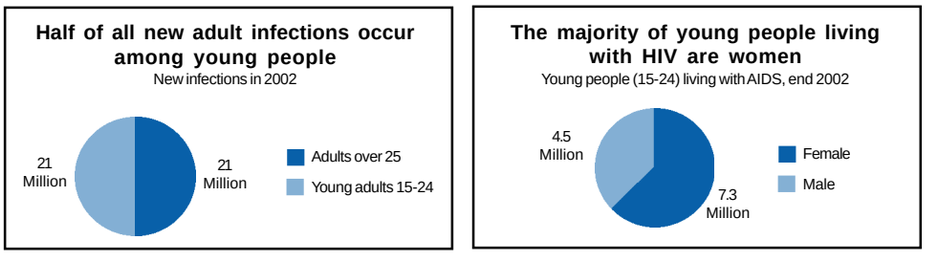
HIV/AIDS, Gender and Young People

Key Issues

The world's young people (aged 10-24) are especially vulnerable to HIV/AIDS. Of the 42 million people living with HIV/AIDS, more than a quarter are aged 15-24. Half of all new adult infections now occur among 15-24 year olds (UNAIDS 2002).

Girls and young women are the face of the HIV/AIDS pandemic. Of the young people living with HIV/AIDS, 62 percent are young women (UNAIDS 2002). Women are biologically more susceptible to HIV infection than men (Carpenter et al. 1999), but young women and girls are especially vulnerable because their immature genital tracts are not yet fully developed. Additionally, the social impact upon girls is greater since they often assume a greater burden of care when family members are affected by HIV/AIDS. This limits their access to education and holds back social development.

Lower social status and gender inequalities, including in relation to education and access to economic resources, also contribute to placing young women and girls at particular risk of HIV infection. Young women and girls may be subjected to gender-based violence, abuse, coercion or contractual sex for goods or money, and are often inadequately able to protect themselves against these sources of risk. This is particularly true in sub-Saharan Africa, where sexual relationships between adolescent girls and older men are the most likely explanation for the significantly higher infection rates among girls aged 15-19 than among their male peers (Luke and Kurz 2002). Since older men tend to be sexually more experienced than young men, young girls are much more prone to HIV infection when marrying a much older man. Marriage to a much older husband also places a girl at higher risk of infection than her unmarried peers.



Source: UNICEF, UNAIDS, WHO, Young People and HIV/AIDS. 2002.

Gender-based violence is increasingly being recognised as one of the most significant risk factors for HIV transmission. For instance, among adolescent girls aged 15-19, ten percent in KwaZulu Natal, South Africa (Manzini 2001), and twelve percent in Jamaica report having been raped (Adolescent Condom Survey, Jamaica, 2001). Violent sex is known to foster HIV transmission. Other forms of gender-based violence include trafficking, forced/early marriage, sexual commercial exploitation and prostitution, and sexual exploitation and abuse of young women and girls in situations of conflict or in other humanitarian emergencies.

Poverty and unequal economic rights limit the bargaining power of girls and place them at greater risk of sexual exploitation and abuse, including transactional sex. Young women and girls who are orphaned are often forced to resort to such 'survival sex' to fend for themselves and younger siblings.

Stereotypical gender norms of male dominance make both sexes vulnerable to infection, by encouraging men and boys to engage in risky and sometimes aggressive sexual behaviour. Boys and young men need skills and information on how to prevent HIV infection, how to live positively with HIV/AIDS, and how to adjust to new roles of caring and nurturing. These include skills for working towards collective change of customs and practices that promote and perpetuate gender-based violence and thereby increase the risk of infection.

In some regions, particularly where the epidemic is still considered "low" or "concentrated", young men are at higher risk of HIV infection than young women. For example, in Eastern Europe and Central Asia, nearly all reported HIV infections are linked to drug injection, which has become particularly widespread among young men. In parts of Latin America and Asia, and in many industrialised countries, concentrated epidemics exist among men who have sex with men.

Key Actions Required

Young women and girls, young men and boys, are key to defeating the HIV/AIDS pandemic. Because adolescence is a time when girls and boys are choosing their identities and laying the foundations for the women and men they will become, values such as tolerance, respect for the opposite sex and equality must be instilled early on to establish enduring patterns of healthy behaviour.

The Declaration of Commitment adopted at the UN General Assembly Special Session on HIV/AIDS in June 2001 recognised the special needs and crucial role of young people in halting and reversing the spread of HIV/AIDS. The Declaration outlined specific, time-bound goals and targets, which were reiterated at the UN General Assembly Special Session on Children in May 2002.

The Declaration of Commitment on HIV/AIDS, 2001

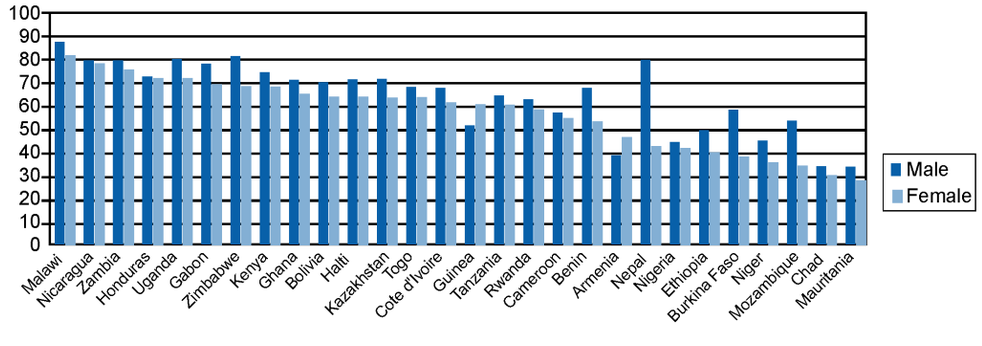
"By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers." (Art. 53)

"By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework." (Art. 60)

In order to ensure that the declaration targets are met, and that our responses are grounded in reality, emphasis must be placed on age- and sex- disaggregated data and on sound methods of data collection, processing and analysis.

Young people, especially young women, still lack the knowledge to protect themselves

Percent of young men and women (15-19) who know that a healthy-looking person can have the AIDS virus



Source : HIV/AIDS Survey Indicator Database (www.measuredhs com'hivdata) DHS survey 1997-2002

Young people are vital to halting the spread of HIV/AIDS and many of them are playing a significant role in the fight against the epidemic. But they urgently need the knowledge**,** skills **and** services **to protect themselves against STIs including HIV/AIDS. To achieve these conditions,** an enabling environment **also needs to be in place that protects young people from disease, ill-treatment and discrimination.**

Knowledge

In many cultures, girls are expected to be ignorant on sexual matters, and may fear being perceived as promiscuous if they show an interest in or have knowledge about sexuality issues, including STIs and HIV/AIDS. By contrast, many boys are brought up to believe that males are expected to be experienced in and knowledgeable about sex, which may encourage them to have multiple sexual partners and deter them from asking questions or seeking health-related information. Because untreated STIs increase the risk of HIV transmission, it is important that information for all young people includes facts on other STIs, including asymptomatic infections.

Young people can only make safer choices to protect themselves and their sexual partners if they know the basic facts about HIV/AIDS. This requires overcoming stereotypical gender norms that contribute to preventing young women and girls, as well as young men and boys, from acquiring this knowledge.

Policies that target children and young people need to be mindful of the proportion of these population sub-groups who are outside formal education systems, permanently or for protracted periods. Information will need to be provided in informal settings, using communication methods that do not disadvantage the illiterate or those who communicate orally (including deaf people, blind people, and non-speakers of main languages). Special consideration may be given to groups with particular needs – such as orphans, child soldiers, young domestic workers, disabled children, and child heads of households.

Skills

Socialised to be submissive towards men and lacking negotiating power and equal economic rights, young women and girls often have little control over when, where and with whom they have sex. Young women and girls need the skills and power to negotiate in sexual matters so that they can protect themselves from HIV/AIDS.

In order to put their knowledge on how to protect themselves into practice, young women and girls, young men and boys, need the skills and confidence to use the information they receive. This includes self-esteem and negotiation skills, skills to delay sexual activity, practising safer sex (including consistent and correct condom use), and having a reduced number of sexual partners.

Services

Education provides young people with greater opportunities and life choices and empowers them to protect themselves against HIV/AIDS. Research confirms for example that higher educational levels are associated with higher rates of condom use. Young people have the right to education that is affordable, of good quality, promotes gender equality and is available to all. This includes non-formal education, such as youth centres, that can help build skills, nurture healthy behaviours, and enhance the self-esteem of young women and girls as well as young men and boys.

Young people also need access to gender-sensitive, youth-friendly health services and supplies for STI/HIV/AIDS prevention and care, including condoms and voluntary and confidential counselling and testing. In many cultures, however, societal norms are not receptive to the needs of young people in accessing reproductive health services. The lack of gender-sensitive, youth-friendly facilities restricts the access of young women and girls, and of young men and boys, to crucial HIV/AIDS-related services and information.

There are particular gender-based differences in access to and utilisation of health services. Young men and boys may use youth centres more than young women and girls, who are more likely to have linkages with health services through antenatal care (ANC) services, and be more motivated by pregnancy than by STI/HIV to seek such services.

As a result of family members falling ill, girls' education is also more likely to be cut short and their access to HIV/AIDS information limited. This provides an added reason why health services must also be available for young people out of school, in rural as well as urban areas, including young people on the street, and those who are sexually exploited, trafficked or involved in sex work.

Comprehensive approaches are also needed to support young people who have been orphaned and made vulnerable by HIV/AIDS, with particular attention to the unique vulnerabilities of girls. In addition to advocacy and raising awareness to create supportive environments, this includes strengthening the capacity of families to care for orphans; mobilising community-based responses; and ensuring that all orphans have access to essential prevention, care and support services.

An enabling environment

For young people to obtain the necessary knowledge, life skills, and access to services to protect themselves from HIV/AIDS, it is fundamental to create an enabling environment for all young people. This includes building resilience amongst young women and girls, young men and boys; challenging unequal gender norms and promoting positive gender relationships; ensuring an effective social support system in the family, school and community; and enhancing protective factors such as feeling valued in society, being exposed to positive rules and expectations; and having a sense of hope in the future. Such an enabling framework for young people's development will include a supportive policy environment, as well as the contribution of parents, service providers, institutions and other adults.

Programmes and policies that focus on young people should address not only the needs of independent individuals to avoid or to reduce the risks of HIV, but also the demand side of sexual exploitation of children and young people, and the link between HIV/AIDS and child labour. If all young women and girls, young men and boys are to grow into healthy, functioning adults, policies will both have to address young people directly and be targeted at those who place them at risk.

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HIV/AIDS, Gender and Male Participation

> All over the world, women find themselves at special risk of HIV infection because of their lack of power to determine where, when and how sex takes place. What is less recognized, however, is that the cultural beliefs and expectations that make this the case also heighten men's own vulnerability.
>
> **UNAIDS (2000). "AIDS: Men Make a Difference**
> *World AIDS Campaign"*

Key Issues

Men Make a Difference

Efforts to incorporate a gender perspective into the response to HIV/AIDS requires a focus on both women and men as well as on their relationships which are based on power: in this context men's views, needs, roles and responsibilities all need to be addressed and reflected in the response. Attitudes, behaviour and commitment of men as individuals, partners and as religious and political leaders directly impact the spread of HIV. The 1994 International Conference on Population and Development (ICPD) in Cairo and the Fourth World Conference on Women held in Beijing in 1995 emphasised the importance of not limiting focus to women but also addressing and involving men (see fact sheet on "HIV/AIDS, Gender, and Global and International Commitments").

Globally, the majority of HIV infections occur through sexual contact between men and women. HIV is more easily transmitted sexually from men to women than vice-versa for biological reasons. Gender stereotypical roles and gender inequality contribute to men having the power to determine where, when and how sex takes place. Frequently, they seek out younger women and girls as sexual partners. In many societies, women and girls are repeatedly exposed to sexual violence that increases risk of HIV infection (see fact sheet on "HIV/AIDS and Violence Against Women").

In order to have a real impact on the epidemic, it is vital that women and men get involved in addressing these issues. In 2000, the World AIDS Campaign sent out the message that "men make a difference".

