Executive Summary

Introduction

Current estimates show that 40 million people were living with HIV in December 2001 and 3 million died from HIV/AIDS-related causes during that year. 24.8 million people died from HIV/AIDS between the beginning of the pandemic and the end of December 2001. Sub-Saharan Africa is by far the worst affected region in the world, but AIDS is also the leading cause of death in the Caribbean for those aged 15–45 and the number of cases is doubling every two or three years. Asia, where more people live than any other region, is seeing alarming increases in the number of infections.

While AIDS was originally diagnosed in homosexual men, there has been a progressive shift towards heterosexual transmission as the epidemic has spread, and increasing infection rates in women. Almost as many women as men are now dying of HIV/AIDS, but the age patterns of infection vary significantly between the two sexes. Looking beyond the statistics, important differences can be identified in the underlying causes and consequences of HIV/AIDS infections in men and women, which stem from biology, sexual behaviour, social attitudes and pressures, economic power and vulnerability. These result in different rates of risk, infection patterns, access to health knowledge and protection, intervention and care management of illness.

Efforts to contain the spread of HIV/AIDS challenge governments and communities to develop policies and programmes that meet the needs of the entire population, including those who are less able to respond to the threat or consequences of infection because of social, economic or gender disadvantage. Education and treatment approaches that do not take into account gender, cultural or social disparities do not use resources efficiently or effectively and are failing to improve long-term population health outcomes. With health systems stretched far beyond their limits by the pandemic, it is vital that the meagre resources available are used in a cost-effective

and equitable way. Action must be taken to ensure that women and girls have adequate access to sexual and reproductive health services and that there is equality in the provision of drugs for treating HIV/AIDS and opportunistic infections and of care to those infected.

At the same time, it has been recognised that HIV/AIDS is not solely a health problem. To successfully address the pandemic, a gender perspective has to be mainstreamed into a broad-based and multisectoral response. The notion of 'gender' as distinct from 'sex' refers to the socially constructed roles, behaviours and expectations associated with men and women. Gender roles vary depending on the particular socio-economic, political and cultural context and help to determine women's access to rights, resources and opportunities. Gender analysis – a tool that uses sex and gender as a way of conceptualising information – helps to reveal and clarify women's and men's different social relationships and realities, life expectations and economic circumstances.

Gender analysis involves the collection and use of sex-disaggregated data that reveals the roles and responsibilities of women and men. It is crucial to understanding HIV/AIDS transmission and initiating appropriate programmes of action, and forms the basis for the changes required to enable women and men to protect themselves and each other. Gender analysis provides a framework for analysing and developing policies, programmes and legislation, and is thus an important tool for gender mainstreaming.

Gender mainstreaming is the most efficient and equitable way of using existing resources for combating HIV/AIDS by focusing on the real needs of the whole population. It is also required to implement a number of international and Commonwealth mandates. The ultimate goal of gender mainstreaming is to achieve gender equality. It requires that both men's and women's concerns are considered in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally. Gender mainstreaming does not, however, automatically remove the need for women-specific programmes or for projects targeting women, which will often remain necessary to redress particular instances of past discrimination or long-term, systemic discrimination.

Because gender mainstreaming cuts across government sectors and involves other social partners, it requires strong leadership and organisation. The Commonwealth approach to gender mainstreaming is through the Gender Management System (GMS). The GMS is an integrated network of structures, mechanisms and processes put in place in an existing organisational framework in order to guide, plan, monitor and evaluate the process of mainstreaming gender into all areas of an organisation's work. It is intended to advance gender equality and equity through promoting political will; forging a partnership of stakeholders including government, private sector and civil society; building capacity; and sharing good practice.

The goal of a GMS for HIV/AIDS is to ensure the integration of gender into all government policies, programmes and activities that impact on the epidemic. Within the GMS, the design, implementation, monitoring and evaluation of such policies and programmes should not only ensure equality and justice for all regardless of sex and gender, but should also take into account the contributions that can be made by all stakeholders working in the area.

A Gender Analysis of HIV/AIDS

In most societies, gender relations are characterised by an unequal balance of power between men and women, with women having fewer legal rights and less access to education, health services, training, income-generating activities and property. This situation affects both their access to information about HIV/AIDS and the steps that they can take to prevent its transmission.

Both men and women are subject to ideas about what is normal behaviour for one or the other sex, what are 'typical' feminine and masculine characteristics, and about how women and men should act in particular situations. For example, men are generally expected to be more knowledgeable than women about sex, which can make them reluctant to seek information. Women may also have limited access to information about HIV/AIDS, sexuality and reproductive health because of social pressures and cultural norms that stress their innocence. Cultural beliefs and expectations tend to make men responsible for deciding when, where and how sex will take place,

while women generally lack control over sex and reproduction. This heightens not only women's but also men's vulnerability to HIV and other sexually transmitted infections (STIs).

Many societies share the idea that women seduce men into having sex and that men cannot resist because their sexual needs are so strong. All over the world, men are expected to have more sex partners than women, including more extra-marital partners, a tendency reinforced by male migration and mobility. Such beliefs and practices are an obstacle to HIV/AIDS prevention because they absolve men from taking responsibility for their sexual behaviour. They also mean that women are more likely to be infected by their steady male partner.

The feminisation of poverty has meant that women and girls are increasingly having to exchange sex for money, food, shelter or other needs, and that much of this sex is unsafe. They are also vulnerable to being trafficked into sexual slavery. Women may also be blamed as the vectors of the disease since they are often the ones who are tested (when they are pregnant). This can lead to discrimination and stigma. The cultural expectation that women will be the prime or only caregivers to their infected family members creates disproportionate social and economic burdens on them. The costs of medicines and treatment are very high, reducing families' abilities to pay for education and other services. Sickness and death cause labour shortages that increase food insecurity.

There are also harmful traditional and customary practices that make women and girls more vulnerable to HIV infection. These include early marriage, wife inheritance, wife cleansing, dry sex and female genital mutilation (FGM). Gender-based violence also increases the risk of HIV/AIDS. The most pervasive form is that committed against a woman by her intimate partner, often connected to marital rape, coerced sex or other forms of abuse that lead to HIV transmission. Gender-based violence is particularly prevalent in armed conflicts. The main perpetrators are military personnel, who tend to have much higher rates of STIs – which can increase the risk of HIV infection – than the civilian population.

Both women and men need to be empowered to protect themselves against HIV/AIDS. Women need information and education, skills, access to services and technologies, access to economic resources, social capital and the opportunity to have

a voice in decision-making at all levels. Men need to become partners in prevention and education, and to be encouraged to adopt healthier sexual behaviour. This means that in addition to health information, education, counselling and services, they should be provided with information about the gender dimensions of HIV/AIDS and the implications of their behaviour for women, families and communities.

In many of the heavily affected countries, young people are the most rapidly growing group of new HIV/AIDS infections, with girls far outnumbering boys. Some of the reasons for this are related to poverty, lack of information, lack of economic and social empowerment and lack of availability of protective methods. Many countries offer no sexual and reproductive health services to adolescents. Even where such services do exist, they may be hard to access for a number of reasons.

Young women and men are establishing their sexual and gender identities, and face various pressures in this area from their peers and from society as a whole. Young women often have less decision-making power regarding sexuality than adult women, especially because they tend to have older male partners. While young men may be expected to be aggressive, in control of sexual relationships and sexually knowledgeable, young women may be expected to be passive as well as innocent about sexual matters. Young men are often encouraged to start having sex from an early age and to have a number of different partners to prove their manhood. Young women are particularly vulnerable because their immature genital tracts may tear during sexual activity, creating a greater risk of HIV transmission. This is especially likely during forced sex.