Men's Vulnerability and Risk Factors

Social norms and expectations shape men's opportunities, attitudes and behaviour, some of which heighten men's HIV/AIDS vulnerability and risk factors. Men are commonly socialised to exhibit masculinity, or manhood - expectations as to how men should act, such as being brave, not showing one's emotions and taking risks (unprotected sex and substance use etc.). Men are also encouraged to seek out, or at least brag about having, frequent sexual intercourse as well as large numbers of sexual partners. This is considered to be one of the socially accepted and expected ways of expressing virility. Injecting drug use raises risk of infection through contaminated needles. Drug and alcohol use are often associated with increasing the likelihood of unprotected sex or violence. Men are often reluctant to seek healthcare, both because relatively few specialised services are available to meet their needs, and also because they view this as a sign of weakness. Men frequently feel pressured into hiding their lack of knowledge, stifling their ability to ask questions and get more information on HIV/AIDS.

In addition, some circumstances place men at particularly high risk of contracting HIV:

- **Migration** for work, seasonal labour and professions such as truck-driving can separate men from their spouses or regular partners for long periods, increasing the likelihood of entering into casual, unprotected sex, including relationships with sex workers, and placing themselves and their future partners at risk of HIV.
- **Sexual violence** against men is a reality that is commonly hidden and dissuades men from seeking information and help.

Successful initiatives to enhance men's participation:

Successful initiatives to enhance men's roles as fathers, including *Fathers, Inc.* in Jamaica and *Papai* in Brazil, provide young men with alternative fathering roles through peer educators, and encourage them to become more emotionally involved with their children. The programmes help them in expanding their ideas of what it means to be a husband and/or a father.

Through open discussions, conversations and in-depth reflection with women and men, including dialogues on men's roles and responsibilities, sexuality and masculinities, communities in Ethiopia identified underlying causes fuelling the epidemic. Actions they identified for change included gender inequalities and some traditional cultural practices which had been regarded as important social practices. The dialogue generated recognition that these practices had been misattributed to religious requirements. Men in the communities, including religious leaders, started to take initiatives to stop these practices in order to protect their wives, and they encouraged their friends to do the same.

The largest effort in the world of men working to end men's violence against women, the White Ribbon Campaign (WRC), was initiated by a group of men in Canada in 1991. Each year, WRC urges men and boys around the world to wear a ribbon for one or two weeks, starting on November 25, the International Day for the Eradication of Violence Against Women, to express their personal pledge never to commit, condone nor remain silent about violence against women.

- In **all-male institutions**, some men who may normally prefer women as sex partners might have no other choice than to have sex with their fellow inmates. Men in prisons are particularly vulnerable to violence, and coerced and unprotected sex.
- **Men in the military** who are away from home and their regular partners may be at increased risk of HIV through coerced or consensual unprotected sex.
- **Men who have sex with men** face enormous stigma and discrimination that can discourage them from seeking information and services to protect and care for themselves and their partners. The specific needs of those who also have sex with women are often not heard and do not get necessary attention.
- **Male sex work** is common in many countries, although it is often hidden and denied. Young male sex workers especially often lack the power to negotiate safer sex.
- **Men who are living with HIV/AIDS** and facing stigma may be reluctant to seek help from and/or join support groups and networks.

Involving Young Men

Young men are vulnerable to HIV/AIDS for a number of reasons. Boys may find themselves reaching manhood in a society where expectations are high but opportunities are rare, and thus they may feel pressured to assert their masculinity through sexual intercourse. Lack of positive male role models from which boys and male adolescents can learn how to nurture caring relationships with girls, women, partners and spouses with equal sharing of responsibilities also plays a part. Young men are more likely than older men to have multiple sexual partners and more likely to discount the risks that endanger themselves. Young men who are orphaned or living on the streets can be especially vulnerable since they suffer from lack of means to meet basic needs as well as to access information and services, and exposure to frequent violence and involvement in substance abuse further increase their vulnerability to HIV infection.

With their innovation and courage, boys and young men can be strong leaders and allies in bringing about collective change against fundamental causes fuelling the epidemic that are based on gender inequality. It is important to involve young men - who are developing their own identities while forming attitudes, beliefs and opinions about women and sexuality - in decisions and actions that promote gender equality and avoid behaviours that endanger themselves, their partners and the children they may have in the future. For example when men understand the risks of sexually transmitted infections that can result from sexual intercourse, they are more likely to delay having sex, reduce the number of partners, and use a condom. Involving their peers, having male role models, and creating supportive environments and

innovative options with them are all important aspects of responses that target young men.

Key Actions Required

While some elements of masculinity can make men vulnerable, others represent valuable potential. For example, strength, leadership and the desire to be a reliable partner and good father are all positive characteristics. Creating opportunities to discuss issues related to masculinity, with women's participation in some cases, is a valuable step. Perceptions of gender roles start at a very early age, but dominant notions of masculinity can change over time. Risky behaviours can be addressed by offering men and women alternative models of masculinities that are not based on unequal power relations. Both women and men must nurture and support **positive expressions of masculinity** and promote the core concepts of inner strength, respect and care for partners and children. For example, as a result of focusing on responsibility and true empowerment, condom use can become positively associated with masculinity in HIV/AIDS interventions.

The challenge is not only to involve men in the response to HIV/AIDS, but also to *engage* them as friends, community members, caring partners, fathers, and leaders. Men must partake fully in dialogues, actions and policies to deal effectively with gender inequalities and the resulting vulnerability that fuels the spread of HIV. Men of every age can take responsibility for their own bodies, they can help peers to understand the forces that push them to sometimes put themselves as well as others at risk, and they can point to the benefits gained by accepting responsibility. Men in their many roles, personal and professional, can engage as role models in society by advocating positive attitudes towards women and people living with HIV/AIDS. They can also promote prevention such as condom use. As fathers, men can offer positive role models for their sons and daughters by respecting women and themselves. Men and women benefit from open communication that can help build equal and safe partnerships. It is therefore important to learn what men want and need, and to empower them to be able to take responsibility for their behaviours.

Within families, it is women and girls who are expected to look after those who are ill and provide unpaid household labour. Expanding the role of boys and men within the families can be achieved by fostering men's understanding of responsibility and by engaging them more fully in childcare and care for the sick. This contributes to families and communities being able to deal more equitably as well as effectively with the burdens of the epidemic.

HIV/AIDS, Gender and Male Participation

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HIV/AIDS, Gender and Violence Against Women

Key Issues

Violence against women is a major human rights, development and public health problem the world over and has particular implications for HIV/AIDS. It is a major reason why women are more vulnerable to HIV infection than men.

It is both a cause and a consequence of infection, and as such is a driving force behind the epidemic. HIV-transmission risk increases during violent or forced-sex situations. The abrasions caused through forced penetration facilitate entry of the virus – a fact that is especially true for adolescent girls, whose reproductive tracts are less fully developed.

While the full extent of violence against women is not known, current research indicates that intimate partner violence ranges anywhere from 10 to 69 percent, and that in some countries one in four women may experience sexual violence by an intimate partner in her life time. Added to this is the violence that women experience from strangers.

Economic disruption, war or conflict also exacerbate gender-based violence in numerous ways, all contributing to the transmission of HIV. In Rwanda, during the 1994 genocide, hundreds of thousands of women were raped, many by men who were HIV-positive. Globally, up to two million women are trafficked every year, many of them at great risk of sexual abuse, and all at risk of HIV infection.

According to a study published in 2004, women who are beaten or dominated by their partners are much more likely to become infected by HIV than women who live in non-violent households. The research was based on 1,366 South African women who attended health centers in Soweto and agreed to be tested for HIV and interviewed about their home lives. After being adjusted for factors that could distort the outcome, the figures showed that women who were beaten by their husbands or boyfriends were 48 percent more likely to become infected by HIV than those who were not. Those who were emotionally or financially dominated by their partners were 52 percent more likely to be infected than those who were not. A smaller study in Tanzania found that HIV-positive women were over two and a half times more likely to have experienced violence from their partner than HIV-negative women.

Fear of violence is an undermining factor in terms of seeking treatment. Women may hesitate to be tested for HIV or fail to return for the results because they are afraid that disclosing their HIV-positive status may result in physical violence, expulsion from their home or social ostracism. Studies from many countries, especially from sub-Saharan Africa, have found these fears to be well founded.

Anecdotal evidence, based on stories by women both emotionally and physically abused upon disclosure which have been reported by the media and related in other settings, further attest to this reality for many women. In Tanzania, a study of voluntary counseling and testing services in the capital, found that only 57 percent of women who tested HIV-positive reported receiving support and understanding from partners. In Botswana, women have admitted to health professionals that they are afraid of their partner's reaction if he finds out they are HIV-positive. This fear has kept them from being tested, from returning for their results if they are tested, from participating in Prevention of Mother to Child Transmission (PMTCT) and treatment programmes, and for those who agree to be treated, from adhering to the regimen because they are trying to hide their pills.

Both men and women are victims of stereotypes and norms about masculine behaviour which may lead to unsafe sex and/or non-consensual sex. Power roles and dominant social expectations prevent communication, joint decision-making and negotiation of condom use. A recent study on sexual violence and risk of HIV infection in South Africa highlighted widespread perceptions about intimate partner violence conducted in over 5,000 classrooms for 10 to 19 year-olds, and showed that 60.8 percent of 10-14 year old and 55.2 percent of 15-19 year old males believed that sexual violence does not include forcing sex with someone you know. For females 62 percent of 10-14 year olds, and 58.1 percent of 15-19 year olds held the same belief.

Several studies from different parts of the world indicate that up to one third of adolescent girls reported that their first sexual experience was coerced. Many are married at a young age to older men, and the power inequities inherent in these relationships can lead to violence or the threat of it. The risk of violence and sexual abuse is high among girls who are orphaned by AIDS, many of whom face a heightened sense of hopelessness along with a lack of emotional and financial support. In a study in Zambia, Human Rights Watch found that among girls who had been orphaned by AIDS, hundreds were being sexually assaulted by family members or guardians or forced into sex work to survive.

UN Declaration on the Elimination of Violence against Women, 1993

- The term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.
- Violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men.

The recognition of the link between the way in which violence against women and the fear of such violence fuels the epidemic is being increasingly recognised, and measures are being taken the world over to address it. Actions include the involvement of men who are beginning to examine their own perceptions of masculinity which can contribute to such violence and hence HIV transmission, as well as organising men to work for change. Countries such as South Africa, Kenya, Nigeria, India, Brazil and Nicaragua see growing efforts by men's organisation in this regard. In many countries, health centres have been established that treat survivors of violence, and include services such as counselling and legal referrals. Although still limited in number, they have potential as an important source of HIV education and treatment. Another response involves advocacy campaigns over the past few decades in most regions of the world which have resulted in changes in law, particular around domestic violence, and the requirement that policy treat it as a crime. In a few countries, marital rape has been recognised as a crime. These responses contribute in turn to reversing the risk of HIV transmission.

Key Actions Required

A comprehensive response to tackle violence against women and HIV/AIDS needs to include:

- Mobilising leadership at global, national and community levels to generate action to ensure that legal and policy change occurs to make violence against women unacceptable;
- Expanding the evidence-base highlighting the prevalence of violence against women, including the economic, social and health costs, and its links to HIV/AIDS;
- Building on the knowledge-base on the relationship between violence against women and HIV/AIDS and disseminating this information to researchers and practitioners in both fields;
- Promoting national and community level action that improves the education and legal standing of women, builds on successful efforts and encourages innovations and partnerships among groups working on both issues.

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HIV/AIDS, Gender and Violence Against Women

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS

HIV/AIDS, Gender and Conflict Situations

Key Issues

Population Displacement

Today's conflicts have resulted in unprecedented waves of population displacement, both within and across borders. A large proportion of these people are displaced in or to countries with high HIV prevalence. Roughly 75 percent of the more than 35 million people made refugees or displaced by conflict are women and children.

HIV/AIDS spread during conflict

The power imbalances that make girls and women disproportionately vulnerable to HIV / AIDS infection become even more pronounced during conflict and displacement. Gender-related factors contributing to the spread of HIV in these settings include:

- Breakdown of family and other social and community structures;
- Lack of access to health care, including safe blood supply, and social services;
- Increased sexual and gender-based violence including coerced sex with men infected with HIV;
- Sexual interaction between civilians and combatants (who often have much higher STI and HIV prevalence than civilian populations), and the increased presence of sex workers near military installations.