Young people are the key to controlling the HIV/AIDS epidemic since adolescence is the critical time for intervention to ensure that high-risk sexual behaviour patterns do not become entrenched. Behaviour begun in adolescence affects the current and future health of the individual and the population as a whole. An important first step would be to acknowledge that many young men and women are sexually active and thus need to receive sex education. Far from sex education promoting promiscuity, numerous studies have found that it is ignorance that increases vulnerability to infection. When young people have information about sex, they tend to delay sexual intercourse or use condoms. Young people should also

play a central role in AIDS prevention and care programmes, and strategies need to be developed that utilise their energies and expertise.

A Multisectoral Response to HIV/AIDS

Since HIV/AIDS is not just a health issue but is affected by and impacts on every aspect of life, it is vital that it is met by a multisectoral response. This response must be dynamic and react to the epidemic as it evolves. It calls for strong and creative leadership, including political will at the highest level. Governments must take the lead in fostering a supportive environment and providing a framework for action that works both horizontally (with government, business and civil society organisations) and vertically (at international, national and community levels).

Every level of society should be involved, and partnerships need to be developed between ministries responsible for different sectors, and between them and the private sector, civil society organisations, communities and people living with HIV/AIDS. Different partners bring different strengths and experiences of partnership development, and best practice in multisectoral responses need to be shared.

Since the pattern of HIV transmission and the stage of the epidemic are different in each country, depending on the underlying social, economic, political and cultural context, a consensus needs to be reached of what needs to be done in that particular country. In preparing culturally-appropriate national HIV/AIDS policy guidelines, case studies, tools and resources, government analysts and decision-makers need to factor in gender indicators. The Gender Management System is flexible enough to be adapted to the issue of HIV/AIDS and to the distinctive national context.

Mainstreaming gender calls for skills in gender analysis and planning; the capacity to collect and interpret sex-disaggregated data; a commitment by government to action to achieve gender equality; and the availability of human, technical and financial resources. Both short- and long-term gender-sensitive strategies need to be developed from the community to the national level. Short-term strategies might focus on people's immediate needs, such as information, support to

home-based care and access to treatment for STIs. More long-term strategies need to address the underlying social and cultural structures that sustain gender inequality.

In all areas, programmes have to deal with issues of economic power imbalances, migrations, economic and social marginalisation, development of community responses, participation and capacity building for sustainability. It should be recognised that education has a key role to play as a means of imparting the knowledge and skills essential for individual, communal and national survival. Any successful response will integrate prevention and care. It is not enough to focus on individual behaviour change because poor health, gender, poverty and other factors also play an important role in vulnerability and susceptibility to HIV. The poorest and most vulnerable groups, including women and young people, need to be seen as resources and not just victims.

Each sector must plan and make available resources for an integrated response, including an analysis of the factors within the sector that contribute to the spread of HIV/AIDS, the impact of the disease on its workforce and products, and the consequences for both the sector and the community. Practical short-term and long-term interventions need to be developed to protect the sector's workers, to cope with the skills shortages that will arise and to mitigate the adverse effects on society.

In **agriculture**, for example, it is likely that the AIDS epidemic will cause a major labour shortage in many countries. If a family member is sick with AIDS, it will usually be a woman who cares for them, meaning she may be unable to carry out her usual agricultural tasks. This in turn may result in chronic food insecurity as well as high levels of malnutrition and micronutrient deficiencies. Girls may also be kept out of school to care for the sick or help with household tasks.

In addition, the deaths of farmers, extension workers and teachers from AIDS can undermine the transmission of knowledge and know-how as well as the local capacity to absorb technology transfers. Widows may be left without access to productive resources such as land, credit and technology and their livelihoods may be threatened. HIV/AIDS also leads to a reduction in investment in irrigation, soil enhancement and other capital improvements.

HIV/AIDS not only affects **education** through the loss of

personnel, reduction of available government resources and decline in demand. It also exacerbates the gender-based disparities that already exist in the education sector, which in most cases disadvantage girls in their access to quality education and women in their employment opportunities as educators and administrators.