All of these factors contribute to increased exposure to HIV among women in war zones. They are exacerbated by the already low status of women and girls in most regions of the world that are experiencing conflict. In a number of recent conflict situations – including wars in Rwanda, Sierra Leone, the Democratic Republic of the Congo and the former Republic of Yugoslavia – sexual violence against the female population has been used as a weapon, resulting in the (sometimes deliberate) exposure of large numbers of girls and women to the HIV virus.

Breakdown of Family and Social Structures

The disintegration of communities and family life can lead to the breakup of stable relationships as well as the disruption of social norms governing men's and women's sexual behavior. The economic destitution and psychological trauma of war-affected populations also increase their risk behaviours.

Men who have lost their status in their communities or families may resort to drinking and abuse and engage in unprotected sex with multiple partners – increasing their own risk of HIV infection and that of their wives and other partners.

Women are also made vulnerable by their increased dependence on men for physical or economic security. As many refugees and displaced persons are forced to leave home with little more than the clothes on their backs, women are often forced to trade sex with soldiers, police or even the people who are supposed to be protecting them in exchange for food, water, shelter, protection and other basic commodities for themselves and their children. Such "survival sex" often involves sex with men who are infected with STIs, including HIV. Women also suffer at the hands of boys and young men who become child soldiers, who are forced to become violent and abusive as part of their training.

Lack of Access to Health Care

Childbirth becomes more dangerous during conflict. Women who haemorrhage during delivery are at particular risk in situations where there is no blood banking system to test blood for HIV. The transfusion that saves a woman's life - if available - could simultaneously infect her with HIV.

The damage to health facilities, loss or looting of health supplies, and difficulty of reaching facilities with services also mean that other reproductive health needs are not met, including

treatment of sexually-transmitted infections, care for victims of sexual violence, and continued access to condoms for women who use them as both a method of family planning and protection from HIV. Health services may be more concerned with primary care of war casualties than with routine treating of STIs, which make individuals more susceptible to HIV infection. During times of war, reproductive health care including STI and HIV prevention does not receive the attention needed.

Increased Sexual and Gender-Based Violence

Sexual and gender-based violence are rampant in all stages of conflict, including in refugee settings where women are supposed to be protected. Rates of violence between intimate partners often increase dramatically in countries devastated by war. During the conflict itself, women's bodies often become battlegrounds, as sexual violence is used as a weapon of war. In some conflicts, such as Rwanda, women have even been deliberately infected with HIV through rape, as a tool of ethnic warfare. In cases where women are impregnated by an infected man, both mother and child are at risk of contracting HIV.

Sexual and gender-based violence and exploitation are also common during flight and in refugee settings. Many women are vulnerable because they are alone with their children, and are raped or otherwise coerced to have sex by soldiers or other displaced men. In other cases, women are subjected to rape or violent sex by their own partners as the loss of status and idleness of refugee men, and the increased drinking that often accompany it, sometimes lead to a rise in sexual violence against and abuse of women and girls. Violent sex greatly increases the risk of contracting the HIV virus from an infected partner.

Rape by an infected man directly exposes women to the virus, and the abrasions or tearing of vaginal tissue may increase the risk of infection dramatically. Some traditional practices, such as female circumcision (more commonly referred to in the literature as female genital mutilation - FGM), also contribute to HIV vulnerability among women, especially when women are subject to violent sex. Therefore in countries experiencing conflict where the incidence of FGM is high, women are more vulnerable to HIV/AIDS as rape is even likelier to damage their genital tissue, increasing their risk of sexually-transmitted infection.

Sexual violence can also have indirect effects on women's vulnerability to HIV infection, as the depression, stigma and discrimination that often follow rape can lead to further cycles of exploitation or to high-risk activities such as drug use or sex work.

Sexual Interactions Between Civilians and Combatants

Sexual interaction between civilians and combatants (either regular military forces or rebel forces) increases the chances of infection. Even in peacetime military personnel tend to have two to five times higher rates of sexually transmitted infections - which can increase the risk of HIV - than the civilian population (UNAIDS 1998). In war, this difference can skyrocket to 50 times higher or more. These high rates of STI prevalence may be due to the fact that military personnel in the context of migration and mobility engage in unprotected sex with multiple partners, including sex-workers. Military camps also tend to attract the sex industry, bringing together two high-risk groups: sex workers and soldiers.

Key Actions Required

- National governments, national and international NGOs and UN agencies should incorporate STI and HIV prevention measures into all humanitarian assistance. Donors should strongly support these interventions.

- Assessments should be carried out, in collaboration between government and agencies, to determine the links between conflict, displacement, HIV/AIDS and gender inequality in each humanitarian situation. Steps should be taken to ensure that all humanitarian programmes are responsive to issues documented in these assessments.

- All HIV/AIDS programmes and funding in conflict situations should address the disproportionate disease burden carried by women. Effective approaches include sensitisation, training and behaviour change communication programmes targeting men and boys as well as women and girls.

- Steps should be taken to ensure the implementation of internationally agreed guidelines for the prevention of HIV transmission during peacekeeping operations. Peacekeepers should receive training on women's rights and gender-based violence as well as HIV prevention. Because peacekeepers have sometimes been implicated in abuses against women and girls, mechanisms of accountability should also be included.

- Programmes should be designed to support the victims of sexual violence through medical care, counselling, support groups and related activities. Health service packages for girls and women who have been raped should include post-exposure HIV prophylaxis.

- Programmes should be undertaken to improve STI/HIV awareness and treatment within the regular military and rebel forces, where these are systematically demobilised. This will have important impacts on sexual health risks to civilians from ex-combatants. Civilians, including sex workers near military installations, should also be included in these awareness raising and treatment programmes.

Resources and References

"The Impact of Armed Conflict on Women and Girls".
www.unfpa.org/rh/armedforces/index.html

"Women, War and Peace: The Independent Experts' Assessment on the Impact of Conflict on Women and Women's Role in Peace-building".
www.womenwarpeace.org

Femmes Africa Solidarite (FAS). "Linking HIV/AIDS to women's peace advocacy".
www.genderandaids.org/modules.php?name=News&new_topic=7

Relief and Rehabilitation Network. "Gender, HIV/AIDS and Emergencies". Newsletter.
www.genderandaids.org/downloads/topics/Gender%20HIV%20emergencies.pdf

"Women, War and HIV/AIDS: West Africa and the Great Lakes".
www.worldbank.org/html/prmge/womensmonth/benjamin.doc

"HIV/AIDS as a human security issue: a gender perspective".
www.un.org/womenwatch/daw/csw/hivaids/kristoffersson.htm

"Gender, HIV/AIDS, and Human Security".
www.un.org/womenwatch/daw/csw/Sy2001.htm

"Enlisting the Armed Forces to Protect Reproductive Health and Rights".
www.unfpa.org/rh/armedforces/index.html

UNAIDS (1998). "AIDS and the Military, UNAIDS Technical Update", Geneva: UNAIDS

Useful Websites

www.unaids.org/en/in+focus/topic+areas/uniformed+services.asp

www.panos.org.uk/files/COMBAT%20AIDS%20PDF.pdf

www.ourplanet.com/unaids/pages/peerabou.htm

HIV/AIDS, Gender and the Prevention of Mother-to-Child Transmission (PMTCT)

Preventing HIV transmission in pregnant women, mothers, and their children - often referred to as prevention of mother-to-child transmission (PMTCT) - has become a crucial intervention in the global fight against this epidemic. About 200 million women become pregnant each year and need effective maternal and child care. Ninety-nine percent of these pregnant women globally are HIV-negative and need counseling, information, and services to remain so. Preventing HIV infection in these women protects the women themselves for their own sake, and protects their children and partners. The 2.5 million pregnant women who were HIV-positive in 2002 need treatment, care and support for themselves and their families. There is a risk of transmitting HIV to children during pregnancy, childbirth and breastfeeding, and women need to be helped to lower this risk. MTCT is the primary cause of all HIV infections in children under fifteen years of age. When effectively and appropriately implemented, PMTCT has the potential to prevent infection in the 15-35 percent of babies who would otherwise be born HIV-positive.

Key Issues

Most PMTCT programmes are organized around the assumption that women are free to act independently, and have the resources to access testing, counseling, pre- and post-natal care, and alternatives to breastfeeding. In fact, women confront a number of gender-based obstacles to preventing mother-to-child transmission of HIV/AIDS:

The Declaration of Commitment from the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) commits states to reducing "…the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by ensuring that 80 per cent of pregnant women accessing antenatal care have information, counseling and other HIV-prevention services available to them, increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counseling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care." (Article 54)

This commitment cannot be attained without attention to Article 14, which stresses "…that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS."

Source:
UNGASS: http://www.unaids.org/UNGASS/index.html

- Women may be unable to negotiate sex or safe sexual practices (for example, condom use) with an HIV-positive partner (who may or may not know his HIV status), which can lead to their own HIV infection.
- HIV-positive women may be unable to negotiate sex or contraceptive use, or to access contraceptives, which can lead to unplanned pregnancies.
- Women may be unable to access pre-natal health services for a variety of reasons, including because their partners control the household financial or transportation resources, because they cannot take time off work, or because they cannot leave their dependents to travel to a clinic or hospital.
- Fear of rejection, stigmatisation, violence or abuse may prevent women from utilising HIV voluntary counselling and testing services, disclosing their HIV status, accessing PMTCT programmes, or engaging in alternative infant feeding practices.

Historically, there has been a tendency to view the "Mother" in PMTCT as simply a vehicle for producing a healthy baby, with efforts directed mainly at providing anti-retroviral therapy (ARV) to pregnant and lactating women in order to prevent transmission of the virus to the child. The most effective way to prevent MTCT is to ensure that women do not become infected in the first place. PMTCT programmes actually include four critical components, or "prongs", which should be given equal weight in order to respect both the woman and her child's right to health:

- Primary prevention of HIV, especially among pregnant women and young people;
- Prevention of unintended pregnancies among HIV-infected women;
- Prevention of HIV transmission from HIV-infected women to their children;
- Treatment, care and support to HIV-infected women and their families.

As women, mothers face the same vulnerabilities and discrimination faced by women worldwide, and programmes which target pregnant women for PMTCT should address these issues and focus on the health of both the woman and her child. PMTCT programmes are beginning to address these concerns by trying to reach HIV-positive women and HIV-negative pregnant women, as well as HIV-positive pregnant women. PMTCT and MTCT+ programmes have proven to be important entry points for testing, care and treatment of both HIV-positive and HIV-negative women.

Key Actions Required	PMTCT Indicators (examples)
Increase women's ability to negotiate sex and safe sex: empower women to negotiate condom and contraceptive use.	·Indicators relating to women's ability to access condoms/contraceptives. ·Indicators relating to women's ability to negotiate both sex and condom/contraceptive use during sex. ·Indicators of behaviour change (e.g. consistent condom use) among couples.
Increase women's ability to access effective PMTCT programmes and/or Maternal and Child Health (MCH) or Reproductive Health (RH) services: empower women and men to prevent MTCT by disseminating information and increasing availability and acceptability of reproductive health services.	·Indicators relating to women's ability to access RH and MCH services, or PMTCT programmes. ·Indicators relating to accessibility (e.g. location) of RH, MCH or PMTCT services. ·Indicators relating to women's enrollment in PMTCT programmes and delivery of HIV-negative babies. ·Indicators relating to availability of information on PMTCT.
Promote the involvement of men in PMTCT: support women to disclose safely their HIV test results to partners/spouses and encourage couples to provide support to one another.	·Indicators relating to RH/MCH facilities which promote male involvement. ·Indicators relating to men's involvement in PMTCT programmes with their partners. ·Indicators relating to couple communication (e.g. women/men who share their results with their partners).
Provide care and support to HIV-infected women, their children, partners and families: ensure that HIV-infected women receive treatment after the risk of transmission to their child has ended.	·Indicators relating to availability of ARV and other essential care after pregnancy.

Very little data on the gender-based barriers to PMTCT are available, because the issue has not been examined comprehensively. We do know from limited studies that male and community participation are both critical elements of successful programmes. PMTCT programmes are likely to be more effective and sustainable if they take into account the societal restrictions on women (such as denial of women's right to health) and their gendered social and physical vulnerabilities when targeting women for voluntary counselling and testing (VCT), pre- and post-natal care and alternative infant feeding practices. A useful first step would be to develop models for integrating into VCT programmes routine enquiry about violence and other potential barriers to disclosure, as well as support for safe disclosure of HIV-positive status to sexual partners. Quantitative and qualitative indicators developed with a gender perspective can be helpful in understanding gender-based considerations relating to PMTCT, and designing appropriate responses.

Resources and References

PMTCT

UN Inter-Agency Task Team Fact Sheet on PMTCT (draft)

UNAIDS: www.unaids.org

UNFPA: www.unfpa.org/hiv/index.htm

WHO: www.who.int/hiv/pub/mtct/en

World Bank: www1.worldbank.org/hiv_aids/

Gender, HIV/AIDS and Indicators

UNAIDS: www.unaids.org

PAHO. "Gender and HIV/AIDS Advocacy Kit". www.paho.org/english/hdp/hdw/advocacykits.htm

WHO. "Review Paper on Integrating Gender into HIV/AIDS". www.who.int/gender

HIV/AIDS, Gender and Sex Work

The great majority of HIV infections globally are due to sexual transmission. The links between sex work and HIV/AIDS have been a central concern in prevention and care efforts in many countries. In the early years of the epidemic, the concern focused on the role of commercial sex work in HIV transmission. Evidence had shown that preventing transmission among those with high rates of partner exchange is a cost-effective intervention as it can also help avert the spread to members of the wider population. However, there has been a growing recognition that HIV/AIDS initiatives must consider the linkages of the intricate issues underlying sex work beyond the specific commercial sex setting. Thus, it is important to understand the diverse nature of sex work and the attitudes, behaviour patterns and contextual factors involved, as the interplay of these dynamics intensifies the risk of HIV transmission.

Basic aspects of sex work

- **Those engaged in sex work are not homogenous.** The term sex work may be used to cover a broad range of transactions and sex workers are not a homogenous group. Men and women, young and old are involved. A broad definition of sex work would be: 'the exchange of money or goods for sexual services, either regularly or occasionally, involving female, male, and transgender adults, young people and children where the sex worker may or may not consciously define such activity as income-generating'. There is a widespread view that occasional engagement in transactional sex, or sexual barter, constitutes 'sex work'. Whilst women and girls remain the largest group involved in sex work, the numbers of boys and men acknowledged to be involved is growing. Although far less numerous, transgender individuals, - both transvestites and trans-sexuals-, are also active in sex work, often because this represents their only option to generate a livelihood.

- **There is acute discrimination against those involved in sex work.** Those who engage in sex work are generally viewed by society in a discriminatory way. For many, it may be the only employment or survival option. While some may freely choose sex work as their occupation, many more young girls, young boys and women are coerced through violence, trafficking, debt-bondage or the influence of more powerful adults. A wide variety of groups and individuals are directly involved in sex work in commercial sex establishments, or indirectly involved, for example as restaurant servers and escorts.

- **Sex work may be formal or informal.** In some instances, sex work is only a temporary informal activity. Women and men who have occasional commercial sexual transactions or where sex is exchanged for food, shelter or protection (survival sex) would not consider themselves to be linked with formal sex work. Occasional sex work takes place where sex is exchanged for basic, short-term economic needs and this is less likely to be a formal, full-time occupation. Commercial sex work may be conducted in formally organised settings from sites such as brothels, nightclubs, and massage parlours; or more informally by commercial sex workers who are street-based or self-employed. The context in which the transactions occur have implication for accessing those at risk and for information or behavioural change programmes.

Key issues and risk factors:

- In several regions, significantly higher rates of sexually transmitted infections (STIs) and HIV infection are found among sex workers and their clients in comparison to other population groups. HIV infection has been found to spread among sex workers before it spreads into the general population.
- Given the role of STIs as a factor in HIV transmission, high rates of STIs among sex workers are indicators of the potential for rapid spread of HIV among sex workers, their clients, families and extended sexual networks.
- High rates of infection among sex workers may not be due to the fact that they have multiple partners but rather due to a combination of factors that compound this risk. These factors include poverty, low educational level and consequent levels of knowledge about HIV/AIDS and prevention means; limited access to healthcare services and prevention commodities, such as condoms; gender inequalities and limited ability to negotiate condom use; social stigma and low social status; drug or substance

abuse and compromised sexual interactions; and lack of protective legislation and policies.

- Data on HIV prevalence rates among sex workers are not available in many countries and nearly all information that is available to UNAIDS has been obtained from studies in urban areas. In almost all countries where such data are available, prevalence rates among sex workers in general are higher than rates among women presenting in antenatal clinics. Table 1 shows most recent prevalence rates in selected countries in Africa, Asia, Latin America, and the Caribbean. Further details on prevalence rates are available in the *UNAIDS Report on the Global HIV/AIDS Epidemic 2002.*

Median HIV prevalence of female sex workers in major urban aeas in selected countries: 1999-2001

Country	Year	median HIV prevalence (percent)
Ecuador	2001	1.1
Bangladesh	2000	20.0
Cambodia	2000	26.3
Guyana	2000	45.0
Kenya	2000	27.0
Lao PDR	2000	1.0
Mali	2000	21.0
Myanmar	2000	38.0
South Africa	2000	50.0
Thailand	2000	6.7
UR Tanzania	2000	3.5
Vietnam	2000	11.0
Angola	1999	19.4
Benin	1999	40.8
Cote d'Ivoire	1999	36.0
Honduras	1999	7.7
Mexico	1999	0.3
Nepal	1999	36.2

Source: UNAIDS Report on the Global HIV/AIDS Epidemic, 2002.

Gender Aspects of HIV/AIDS and Sex Work

Gender norms, the increased risk of violence, stigma and discrimination, poor work environments, and lack of legislative frameworks all play a critical role in intensifying vulnerability to HIV infection for those engaged in sex work.

- Sex workers are generally perceived as defying acceptable social norms and roles for women and men. Women who ask for compensation for sex break traditional norms expected of women in many societies, and those who engage in transactional sex are still labelled as prostitutes. Expressions of female sexuality are expected be restricted to marriage or legal unions and to observe traditional notions of femininity, such as passivity, virginity and sexual innocence, which are dissonant in sex work. Men who have sex with men do not exemplify masculinity and face high levels of stigma and vulnerability especially where homosexuality is illegal. Deeply entrenched social standards marginalise sex workers and seriously limit their access to quality health services, particularly STI management, an essential component in HIV prevention.

- Sex workers frequently lack the personal or social status to negotiate safe sexual practices, being under the threat of violence or loss of clients. Studies show a correlation between income level and HIV prevalence among sex workers possibly due to the inability of poorer sex workers to negotiate condom use (David 1997). Condom use is less regular with the intimate partners of sex workers than with their clients thus even where barrier methods are used sex workers and their intimate partners may remain at risk.

- Men who sell sex are often victims of multiple discrimination that may hinder their ability to access prevention resources (UNAIDS 1999). They face aggression from other men, clients, and law enforcers and have to work underground.

- Because sex workers are often outside the protection of the law they are particularly vulnerable to coercion and rape. Social stigma and discrimination against sex workers create an environment that perpetuates a culture of violence. Their basic human rights to protection and redress are commonly disregarded; they are more often penalised and regarded as criminals. They are often targets of harassment, extortion, and deportation from within their own networks of clients, pimps, regular partners and law enforcers.

- Sex workers frequently work in abusive conditions that endanger their physical safety and health and are outside the protection of the law. More countries are now reviewing their legislative frameworks, in view of the increased public health awareness of the need to reach sex workers with health information and HIV prevention and services. However, even where sex work is legal and licensed, the diagnosis of an STI may cause a sex worker to lose their licence and with it the means of supporting themselves. As a result sex workers may avoid health care facilities and go underground to escape rules and restrictions that threaten their welfare (d'Cruz-Grote 1996). Because sex work is illegal in many countries, sex workers are outside the scope of national HIV/AIDS programmes.

Key Actions Required

HIV prevention programmes among sex workers have reported success in reducing HIV and STI incidence. Various countries, such as, Cote d'Ivoire, Benin, Bangladesh, the Philippines, India, Dominican Republic, Nicaragua, Thailand, South Africa, and Ukraine, have provided evidence that targeted, comprehensive HIV prevention programmes combining STI treatment, condom promotion and provision, and prevention education interventions delivered through outreach, peer education, and sex worker empowerment approaches have made sex work safer.

Interventions designed to prevent HIV infection among sex workers must take into account the context in which sex workers are working, and the specific practices of individual sex workers (Center for Health and Gender Equity 1999). Prevention interventions often include distribution or promotion of condoms; provision of health services, especially to treat STIs; discussion groups or classroom-based HIV and sexual health education; networking to promote better laws, working conditions and health services for sex workers; dissemination of information through printed materials and street theatre; and economic development programmes for sex workers seeking other types of employment (UNAIDS 1999; UNAIDS 2000).

Innovative HIV prevention programmes for sex workers have included the following:

- Interventions taking place in a variety of settings, including bars, clubs, brothels, the street, truckstops, and prisons (UNAIDS 2000).

- Targeted interventions that also deal with drug addiction (DeCarlo, Alexander and Hsu 1996).

- Interventions directed towards the male clients of female sex workers (Leonard, Ndiaye et al. 2000).

- Emphasis on the power of sex workers to help stop the spread of HIV through the promotion of condom use with clients (Day 2000).

- Engagement of sex workers in policy and programme development and implementation as part of the overall empowerment-building process and for greater programme effectiveness (UNAIDS 2000).

Resources and References

Center for Health and Gender Equity (1999). "Women at Risk: Why are STIs and HIV different for women?" Takoma Park, Maryland (USA): Center for Health and Gender Equity.

d'Cruz-Grote, D (1996). "Prevention of HIV infection in developing countries". *Lancet* 1996, 348: 1071-1074.

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UNAIDS (2000). "Innovative Approaches to HIV Prevention: Selected case studies". Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS (1999). "Summary Booklet of Best Practices". Geneva: Joint United Nations Programme on HIV/ AIDS.

UNAIDS Technical Update on Sex Work and HIV/AIDS, 2002.

UNAIDS Gender and AIDS Resource Packet, 2001.

HIV/AIDS, Gender and Microbicides

What are microbicides?

Microbicides are substances that may be able substantially to reduce transmission of and infection with HIV and other sexually transmitted infections (STIs) when applied either in the vagina or rectum. They could therefore be used by both women and men who have sex with men.

Microbicides could be produced in many forms, including gels, suppositories, films and lubricants. They may be able to prevent HIV and STIs by killing or otherwise immobilising pathogens, blocking infection by creating a barrier between the pathogen and the cells of the vagina or rectum and/or preventing the infection from taking hold after it has entered the body.

However, at present, microbicides are still under development and are yet to be shown to be effective against HIV and/or STIs. It is hoped that a first generation microbicide may be available in five to ten years. Although this variety of interesting potential ingredients in tackling HIV/AIDS have been identified, they remain for the moment an important possibility that needs adequate funding for further research and the clinical testing necessary to bring them into reach for those at risk of HIV.

Why are microbicides particularly important for women?

Microbicides could be used alone and in combination with other barrier methods such as male and female condoms to provide additional protection against HIV. Research from many countries has revealed that a number of issues, most of them related to gender norms and behaviours, greatly affect condom use, particularly the use of male condoms. Many men dislike wearing condoms for reasons including their interference in the enjoyment of sex, their impression that being asked to use condoms implies they may have STIs, and gender norms that associate masculinity with risk taking. For many women, fear of being accused of promiscuity or infidelity, or of angering their partner, prevents them from requesting condom use. Therefore, in cases where men are unwilling to wear a condom, their female partners are placed at risk of HIV and other STIs. In these instances where condom use is problematic, microbicides may be an effective alternative since they can be used by women with or without their partners' consent or knowledge. Promising microbicide products are also currently being evaluated for use in combination with diaphragms and cervical caps.

Another potential advantage of microbicides is that both non-contraceptive and contraceptive types could be made available. For women who want to have children and protect themselves from HIV infection, non-contraceptive microbicides could be used. For other women, 'dual action' microbicides can simultaneously decrease the risk of unwanted pregnancy as well as the risk of STIs including HIV.

Microbicides may benefit women living with HIV/AIDS

It is hoped that microbicides could also help protect seropositive women from sexually transmitted and reproductive tract infections that can be dangerous when a person's immune system is weakened. In addition, it may be possible for non-contraceptive microbicides to give HIV-positive women who want to have children the ability to do so with less risk to an HIV-negative partner.