Schools need to play a positive role in helping learners and teachers to cope with the issue of HIV/AIDS. They can influence social attitudes and cultural norms acquired by young people. Schools can also play an important role as focal points for the community. Teachers, parent-teacher associations and governing bodies often command a degree of respect and authority that can be used to advantage in mobilising community action. Schools also need to produce an adequate supply of educated people with the skills and training needed to support themselves, their families and communities against a background where there are increasing human resource shortages due to the devastating impact of HIV/AIDS.

The epidemic has had a profound impact on **health** services in most of the affected countries, with more people requiring hospital care at the same time that there are reduced numbers of health staff. Treatments for controlling HIV, such as triple, double or combination antiretroviral therapy are often prohibitively expensive. Yet a single dose of an antiretroviral given to an infected woman in labour, and another dose given to her baby within three days of birth, could prevent some 300,000 to 400,000 babies per year being born infected with HIV.

If costly drugs are unobtainable, people living with HIV/AIDS must at least have access to basic pain relief and treatment for 'simpler' opportunistic infections such as pneumonia and tuberculosis. Care and support for people living with HIV/AIDS can help to protect the health of the rest of the population by making prevention more effective.

HIV/AIDS brings about reduced **labour** quality and supply, more frequent and longer periods of absenteeism, and losses in skills and experience. This results in a younger, less experienced workforce and causes production losses. Women who become HIV positive are more likely than men to lose employment in the formal sector and to face discrimination and even expulsion from their homes. When they are forced to become the main breadwinner due to their partner becoming infected,

women who lack education and skills may be forced into hazardous occupations, including sex work, that further increase their vulnerability.

HIV/AIDS is exacerbating the difficulties that women face in the area of **law and justice**. In many countries, women experience substantial discrimination in this area and may lack the right to hold, inherit or dispose of property, to participate in democratic processes, or to make decisions about marriage or about the education of their children. When they or their partner become HIV positive, it may be difficult for them to exercise their rights to their property, employment, marital status and security. More women are now being widowed at a younger age and may be disinherited by the husband's relatives and unable to support themselves. They may also expect to die early themselves, yet be unable to provide for their children

Laws are needed that actively promote a supportive environment. These include those that protect the right to privacy; provide redress in the event of discrimination in employment, housing, access to health care, etc.; ban discrimination against people with HIV or their family or friends; protect the confidentiality of a person's HIV status; and require consent for HIV testing.

Case Studies, Tools and Resources

The case studies illustrate how programmes that promote HIV prevention by addressing gender and the social and economic factors that increase people's risk of infection are more likely to succeed in changing behaviour. It is particularly important to listen to women's voices and address their lived realities in developing HIV/AIDS prevention campaigns. Research on HIV/AIDS that is carried out in co-operation with local communities has considerable potential to influence national policy and promote action on the social factors that affect women's and men's health and wellbeing. This increases the likelihood of being able to target strategic interventions to high-risk populations.

These populations include sex workers, and one of the case studies looks at female prostitutes and HIV prevention programmes in Canada. Other case studies from Canada include one on HIV counselling and testing among pregnant women,

which offers an example of best practices in this area, and one on gender differences in sexual health promotion among adolescents.

Two case studies come from Africa. The first looks at marketing the female condom in Zimbabwe and suggests that female condoms are providing new and additional STI/HIV protection to some study participants, though more research is needed. The second describes an innovative mechanism for the transfer of local knowledge for HIV programming in Southern Africa called the ‘School Without Walls’.

Involving men in preventing gender violence and HIV transmission is the focus of an international case study of a programme called ‘Stepping Stones’. This uses peer groups to help people translate information about prevention into behavioural change. The need to mobilise the community for effective control and prevention is also emphasised by a case study on sexual and reproductive health integration in Bangladesh.

A final chapter on tools and resources includes a checklist that aims to provide HIV/AIDS educators and policy-makers with a tool to assess the gender sensitivity of their programmes and policies, and an extensive list of online resources.