Key issues in policy and programming

Despite enormous public health potential, microbicide research and development is currently under-funded. Neither pharmaceutical nor major biotech companies have made large investments in this field because of uncertainties on returns to investment, and no product has yet proven to be effective in a satisfactory way. Therefore, increased public and private investment is vital to accelerate microbicide research and development and to try to formulate safe and effective microbicides that could be made available after adequate safety testing.

- Microbicides are likely to be more expensive than condoms. However, research conducted in resource poor settings has found that women at risk were theoretically willing to pay up to five times the local price of a condom for a prevention method they controlled. In Kenya, 68 percent of women interviewed were willing to pay twice as much for a microbicide as for a condom.

- However, if microbicides were too expensive, necessary purchases of food, clothes and other survival goods could be affected. As women would be the main market for microbicides and, in many contexts, have less income than men, they may be further economically disadvantaged. It is therefore critical that microbicides are not priced as 'luxury goods' and are easily affordable for all.

- Microbicides must be available at convenient and easily accessible locations, such as government health and family planning clinics, NGOs, pharmacies, local shops and convenience stores and through various organisations and programmes targeting vulnerable populations (for example, women's groups, sex workers and youth programmes).

- Microbicide trials must meet the highest ethical standards possible, including protecting the safety and confidentiality of women living with HIV/AIDS.

Potential Public Health Impact of Microbicides

An epidemiological model developed by researchers examined the impact of introducing a microbicide in 73 lower income countries. The model assumes that the microbicide is used by 20 percent of those individuals likely to be reached by existing services, and that it is used in 50 percent of sex acts where condoms are not.
The study found:

- Introduction of a microbicide that is 60 percent efficacious could over three years avert 2.5 million HIV infections in women, men and children.
- At 30 percent coverage of those easily reached through existing services, 3.7 million infections could be averted.

Source: Watts et al. (2002). "The public health and economic benefits of microbicide introduction: model projections". XIV International AIDS Conference, Barcelona.

Key Actions Required

- Most microbicide products are undergoing safety evaluation in healthy volunteers. The next step would be to move these products to effectiveness trials.

- There needs to be increased research on rectal microbicides to address the needs of men having sex with men, as well as heterosexual women. Rectal tissue is more fragile than the tissue lining the vagina and could be sensitive to chemical compounds contained in topical microbicides.

- There is a need to explore combination products since there is as yet no evidence that products with single modes of action would be effective against HIV/STIs.

Resources and References

The Alliance for Microbicide Development:
www.microbicide.org

Global Campaign for Microbicides based at PATH (Program for Appropriate Technology in Health):
info@global-campaign.org

The International Partnership for Microbicides:
www.ipm-microbicides.org

Department of Reproductive Health and Research, World Health Organization:
www.who.int/reproductive-health/

HIV/AIDS, Gender and Microbicides

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS

HIV/AIDS, Gender and Male and Female Condoms

Addressing the gender roles and power dynamics between women and men is critical in preventing HIV infection. Gender issues have profound implications for condom acceptance and use. Used consistently and correctly, both male and female condoms protect against pregnancy and sexually transmitted infections (STIs), including HIV, by providing a barrier to prevent the exchange of bodily fluids. They are available without a prescription from a variety of outlets, including community-based distribution programmes, health services, vending machines and shops. The most recent meta-analysis of 25 published studies examining the effectiveness of condoms (Weller 1993; Weller and Davies 2003) found them to be about 90 percent effective, with a high range of about 96 percent. The studies have demonstrated that male condoms reduce the risk of gonorrhea in men. Although clinical studies have not been carried out on the female condom for this purpose, laboratory studies indicate that it is similarly impermeable to STIs and HIV. While male and female condoms are both effective, they should not be used together.

Main Characteristics of Male and Female Condoms (WHO and UNAIDS 2000)

Male Condom	Female Condom
Rolled on to the man's erect penis.	Inserted into the woman's vagina; can be inserted prior to sexual intercourse.
Made from latex; some are also made from polyurethane.	Made from polyurethane.
Lubricant: ·Can include spermicide. ·Must be water-based only; cannot be oil-based. ·Located on the outside of the condom.	Lubricant: ·Can include spermicide. ·Can be water-based or oil-based. ·Located on the inside of the condom.
Must be withdrawn with the penis soon after ejaculation.	Does not need to be removed immediately after ejaculation.
Covers most of the penis and protects the woman's internal genitalia.	Covers both the woman's internal and external genitalia and the base of the penis.
Latex condoms can deteriorate if not stored properly; polyurethane condoms are not susceptible to deterioration from temperature or humidity.	Polyurethane is not susceptible to deterioration from temperature or humidity. It also does not produce irritation or allergic reactions in people sensitive to latex.
Recommended as a one-time use product.	Recommended as a one-time use product. Re-use research is currently underway.
The average international price of a male condom is US$0.03.	UN preferential unit cost is about US$0.60.
Age is a strong predictor of condom use: younger people are more likely to use them.	Level of education is a strong predictor of condom use: women with higher level of education are more likely to use them.

Studies show that men are more likely to transmit HIV to women than vice-versa. Although condoms can provide effective protection against HIV infection, and female condoms are agreed to increase women's empowerment, several issues impact upon the use of both male and female condoms. Cost, availability and perceptions of risk are important factors. Power relations between men and women including the relative social and economic status of partners influence the extent to which condom use can be successfully negotiated.

Accepted notions of masculinity and femininity also come into play. For instance, in many cultural settings, young women are supposed to be sexually innocent and may therefore be reluctant to carry or suggest using condoms for fear of being seen as promiscuous. Many young men dislike condoms for their interference in the carefree enjoyment of sex, an attitude strengthened by a stereotypical association of sex with risk-taking as a marker of masculinity.

Since condoms are also associated in many contexts with illicit or extra-marital sex, married women are often powerless to request their partner to wear a condom despite suspecting that he may be infected with HIV, for fear of reprisal at the implied accusation of being unfaithful. Research conducted in a diverse range of countries has found that women avoid asking their partner to wear a condom for fear of violent response or accusations of her own suspected infidelity.

Although dual protection from infection and unwanted pregnancy is often seen as a benefit of condoms, the fact that condoms act as a contraceptive may provide a disincentive for some men and women to use them. In many settings there is pressure not to use barrier methods since motherhood is considered an essential part of womanhood and often guarantees a woman's social status.

The female condom is not a replacement for the male condom, but since its availability in 1992 it has expanded options for safer sexual behaviour, especially for women. Its availability is to a degree limited by demand and by factors such as lack of knowledge, lack of trained staff able to demonstrate its fitting and use, and by higher cost.

Although both types of condoms usually require some level of partner cooperation, the female condom may provide women with a greater opportunity to engage in safer sex, for example with men who refuse to use the male condom. Since the female condom is worn by the woman and can be inserted prior to sexual activity, it can be less disruptive thereby increasing the likelihood that safer sex is practiced and taking the onus off the male partner. Although most women use female condoms with the full endorsement of the male partner, some women are apparently able to use them without the male partner being aware that the device is in place, hence circumventing partner compliance. While the goal of gender equity would best be served by open communication and shared responsibility, the need to protect oneself, some would argue, takes precedence under these circumstances.

Important Recent Insights:

- Inadequate quality control procedures have led to poor standard condoms being distributed in some countries with a consequent negative impact on reliability and acceptability. This has unwittingly provided ammunition for those who are reluctant to use condoms, thereby making condom negotiation even more difficult.
- Condom uptake is higher in non-traditional outlets - for example, in bathrooms, walk-ways, hotel rooms, and from dispensers, - although there can still be a discrepancy between uptake and use. Availability of condoms is essential but does not ensure that they get used.
- HIV awareness is not a predictor of condom use; the gap between condom use and HIV awareness remains high, with use often determined by gender issues.
- A favourable enabling environment (including formal endorsement by leaders and adequate funding) facilitates condom use especially when gender dimensions are addressed.
- A positive provider attitude is essential in making condoms available to young people, including attention to the nuances of gender differences in attitudes to their use.
- Myths, misperceptions and fears about condoms are significant deterrents to their use, and often exhibit underlying gender inequalities.
- Targeted interventions (for example in Thailand) have been effective in reducing HIV incidence rates.

Key Actions Required:

At country level:

- Disseminate information on the purpose, efficacy, and relevance of condom use including through reproductive health workshops where men and women can learn to store and use condoms correctly.
- Make high quality condoms readily and consistently available and affordable.
- Scale up the number of non-traditional outlets.
- Implement gender-sensitive behaviour communication change messages that will close the gap between HIV awareness and condom use.
- Strengthen negotiation skills around condom use particularly amongst young people and women.
- Integrate condoms for STI / HIV prevention into Sexual and Reproductive Health (SRH) programmes.
- Help providers develop positive attitudes to make condoms available to young people.
- Address myths, misperceptions and fears about condoms, including the gender dimensions of these attitudinal barriers.
- Create a supportive environment that addresses the gender dimensions of condom programming.
- Develop and implement dual protection strategies, oriented especially to young people bearing in mind the gender implications of this strategy.

At a global level:

- Reduce the current unit cost of the female condom.
- Accelerate research on the acceptability and safety of female condom reuse, and on improving female condom comfort and ease of use.

At both country and global levels:

- Provide more advocacy on condoms and their gender dimensions among political, religious, and community leaders and in civil society.
- Raise awareness to address gender inequities and stereotypes affecting access to and use of condoms.
- Promote dual protection as a prevention method against STI / HIV and unwanted pregnancies.

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HIV/AIDS, Gender and the World of Work

HIV / AIDS is a major threat to the world of work. It affects the most productive segment of the labour force, reduces earnings, and imposes huge costs on enterprises in all sectors through declining productivity, increasing labour costs and loss of skills and experience. It also threatens fundamental rights at work, particularly with respect to discrimination and stigmatisation aimed at workers and people living with and affected by HIV / AIDS. The epidemic and its impact strike hardest at vulnerable groups including women and children, thereby increasing existing gender inequalities and exacerbating the problem of child labour. The epidemic changes the age and sex distribution of the labour force as it hits hardest the population aged 15-49, decimating economically active age groups and increasing the number of widows, orphans and elderly facing economic uncertainty and devastation.

The *ILO Code of Practice on HIV/AIDS and the World of Work* (2001) includes the principle of gender equality, stressing that successful prevention and impact mitigation will depend on "more equal gender relations and the empowerment of women". It provides practical guidance for formulating and implementing appropriate workplace policies and programmes for prevention and care in the formal and informal sectors. It covers key principles, such as the recognition of HIV / AIDS as a workplace issue, non-discrimination in employment, gender equality, screening and confidentiality, social dialogue, prevention and care, and support, as the basis for addressing the epidemic in the workplace. To guide implementation of the Code, an education and training Manual has been produced, including case studies, learning activities, and examples of laws and gender sensitive policies.

Key Issues

Inequality and vulnerability

Gender affects the world of work because people take their gender identities to work, while the workplace mirrors and sometimes exacerbates the gender inequalities and discrimination present in wider society.

Women constitute a substantial part of the global workforce and their contribution to the care economy, the informal sector as well as within formal, paid work is recognised but poorly quantified in both economic and numerical terms. Women's savings and investment groups provide substantial capital into the informal credit and business sectors. HIV is having a direct and multiple impact upon women and consequently upon the work that they are able to do. This in turn has a noticeable impact upon the economy and the economic development of any nation with high HIV prevalence, where large sectors of the workforce are being lost to HIV / AIDS.

Women are more easily infected than men for biological reasons and are more often adversely affected by the HIV / AIDS epidemic for socio-cultural and economic reasons. Sex discrimination limits the position of women, rendering them poorer and less powerful. Poverty has a direct impact upon HIV risk and its repercussions. As a result of family responsibilities based on the gender division of labour, the burden of caring for the sick falls more often on women and girls, thus increasing their workload and diminishing income-generating and schooling possibilities.

In general, women's access to income-generating possibilities is – compared to men's – already limited. Women are more likely to be engaged as traders in the highly competitive urban informal sector; in agriculture where marketing of cash crops is often dominated by men; or in the lower paid jobs in the formal sector, which provide little social and economic security in terms of income, savings, insurance or social security. HIV within a family places an immediate drain both on the family economy for cash for drugs and treatment, and on the time available for productive work. Women's income, already insecure, becomes crucial when the family is affected by HIV.

Sexual harassment at work

Research by the International Labour Rights Fund in 2002 in Kenya's export-oriented sectors - coffee, tea, and light manufacturing industries - found that women experienced violence and harassment as a normal part of their working lives:

- Over 90 percent of the women interviewed had experienced or observed sexual abuse within their workplace.
- 95 percent of all women who had suffered workplace sexual abuse were afraid to report the problem, for fear of losing their jobs.
- 70 percent of the men interviewed viewed sexual harassment of women workers as normal and natural behaviour.

Women are exposed to the risk of sexual harassment or abuse in the workplace. Their economic fragility may make them more vulnerable to sexual coercion within the context of work, thereby increasing their risk of exposure to HIV.

Where men are expected to be the chief providers of income through work this can be a source of pride, but also of stress. As a result of economic pressure, both men and women may accept work that is dangerous, dirty or unpleasant and involve their children in productive activity rather than education.

Certain types of work or work situations may carry inherently high risks of HIV infection

- Migration for work (such as for those who leave family units to work in factories, mines, or domestic service) or the obligation to travel regularly with long periods away from spouses and partners (such as for transport workers, armed forces, or market traders who travel to obtain goods) exposes both men and women to HIV risk if other sexual partners are taken and sexual networks extended.

- Long periods away from the family in all-male working and living arrangements can expose spouses to HIV risk on return. These conditions may lead to unprotected casual sex with various partners and favours an increase in men who have sex with men.

- Working in geographically isolated environments with limited social interaction and limited access to health facilities such as on plantations and commercial farms may carry higher risks.

- Domestic workers are frequently at risk from sexual coercion from employers or other household members, and isolated from support and information networks. Sex workers are also at greater risk from STIs and HIV.

- Workers within medical services may face occupational risks (needle-stick injury, exposure to infected blood) where Universal Precautions are not followed and/or equipment is inadequate.

Truck drivers

The International Transport Workers' Federation (ITF) in a study in East Africa (World Bank 2003) found that truck drivers separated from their families for a long time, waiting for days at border crossing points, and using routes well supplied with bars, frequently engage in unprotected sex with sex workers and are at a high risk for STIs including HIV. The ITF study concluded that: "Without observance of the rights of truckers, starting with a redress of their working and living conditions, no meaningful response to the control of HIV transmission…is possible."

Many workers who are used to experiencing poor working and living conditions will include risk-taking and exploitative activities within their behaviour patterns outside the work place. This includes unprotected sex, use of alcohol and drugs and the violence that these may fuel.

Migrant workers

Trade unions in the Wazirpur area of New Delhi say that workers there carry out heavy and dangerous work for twelve hours a day. They are young male migrants from other parts of the country, who send money back to their families. They feel at risk of serious injury or death. In this situation, they have developed a 'macho' sense of themselves: "Being a man means facing hardships, providing for the family and chasing women". They are frequent users of commercial sex workers and generally have unprotected sex (ILO/AIDS 2002).

Groups at particular risk of HIV infection and its impacts

- Unemployed workers are exposed to pressures to engage in transactional sex for income or the potential of employment.
- Informal sector workers (mostly women) are especially exposed to the consequences of HIV/AIDS since they lack health facilities and social protection arrangements at work; their activities depend heavily on their own labour and rarely lead to financial security; they can easily lose their precarious livelihoods when they are sick or forced to withdraw from work to care for family members.
- Girls and boys orphaned by AIDS are often denied educational opportunities and may be drawn into the worst forms of child labour, with young girls being especially vulnerable to sexual exploitation.
- Migrants who arrive in search of work lack social networks and the security these provide. Living in precarious conditions, they are prey to sexual aggression or may be forced into survival sex.

Key Actions Required

Key actors in the world of work (governments and labour ministries, employers, trade unions and worker associations) have an important leadership role to play in modifying attitudes and practice within the world of work and beyond. Backed up by government messages and action and through changes to the laws, statutory benefits, taxation, child-care provision, and equal opportunities initiatives, attitudes and structures that disadvantage women must be challenged and changed. By providing a greater range of economic alternatives, more financially independent women will be under less pressure to resort to using sex for survival or to continue in unequal relationships with men who refuse to practise safe sex.

Employment policies and structures should be reviewed to address gender inequality in the context of HIV/AIDS through:

- Opposing discrimination at work.
- Providing workplace education for men and women (including sex education/information, psychosocial health, violence at work, reproductive health, men's and women's social and economic roles and family responsibilities).
- Avoiding work patterns which separate workers from their families for prolonged periods or providing facilities for rest and recreation, or family accommodation.

- Ensuring that business practices do not encourage or condone risk-taking behaviour: it is relatively common practice to entertain clients by paying for sex services as part of business entertainment expenses.
- Zero tolerance for violence and harassment against women at work: trade unions should stress this as a trade union issue, and employers should explicitly state that violence or harassment is a disciplinary offence.
- Encouraging workplace medical facilities to diagnose and treat STIs, which increase vulnerability to HIV.

Sector-specific measures

Some industries have taken very practical measures. The World Tourism Organisation, for example, has promoted a multi-stakeholder initiative against child prostitution and exploitation in the tourism industry.

Action against sex tourism

Based on a model agreement developed by the International Union of Foodworkers (IUF), the Philippines National Union of Workers in the Hotel, Restaurant and Allied Industries (NUWHRAIN) has included a clause about sex tourism in its collective agreements with hotels, including:

1. Hotels, restaurants, bars, etc. shall inform customers that they fight against sex tourism.
2. Employees have the right and should make it their duty to:
   - Report any customer request having to do with child prostitution. Unions inform management about those matters and examine ways to discourage this type of request.
   - Refuse to respond to any request having to do with child prostitution. Management supports employees in any dispute with customers.

Relevant ILO international labour standards

- Equal Remuneration Convention, 1951 (No. 100) and Equal Remuneration Recommendation, 1951 (No. 90)
- Discrimination (Employment and Occupation) Convention, 1958 (No. 111)
- Workers with Family Responsibilities Convention, 1981 (No. 156)
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HIV/AIDS, Gender and the Care Economy: The Social and Economic Impact of HIV/AIDS

> "As AIDS strikes at the lifeline of society that women represent, a vicious cycle develops. Poor women are becoming even less economically secure as a result of AIDS, often deprived of rights to housing, property or inheritance or even adequate health services. In rural areas, AIDS has caused the collapse of coping systems that for centuries have helped women to feed their families during times of drought and famine – leading in turn to family break-ups, migration, and yet greater risk of HIV infection. As AIDS forces girls to drop out of school – whether they are forced to take care of a sick relative, run the household, or help support the family – they fall deeper into poverty. Their own children in turn are less likely to attend school – and more likely to become infected. Thus, society pays many times over the deadly price of the impact on women of AIDS."
>
> *Kofi Annan, UN Secretary-General*
>
> Excerpt from Statement on International Women's Day 2004

Behind every tragedy of death and illness from AIDS, there is a care giver – usually a woman – who has borne not only the impact of loss of loved ones, but also the enormous cost of time, energy and resources to provide this care. Regardless of continent and culture, women are primarily responsible for domestic work within the household and the provision of care to family and relatives, ranging from bringing up children to caring for the sick and elderly. Women pay an opportunity cost when undertaking unpaid care work for HIV/AIDS-related illnesses as their ability to participate in income generation, skills-building and leisure activities is drastically reduced. This is also an 'empowerment cost'. Through it entire families are affected, as vulnerability increases when women's time caring for the sick is taken away from other productive tasks within the household.

Older women "grandmothers" often find themselves the sole carers and providers for orphan children and the sick parents. Loss of household income due to sickness and death can also force older women back into the productive sector.

The burden of care work multiplies where treatment, medical care, or social and economic resources are not available. In a context of poor access to water, for example, even longer hours are spent fetching the increased quantities needed to care for the sick.

Key Issues

Women's care work in the context of HIV/AIDS has a very high opportunity cost and an unsustainable impact on social and economic levels:

Intensification of Feminised Poverty

The feminisation of poverty refers to a process in which women and girls experience poverty and insecurity differently and more intensely than men as a result of gender inequalities in households, communities and institutions. Women's role in the care economy intensifies women's poverty and insecurity as opportunities for income generation are lost and a large proportion of an already meager income is spent on care, such as water, gloves, funerals, or medical needs. A study in Kagabiro village in Tanzania demonstrated that when a household included someone with AIDS, 29 percent of household labour was spent on AIDS-related matters. In two-thirds of the cases two women were devoted to nursing duties and on average the total labour lost to households was 43 percent (Tibaijuka 1997). Additional care-related expenses, the reduced ability of caregivers to work, and mounting medical fees and funeral expenses collectively push affected households deeper into poverty. A study in Cote D'Ivoire revealed that health care expenses rose by 400 percent when a family member had AIDS (Bechu 1998). Further exacerbating strains on the household, customary law and gender inequalities often mean that women are unable to inherit property or land, may themselves be 'inherited' by other family members (widow inheritance), or are left destitute and stigmatised by their communities. HIV/AIDS is also increasing the numbers of orphans and other dependents within households and communities.

Reduction in Women's Empowerment

The more the burden of care falls to women in communities and households, the less women are able to engage in activities that have the potential to empower women vis-à-vis families, communities and markets. Gender inequality is at the centre of this crisis and prevents women from realising their human rights. The uneven burden of care responsibilities detracts from women's formal and informal sector income-generation, literacy and skills building, schooling and leisure time activities. When women are unable to attend to family crops, the likelihood of a surplus that can be marketed is reduced, thereby further limiting women's ability to access income that would usually be in their control within the household.

Impact on children

Young girls and adolescents are often forced to sacrifice their education to assist in providing care within households and therefore face reduced prospects for gaining decent work opportunities. In Swaziland, school enrolment is reported to have fallen by 36 percent due to AIDS, with girls most affected (UNAIDS 2001). Boys and girls are also pulled out to seek income-generating work, usually under high risk conditions.

Reduction in Food Security

While women produce between 60-80 percent of the food in most developing countries, the extra burden of care and support for those infected and sick has often meant moving away from productive agricultural work (Williams 2002). This is exacerbated in Africa, where women are widely responsible for producing and processing family food crops. In Uganda, there has been a decrease in cultivated land area to accommodate the shortage in labour, largely female labour. Food security and nutrition are threatened due to falling agricultural production, loss of family labour, land, livestock and other assets.

Key Actions Required

While addressing HIV/AIDS requires a holistic approach that deals with the provision of access to drugs, investment in prevention and access to information, the provision of support mechanisms for women's work in relation to HIV/AIDS is also critical to address the vulnerability of poor households and communities. Little has been done to mitigate or alleviate the social and economic impacts of the HIV/AIDS pandemic on the lives of people in affected households. Those initiatives that are in place generally form part of community-based home-care projects, which have low coverage, little support from governments, are critically short of home-care kits containing gloves, soap, disinfectants and other basic necessities, and whose volunteers are barely able to cope. In this regard, some specific points for action are proposed:

- Programmes, policies, and strategies directed at HIV/AIDS need urgently to address the provision of services to poor households coping with HIV/AIDS, taking into consideration the gender dynamics and dimensions and the implications of the care burden on prevention and poverty eradication.

- Social protection benefits to compensate for loss of income are increasingly urgent in societies heavily affected by the pandemic - particularly for women and girls. A social protection benefit would reduce the need for the elderly to seek income-earning opportunities, and could avoid the necessity for children, in particular adolescent girls, to leave school prematurely to seek work. In addition, more time could be spent on ensuring food security such as agricultural activities, engaging in some form of income-generating activity, raising children and supporting their development, on community activities and on the quality of care provided within the household.

- Advocacy and education campaigns are necessary to raise the visibility of women's work within the household and how this work is affected by HIV/AIDS. Campaigns should also promote change in gender relations at the household level, encouraging sharing in the tasks and responsibilities associated with household provisioning by women and men, thereby reducing the untenable burden on women within the household. This requires sustained efforts over several generations to challenge and sensitise children, adolescents and adults to gendered roles and shared responsibilities within families and communities.

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HIV/AIDS, Gender and the Care Economy

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS

HIV/AIDS, Gender and Food Security

Key Issues

> "Food aid plays a pivotal role in responding to HIV / AIDS. The first thing poor families affected by AIDS ask for is not cash or drugs, it is food. And food has to be one of the weapons in the arsenal against this disease."
>
> *James T. Morris, Executive Director, WFP*

HIV/AIDS, food insecurity and poor nutrition

Agriculture is the mainstay of predominantly rural economies which characterise many of the developing nations of the world. A significant proportion of the population relies on farming as their main source of livelihood, not only for feeding their own families but also for generating small surpluses of income in order to meet their household cash requirements. Women comprise the backbone of the agricultural workforce, being involved in almost all agricultural operations with the exception, in some cultures only, of ploughing with animal traction. Women spend more time than men on all other operations and are principally responsible for several, such as weeding, thinning and harvesting. The impact of HIV / AIDS severely erodes the asset base of farming households: as adults fall sick, women and young girls are forced to spend more time on care functions than on production; when adults die before being able to hand on knowledge and techniques to their children, there is a sharp decrease in the range and depth of agricultural knowledge and skills; and in order to be able to pay for medical care agricultural tools and implements are sold. The potential to earn cash from off-farm activities is compromised when a family member falls sick as their labour is lost and a second person, usually a woman, is required to spend time giving care. This further undermines the household ability to purchase, maintain and replace essential farm inputs.

Hence HIV / AIDS is inextricably linked with a farming household's ability to cultivate land, to sustain itself, and to maintain adequate levels of nutrition of members. In turn, poor nutrition hastens the onset of full-blown AIDS and increases the vulnerability of the whole household to opportunistic infections such as tuberculosis. Women and girls are doubly disadvantaged: they already spend more time on agricultural activities and have to compensate for any reduction in workforce within the family unit; they also bear the main responsibility for care of sick people and orphans. In situations of food scarcity women also tend to allocate choice foodstuffs to men and to their children. If their own health status is weakened by HIV infection this strategy will hasten the onset of AIDS and other infections in themselves.

HIV/AIDS erodes the labour base

One of the most immediate impacts of HIV / AIDS is the creation of labour shortages at both household and community levels. This has significant implications for the viability of rural livelihoods where humans and most commonly women are the principal source of labour power. Household tasks, such as fetching water and firewood, food preparation and cooking, cleanliness and childcare are very time-consuming and repetitive, with the burden of work traditionally falling on female members of a household. Most farming activities, such as planting, weeding and harvesting are labour intensive and in large part performed by women; only the initial tilling of land benefits from mechanisation (from either draught animals or tractors) in certain farming systems and amongst less poor households. The exchange of labour, either on a reciprocal basis amongst poorer households or on a hire basis for less poor households, is an important mechanism for overcoming labour peaks and timeliness constraints in the farming calendar.

The drain on household labour availability starts as soon as any one member falls sick and women and girls have to take time away from their livelihood activities in order to care for them. This phase also has high cash requirements for medical treatment which can trigger the sales of crops and livestock which would normally be used to feed the family, as well as the liquidation of other assets. Following the death of key family members, although the time of carers is regained for farm work (provided they are not also infected with the virus), the household commences the long-term loss of family labour and further expense for funeral costs. Where the male head of the household dies, this may have a

severe negative impact on the widow's legal position, her access to resources, and the family's ability to secure a livelihood. In many parts of the world female members of the household will not be in the position to inherit the father's or husband's land and will lose entitlements and securities that had been previously mediated by him, thereby posing a serious threat to livelihood sustainability. Where mother dies, the well-being of children is severely endangered, with especially grandmothers and girls having to cope with the double burden of household work and engaging in agricultural (and other) labour for survival.

HIV/AIDS and food security: the scale of the problem

At present, the scale of the problem is most severe in sub-Saharan Africa where FAO estimates that approximately seven million agricultural workers have already been killed by HIV/AIDS since 1985, and a further sixteen million may die by 2020. In the absence of effective action, it is estimated that some countries could lose over 25 percent of their agricultural labour force by 2020. The current food crisis in southern Africa is cited by key UN agencies, such as WHO and FAO, as a clear example of how the impact of HIV/AIDS is much more than solely a health issue. Although the famine has been averted, the ability of many farmers in Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe to recover is severely compromised by the effects of HIV/AIDS. All six countries have HIV prevalence rates of around 20 percent of the adult population. Moreover, the impact of HIV/AIDS is seriously undermining efforts to reduce poverty and, in many countries, is reversing some of the development gains made during recent decades. Although 70 percent of people with HIV/AIDS at present live in sub-Saharan Africa, trends elsewhere suggest that within the next ten years, the largest number of infections is likely to be in Asia.

Labour shortages contribute to food insecurity

The emerging crisis in labour availability in rural communities needs to be addressed urgently in order to avert substantial and sustained food insecurity. The cumulative effect of labour shortages is to undermine the capacity of households to feed themselves. They result in reduced land area under cultivation, less timely operations and the abandonment of labour-intensive activities (including the investment of time in soil and conservation work). Associated with the loss of labour is the loss of local knowledge and the opportunity to participate in traditional exchange mechanisms. Many agricultural activities are gender- and age-specific, and the loss of one household member has significant implications for the knowledge base of those remaining.

The spiral of decline

Households headed by women, children and orphans face additional challenges in communities where property rights are ill-defined or not recognised. Widowhood can result in the further loss of core productive assets, such as land, draught animals and implements where they are seized by other relatives and where women's rights of ownership are not recognised. The depletion of the asset base is usually irreversible, thereby compromising the ability of a household to feed itself not only in the short term but also in the medium term. The withdrawal of children from school in order to overcome immediate labour shortages, compromises their long-term livelihood options - especially for girls who are most likely to be withdrawn first to care for other family members.

Food insecurity and poverty fuel the HIV epidemic, as people are driven to adopt risky strategies in order to survive. The break-up of households due to labour migration in times of food insecurity as well as the exchange of sex for money or food during crises increase vulnerability, with women and children being particularly exposed.

Key Actions Required

Nutrition

HIV/AIDS and malnutrition are interrelated through a vicious cycle. HIV/AIDS often leads to malnutrition in individuals infected by the virus which, in turn, exacerbates the effects of HIV by wearing down the body faster and leaving people with the virus more

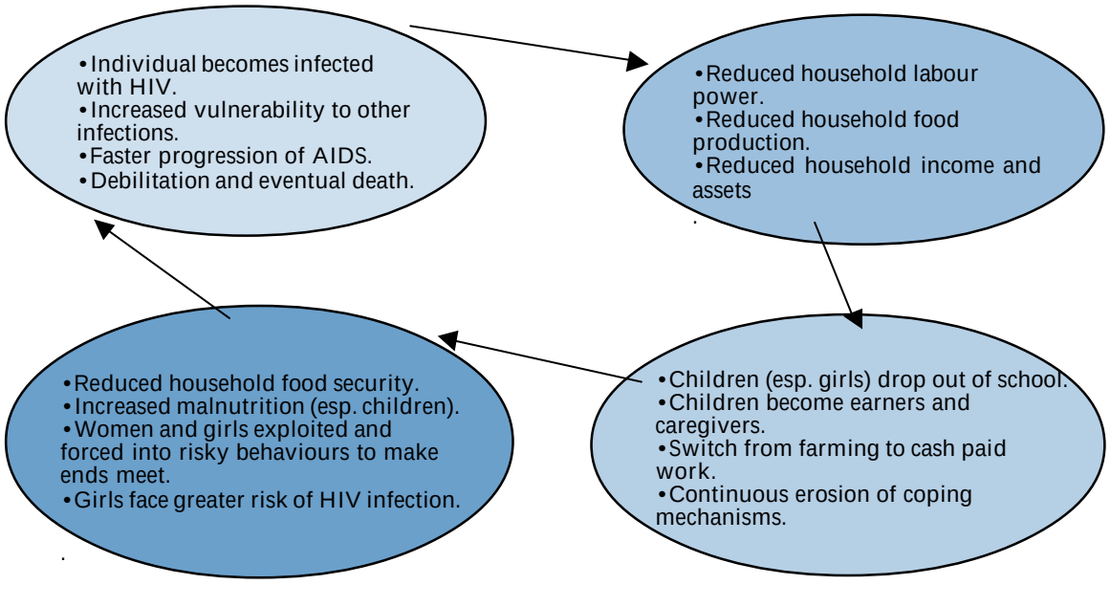
vulnerable to opportunistic infections. Recent research indicates that certain nutritional deficiencies are associated with progression of HIV to full-blown AIDS in adults. People with HIV have heightened nutritional needs: sufficient protein, vitamins, and minerals are essential in order to fight off opportunistic infections given weakened immune systems. Women who are pregnant and breastfeeding have higher nutritional needs irrespective of their HIV status. Providing vitamin and mineral supplements to HIV-positive women has beneficial effects on birth outcomes of pregnant women with HIV, including the increased birth weight of their babies. Even where anti-retroviral drugs are available, access to nutritious food is essential as many drugs have nutrient interactions or need to be taken on a full stomach. Moreover, improved nutrition enables people living with HIV/AIDS to continue to be productive members of their households for as long as possible.

An integrated approach

Due to the depletion of productive adult labour and the irreversible impact of an adult death on the family, many households will never fully recover or regain their equilibrium through agricultural production or cash income alone. Poor HIV/AIDS-affected households become trapped in a cycle of poverty, food insecurity and malnutrition, each making the negative effects of the others worse. To break out of this trap and reduce households' vulnerability to the long-term adverse consequences of food insecurity, including the increased risk of HIV/AIDS, a drastic change in approach is required. An integrated approach must be adopted that covers prevention, mitigation and care for HIV/AIDS-infected and affected families, taking full account of the age and gender dimensions of the epidemic. No longer is it acceptable to only offer prevention information without also providing support services that include voluntary counselling and testing, treatment for HIV and other infections, nutrition education and counselling, coupled with links to vocational and skills training, and income and credit opportunities for healthy family members. The adoption of labour saving technologies and different cultural practices which reduce or diffuse the labour requirements for either farming or household activities will assist households already directly affected by the epidemic as well as those whose resource base is still intact but whose farming activities are compromised by a general shortage of labour and farm power within a community.

In order to design and implement such an integrated approach, partner agencies must find new ways of working together both at the secretariat and headquarters level as well as on the ground. Governments, international and local NGOs, faith-based organisations, donors and the communities themselves all have key roles to play in the search to reduce household vulnerability to food insecurity.

The vicious cycle of food insecurity and HIV/AIDS



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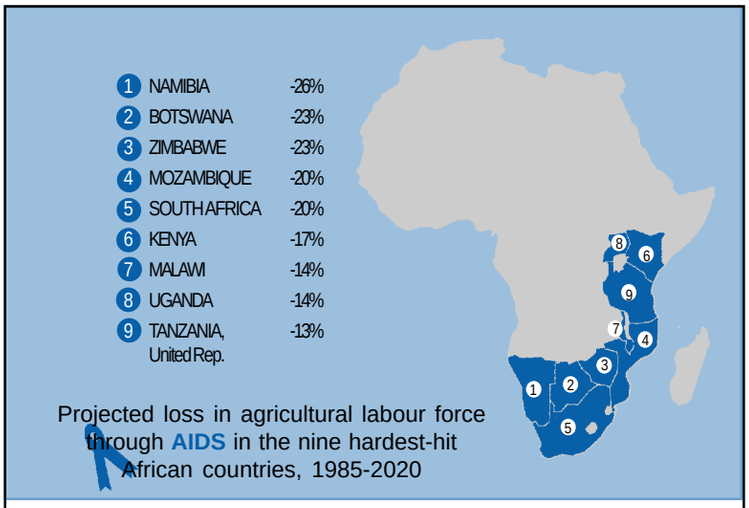
HIV/AIDS, Gender and Rural Development

HIV/AIDS had its origins and was once thought of as an urban problem. In many rural communities the myth persists that HIV does not affect rural people, though the virus is now rapidly spreading in rural areas and seriously affecting the livelihoods of rural populations. Its spread is accelerated by conflict, population movements and mixing of communities as well as urban-rural migration in both directions. Rural women, who form a major part of the rural economic workforce and the backbone of the care economy, are particularly affected. According to FAO estimates (2000), HIV/AIDS has killed seven million agricultural workers since 1985 in the 25 hardest-hit countries in Africa, and could kill another sixteen million before 2020. Over the next decade, the epidemic is expected to spread even further in developing countries. Those African countries most affected could lose up to 26 percent of their agricultural labour force within two decades.



Projected loss in agricultural labour force through **AIDS** in the nine hardest-hit African countries, 1985-2020

Source: FAO (2000).

Key Issues

Poor health service infrastructure and limited mechanisms for promoting HIV/AIDS information make rural areas vulnerable to HIV. Widespread poverty leads to poor nutrition and poor health, fuelling HIV/AIDS infection rates. Rural people are less likely to know how HIV is transmitted, recognise symptoms, or be able to access and afford treatment for related infections. The same is true of STIs thus exposing rural populations to greater risk of HIV infection.

Rural women are particularly hard hit by the pandemic. Women are biologically more susceptible to HIV infection, and as a result of oppressive gender and cultural norms prevalence rates are now higher amongst women than men in sub-Saharan Africa. In many contexts, men are expected to dominate and women to be passive in taking decisions about sexual relationships. Illiteracy amongst rural women is high and this hampers their knowledge and their ability to negotiate when, how and with whom to have sex. Relationships between older men and younger disempowered women have contributed to prevalence rates that are two times higher among young women than among young men.

With farmers dying in the prime of life, before they can pass on knowledge to their children, the pandemic has a long-lasting impact on agricultural practices and food security (see Fact Sheet on Food Security). The declining number of productive family members coupled with a growing number of dependants adds to a vicious cycle of inadequate nutrition and vulnerability to infection.

The phenomenon of child-headed households has also contributed to the under-exploitation of agricultural land as the adult labour force dwindles. According to UNAIDS, there were 13.2 million AIDS orphans in 1999, most of them in rural areas in sub-Saharan Africa. Shrinking incomes available from agricultural production are increasingly stretched

to cover expenditure related to medical bills and funeral expenses. Inadequate labour makes collection of water and fuelwood more onerous and yet the need for water only increases where family members are sick.

The migration of men to towns to seek employment increases the risk of infection for their sexual partners at home, and overall community vulnerability. Urban residents often return to their villages of origin to seek care when they fall ill which increases rural vulnerability, and further stretches rural safety nets. Children are withdrawn from school and families limit the number of times they are able to eat in a day, in the long term further hampering their capacity for productive work. Distress-sales of productive and non-productive assets are made (including livestock, implements and land) further undermining potential production. As women provide care for sick family members and orphans, HIV/AIDS adds to an already heavy workload for women, limiting their ability to engage in income-earning activities and food production.

Despite the essential and major role of women in agricultural production and income-generation, women have significantly less access to financial, physical and social assets than men do. They have fewer opportunities to improve their knowledge and skills, and less voice in public decision-making. This imbalance between what rural women do and what they have makes them particularly vulnerable to rural poverty. Rural women provide most of the work in small-scale and labour-intensive agriculture, and the proportion of woman-headed households reaches almost one third in some developing countries. Yet women receive only five percent of extension services worldwide, and women in Africa access only one percent of available credit in the agricultural sector (FAO 1995).

Women are rarely the owners of productive assets such as land and livestock although they may be the main producers and the principal carers/users of these same assets. Rural women are particularly vulnerable to the impacts of the epidemic because if widowed they often have no legal rights to retain their husband's property. Family assets may be grabbed by relatives of the deceased husband upon his death and the widow chased away, particularly if she is already exhibiting symptoms herself. Rural women and girls are often forced to adopt risky survival strategies, such as engaging in transactional sex. Girls living in child-headed households are particularly likely to seek adult protection in exchange for sex, or to marry early to try to gain stability for their siblings. Sibling abuse amongst child-headed households is a growing problem, in particular where a young brother assumes leadership and adopts masculine norms observed in the wider community. Increasingly, elderly women are faced with the need to take on the heavy burden of caring for large numbers of orphaned grand-children without adequate economic, social and physical resources.

Thus, HIV/AIDS is fuelled by gender inequalities and is also creating new gender inequalities.

Key Actions Required

Since HIV/AIDS affects every sector in rural development, an integrated and gender-sensitive approach must be used that combines elements including labour-saving and improved food production technologies, HIV/AIDS awareness and prevention campaigns, vulnerability assessment and mapping systems, education, and social analysis. For these to be effective, rural women's participation and empowerment is an essential precondition.

HIV/AIDS is a root cause of labour shortage and deteriorating agricultural production in some rural areas. To meet the limited availability of labour, **labour-saving technologies** are needed. These may include for example lighter ploughs that can be used by youths, women and the elderly, and animal-drawn weeders. Improved access to potable water, the means to transport it in quantity and fuel-efficient stoves can also greatly alleviate women's workload. New technologies introduced need to be context-specific and tested for their physical, agro-ecological and cultural relevance. Together FAO and IFAD (2002) have identified how labour-saving technologies and practices assist in overcoming labour shortages and recommended key factors to improve their adoption and sustained use by poor rural women.

HIV/AIDS has obliged some farm households to shift their production systems, for example from cash to subsistence crops, or to sell off livestock and other resources to finance medical expenses. **New practices and technologies** are needed to meet the challenges within this changing context. These include the provision of low-input, low-risk, early-maturing and disease-resistant crop varieties and new practices such as the raising of nutritious vegetable crops close to home using household waste and water (sack gardening). Agro-processing technologies and agribusinesses could also provide rural women with much needed income. An IFAD-supported project in Uganda promotes crops that are more easily managed by HIV/AIDS affected populations; sunflower production is particularly suitable, as it is not labour-intensive, requires little weeding and matures early. The FAO is also supporting adapted programmes of small-scale animal production and medicinal crops in AIDS-affected areas.

Given low levels of literacy, limited access to mass media, and insufficient health and education services, **HIV/AIDS education** is difficult in rural areas. The outreach capacities of agricultural extension services have broken down as the disease has affected government workers. In addition, IFAD found that project beneficiaries in some countries could not attend training activities due to their caring responsibilities. There are several ongoing initiatives to provide HIV/AIDS education to rural areas. In Cambodia, FAO is supporting an innovative participatory method called Farmer Life Schools, combining active learning of agricultural subjects with AIDS prevention. The FAO is also supporting Ministries of Agriculture in a number of countries to prepare field manuals that can be used to adapt extension systems to the new needs.

Many children lose their parents before learning basic agricultural skills or obtaining nutrition and health-related knowledge. Therefore, **knowledge** needs to be preserved and the new generations have to be reached by extension services**.** Key actions include support to training programmes for households fostering orphans; apprenticeship programmes for adolescent orphans; and training in agricultural skills for orphans. IFAD has been engaged in such rehabilitation work through its *Uganda Women's Effort to Save Orphans (UWESO)* project. FAO supports several orphanage projects, and provides agricultural education to primary schools.

In addition, new **social and economic safety nets** are needed and rural institutions need to be strengthened. This includes the need to provide rural financial services specifically for women. Support is also needed to allow adolescents to take over the business (and the loan) from a sick parent. IFAD supports a rural finance programme in Tanzania that offers its clients insurance coverage through a fund, covering loan defaulting for a variety of reasons, including non-repayment due to AIDS-related incapacitation or death. Insured clients pay half of the insurance premiums, and the programme will pay the rest.

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UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS

Gender-Sensitive HIV/AIDS Indicators for Monitoring and Evaluation

Due to the crisis nature of the HIV/AIDS pandemic, many institutions have intensified their efforts to fight the epidemic by emphasising speed in project preparation, sometimes compressing the design and identification stages of the project cycle, and focusing instead on capacity building and "learning by doing." According to UNAIDS, this approach "relies on immediate monitoring and evaluation (M&E)[1] of programmes to determine which activities are efficient and effective and should be expanded further, and which are not and should be stopped or would benefit from capacity building" (UNAIDS 2002).

The role of indicators in Monitoring and Evaluation systems

M&E systems in turn rely on indicators to enable effective tracking of changes, either against a baseline, or over time. Gender-sensitive indicators make it easier to assess the effectiveness with which the gender dynamics that fuel the HIV/AIDS epidemic are being addressed. Gender-sensitive M&E requires a mix of input, output, outcome and impact indicators that reveal the extent to which an activity has addressed the different needs of women and men. This information should feed into the programme on a continual basis to improve implementation and maximise efficacy and efficiency, and ultimately, the sustainability of HIV/AIDS programmes.

Developing gender-sensitive indicators

The choice of appropriate gender-sensitive indicators varies according to project goals, the state of the epidemic, the level of understanding of how gender issues affect the spread of HIV/AIDS, and the availability of both quantitative and qualitative sex-disaggregated data. In general, gender-sensitive indicators rely on sex-disaggregated data (wherever possible), take into account existing gender differences in sexual behaviour, and address risk and vulnerability factors for females and males, such as age, socio-economic status, and physiological, cultural, and legal factors.

Information sources for gender-sensitive indicators

The resources available for data collection and the gender issues that are most relevant to the programme/project determine the selection of indicators. Efforts to expand national capacity to collect sex-disaggregated data should include partnerships with community-based organisations and groups working on gender-specific issues at all stages of the project cycle.

Examples of gender-sensitive indicators for HIV/AIDS programmes

Many HIV/AIDS control programmes contain gender-specific statements of goals. For example, a programme goal may be to "mitigate the socio-economic impact of HIV/AIDS by targeting high-risk groups among females and males and strengthening the national capacity to respond to the epidemic". A specific programme component to accomplish this goal would be to "develop preventive programmes targeting males and females in high-risk groups by strengthening national capacity for gender-sensitive responses to the HIV/AIDS epidemic". Assuming such a programme scenario, the table below presents a set of gender-sensitive indicators. Indicators, targets and information sources are essential to the M&E system and to understanding and influencing the course of the pandemic. Unless this programme relies on gender-sensitive indicators, it would risk missing its targets; and unless information sources contain sex-disaggregated information, monitoring even gender-sensitive indicators would be meaningless.

[1] Monitoring is the assessment of ongoing activities and progress. It centers mostly on the **inputs**, **outputs**, and **processes** related to an activity. Evaluation is the episodic assessment of overall achievements and results. It centers mostly on the **outcomes** and **impacts.**

Examples of gender-sensitive HIV/AIDS indicators, with targets and information sources:

Gender-Sensitive Indicators By Type	Targets	Information Sources
Input indicators (the people, training, equipment and resources needed to achieve outputs): · Amount of HIV / AIDS budget targeting gender-sensitive measures · Sectoral ministries that have incorporated gender-sensitive issues in annual plans · Number of gender-HIV / AIDS trainings for government staff and peer educators · Percent of line ministry staff by sex who are active in HIV / AIDS programmes	· UNGASS Article 61: By 2005, ensure development and accelerated implementation of national strategies for women's empowerment. · By 2004, at least 500 line ministry staff trained	· Annual plans of sectoral ministries · Monitoring, disbursement, or supervision reports
Output indicators (activities and services delivered to achieve outcomes): · Participation of women's organisations in HIV / AIDS policy development, implementation & monitoring · Number of programmes / organisations providing skills to women and men · Number of gender-sensitive HIV / AIDS prevention programmes integrated into school curricula · Number of stigma reduction activities, and percent of males and females enrolled	· By 2005 increase by 20 percent the number of organizations providing skills to young women · By end of 2004, increase to *x* the number of NGOs and CBOs preparing and implementing community and civil society initiatives on gender issues	· Mid-term & supervision reports. · Special studies.
Impact indicators (overall measurable HIV / AIDS impacts, e.g., reduced transmission and prevalence): · Prevalence among 15-24 year old males and females, including pregnant women · Rate of mother-to-child transmission · Life expectancy by sex Number of girls and boys orphaned by HIV / AIDS	· MDG 6: Have halted by 2015 and begun to reverse the spread of HIV / AIDS · UNGASS Articles 37: By 2003, […] address gender-based dimensions of the epidemic	· Mid-term & supervision reports · Special studies · National statistical reports, UNAIDS, UNICEF, WHO
Outcome indicators (e.g., changes in behaviour or skills needed to achieve outcomes): · Number of women and men who know at least two methods of protection against HIV / AIDS · Number of women who report using a condom with a regular partner during the last 12 months · Proportion of sex workers (male and female) who report condom use with last client ·	· UNGASS Article 53: By 2005, ensure that at least 90 percent of men and women aged 15-24 have access to Information, Education and Communication (IEC) · Increase from *x* percent to *y* percent the proportion of sex workers reporting using condoms	· Mid-term and completion evaluation reports · Household and special surveys, such as Behavioral Surveillance Surveys

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Gender-Sensitive HIV/AIDS Indicators for Monitoring and Evaluation

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS