2. A Gender Analysis of HIV/AIDS

Overview

Crucial to understanding HIV/AIDS transmission and initiating appropriate programmes of action is an understanding of the socially constructed aspects of relations between women and men that underpin individual behaviour, as well as the gender-based rules, norms and laws governing the broader social and institutional context.

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. Globally, it is estimated that 90 per cent of all cases of infection now occur through vaginal intercourse (UNIFEM, 2001) and 48 per cent of those newly infected in 2001 were women (55 per cent in sub-Saharan Africa) (UNAIDS/WHO, 2001).

Beyond the statistics of sex-based differences in infection rates, there are profound differences in the underlying causes and consequences of HIV/AIDS infections in women and men. These reflect differences not only in biology but also in sexual behaviour, social attitudes and pressures, economic power and vulnerability. Gender analysis can help researchers and policy-makers understand how fundamental cultural norms of masculinity and femininity influence sexual knowledge and behaviours. It can also identify the changes required to create an environment in which women and men can protect themselves and each other.

HIV/AIDS and Men

While the HIV infection rates of women are fast catching up,

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infection rates in men still outnumber those in women in every region except sub-Saharan Africa. Young men are more at risk than older ones: about one in four people with HIV are young men under the age of 25.

Why men are at risk

Through socialisation, both men and women are subject to ideas about what is normal behaviour for women and men; what are 'typical' feminine and masculine characteristics; and how women and men should behave in particular situations. Part of the reason for the high level of HIV/AIDS among men is that many societies subscribe to the idea that women seduce men into having sex and that men cannot resist because their sexual needs are so strong (KIT/SAfAIDS/WHO, 1995). Such beliefs are an obstacle to HIV/AIDS prevention because they absolve men from taking responsibility for their sexual behaviour. As a result of these beliefs, men may be excused for not using condoms or for 'normal masculine behaviour' such as coercing women into intercourse (UNFPA, 2000a). Male condoms are the primary means of preventing HIV transmission during sexual intercourse and men are usually in control of whether this form of protection is used or not. The belief that condoms reduce male pleasure or a concern that their use might indicate infidelity may restrict male usage.

Another problem is the societal expectation that men are knowledgeable about sex. This can make them uncomfortable about admitting that they do not know, limiting their access to information (UNAIDS, 2001a). The cultural beliefs and expectations that make men the ones responsible for deciding when, where and how sex will take place heighten not only women's but men's own vulnerability to HIV and STIs.

All over the world, men tend to have more sexual partners than women, including more extramarital partners. Many societies condone men in having multiple sexual relationships in spite of the clear risks of infection that these pose to their spouse and to their children – and of course to themselves. Male migration and mobility, common in many developing countries where men are forced by economic factors to leave their village and obtain work elsewhere, reinforce this tendency for men to have sexual relationships outside their

Box 4: The Need for Behavioural Changes in Men

The rapid spread of HIV/AIDS among women can only be slowed if concrete changes are brought about in the sexual behaviour of men.

- **A study of female youth in South Africa showed that 71 per cent had experienced sex against their will.**
- **A survey in Tamil Nadu in India showed that 82 per cent of the male STI patients had had sexual intercourse with multiple partners within the last twelve months and only 12 per cent had used a condom.**
- **A study in India revealed that 90 per cent of the male clients of male sex workers were married.**

Source: **Nath, 2001c**

Men may believe that their control of women's lives is an essential element of masculinity.

marriage (Hamblin and Reid, 1991). Predominantly male occupations, such as truck-driving, seafaring and the military, also entail family disruption and create a high demand for commercial sex. When men return home to their households, they re-establish sexual relationships and increase the possibility that HIV/AIDS will be transmitted to rural women (UNIFEM, 2001).

Men may believe that their control of women's lives is an essential element of masculinity. They may become angry or frustrated when they appear to be losing control (UNFPA, 2000a). When gender roles determine that men should provide for their families, those who are unable to do so may respond by becoming dependent on alcohol or inflicting violence on those weaker than themselves, often their partners (UNAIDS, 2001a). Risk and vulnerability are heightened by the link between socialising and alcohol use and by higher frequency among men of drug abuse, including by injection (Nath, 2001b). Men are less likely than women to seek health care or pay attention to their sexual health.

In some parts of the world, men who have sex with men have been disproportionately affected by the HIV epidemic. Contributing factors are multiple sex partners, unprotected

Men need to be involved in prevention and education, and empowered to adopt healthier sexual behaviour.

anal sex and the hidden nature of sexual relations between men in many communities. Risk-taking behaviour may be exacerbated by denial and discrimination, making it difficult to reach them with HIV prevention interventions (Family Health International, 2001b).

Empowering men

Men need to be involved in prevention and education, and empowered to adopt healthier sexual behaviour. This requires a concerted effort by leaders at the highest level, including Presidents, Prime Ministers, parliamentarians, religious leaders, community leaders including chiefs, traditional and spiritual leaders, and leaders of prominent businesses, private organisations and civil society. They need to "speak out as friends, parents, partners and citizens", to affirm their commitment to fight AIDS and to lead by example (UNDPI and UNAIDS, 2001). They should also identify and encourage positive cultural values while discouraging the negative elements preventing men and boys from changing their behaviour.

Since little is known about what men think, and what they might respond successfully to in terms of HIV prevention, it is important to engage them in discussion in order to understand their perceptions, attitudes and practices. The following areas have been suggested as those where research is necessary (Rivers and Aggleton, 1999b):

- Men's beliefs and practices in relation to gender, sex, sexuality and sexual health, especially where the risk of HIV infection is high;
- Sex between men, including an understanding of the meanings attached to male to male sex in the local context;
- Risk-taking behaviour among men, especially among those who work in dangerous and/or isolated environments, since risk-taking appears to be an important part of dominant ideologies of masculinity in a number of societies;
- The kinds of non-stereotypical images and messages that might appeal to men and encourage increased condom use.

As well as health information, education, counselling and

A well-known football player acts as a male role-model as he talks about HIV/AIDS in a school in Kenya
UNAIDS/G. Pirozzi

AIDS education work with miners in Southern Africa.
UNAIDS/Jones

services, men should be provided with information about the gender dimensions of HIV/AIDS and the implications of their behaviour for women, families and communities. Men also need information and services for the prevention, early detection and treatment of STIs. Use of the condom is one obvious measure that can help prevent HIV transmission, but programmes at the community level should also promote other healthy options which reduce the spread of HIV, such as mutual fidelity, reduction in number of partners and respect for women's rights (Iwere, 2000). Vaginal microbicides might also prove more acceptable to men than condoms. In a study of 243 men from three sites in South Africa (STI clinics, the general population and universities), more than 80 per cent wanted their partner to be protected against HIV and other STIs. However, the majority also reported a dislike of male condoms and expressed a preference for microbicides. In addition, they were more likely to prefer a vaginal product that prevents HIV and STI transmission and does not act as a contraceptive than one that acts only as a contraceptive (Ramjee et al., 2001).

Gender-based programmes can help men realise that changing the dynamics of male–female relationships so that they are based on collaboration rather than authority can help the

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whole community to minimise the impact of HIV/AIDS. Engaging men and boys as partners will enhance all aspects of sexual and reproductive health, including family planning and child-care (UNFPA, nd).

The risks and needs of men who have sex with men also need to be addressed through, for example, peer education programmes, community-level interventions to reduce risk through safer sex practices, and the creation of 'safe spaces' where they can discuss personal issues and access STI care, counselling and referral services (Family Health International, 2001b).

HIV/AIDS and Women

Globally, almost as many women as men are now dying of HIV/AIDS but the age patterns of infection are significantly different for the two sexes. In many ways, the inequity that women and girls suffer as a result of HIV/AIDS serves as a barometer of their general status in society and the discrimination they encounter in all fields, including health, education and employment.

Lack of control over sex and reproduction

The fact that a man is far more likely than a woman to initiate, dominate and control sexual interactions and reproductive decision-making creates a tremendous barrier to women being able to adopt HIV risk-reducing behaviour. By and large, most men, however poor, can choose when, with whom and with what protection, if any, to have sex. Most women cannot (WHO, 2000b). They are thus often unable to protect themselves against contracting HIV through sexual intercourse, the predominant mode of infection. For many of them, this is not because they have several sexual partners; rather, it is monogamous women who are increasingly at risk of HIV infection because of the sexual behaviour of their steady male partner. An estimated 60–80 per cent of HIV-positive African women have had sexual intercourse solely with their husbands (UNDPI and UNAIDS, 2001). In studies in Papua New Guinea, Jamaica and India women reported that bringing up the issue of condom use, with its inherent implication that one partner or the other has been unfaithful, can result in violence (Gupta, 2002).

Box 5: The Need for Female-Controlled Protection

Women's and girls' vulnerability to HIV infection is four times greater than that of men and boys, and due to many social and economic power imbalances women may not have the power to insist that their sexual partner wear a condom. There is thus a need for a female-controlled form of protection. The female condom is currently the only such method. It is inserted into the vagina and, like the male condom, it provides a barrier to prevent the exchange of body fluids between sexual partners. However, it is difficult for women to use the female condom without their partner's knowledge.

More promise for women-controlled protection may be offered by microbicides which, when inserted into the vagina or rectum, protect against HIV by killing or inactivating the virus. A microbicide could be used without the consent, or even the knowledge, or a woman's partner. There seems to have been some initial reluctance among companies to invest heavily in the development of microbicides since, to be really useful and available to all, they would have to be inexpensive. However, there are currently several candidates heading towards the last phase of human trials within the next two years. Since they are still in the research phase, the efficacy of microbicides is unclear.

Source: UNAIDS, 2001a; Lerner, 2001

A condom, of course, also prevents conception, and a woman's status may depend on her child-bearing ability. Her fertility and her relationship to her husband will often be the source of a woman's social identity (Hamblin and Reid, 1991). Thus, even where women are informed on how to avoid HIV infection, the need for reproduction and their traditionally subordinate role within the family and society, combined with their economic dependence on men, may prevent them from refusing unwanted, and often risky, sexual intercourse.

Worldwide, there are increasingly more poor women than poor men . . .

Growing female poverty

Legal systems and cultural norms in many countries reinforce gender inequality by giving men control over productive resources such as land, through marriage laws that subordinate wives to their husbands and inheritance customs that make males the principal beneficiaries of family property (Tlou, 2001). Worldwide, there are increasingly more poor women than poor men, a phenomenon commonly referred to as the 'feminisation of poverty'. At the same time, women are the sole economic providers in up to one-third of households in the developing world (Gupta, Weiss and Whelan, 1996). Structural adjustment policies imposed by international financial organisations have worsened the situation. Continuing retrenchments and lack of employment opportunities have resulted in women and girls resorting to both direct and indirect commercial sex work as a survival strategy. They may exchange sex for money, food, shelter or other necessities.

Most of this sex is unsafe because women risk losing economic support from men by insisting on safer sex. In a study of low-income women in long-term relationships in Mumbai, India, the women believed that the economic consequences of leaving a relationship that they perceived to be risky were far worse than the health risks of staying in the relationship (Gupta, 2002).

Where substance abuse is also a factor, the means for obtaining clean needles may be traded for other essentials. Trading or sharing needles is a way to reduce drug addiction costs. Risk behaviours and disease potential are predictable under such compromised circumstances (Albertyn, 2000).

Trafficking and sex work

Widespread poverty and the forces of globalisation have also led to an increasing number of women and children being trafficked into prostitution and sexual slavery where they have even less control over their reproductive lives. For example, two million girls between the ages of five and 15 are introduced into the commercial sex market each year (UNFPA, 2000). Rural women may find themselves conned into joining the trade after taking up offers of work in urban areas. These

women and children are at extreme risk of disease and death, objectified as a readily attainable and disposable commodity in organised criminal economies.

Stigma and legal status make it difficult for sex workers to access relevant health services. Where sex work is illegal, sex workers may not go for treatment of sexually transmitted infections, increasing the likelihood of HIV infection. They may not seek health care even where sex work is legal, since a diagnosis of an STI may cause the loss of their license and hence their means of support.

A study of sex workers in a southern African industrial community that employs a large number of migrant workers revealed that condom use was extremely rare, despite the fact that most people knew the 'facts' about HIV/AIDS. Women said they lacked the economic power to insist on condom use if paying clients refused to use them. They also lacked the psychological confidence to insist on condom use in a strongly male-dominated culture and noted that if a woman refused sex without a condom, the client would simply find a more willing woman in the shack next door (Mzaidume, Campbell and Williams, 2000).

Some sex workers may actually be more at risk of getting HIV from their intimate partners that from their paying customers. Among commercial sex workers in Glasgow, UK, 90 per cent used condoms with their clients while only 17 per cent used condoms with an intimate partner, even among frequent drug users (UNAIDS, 2001a). Similarly, studies of injection drug use (IDU) in Ontario, Canada found that there was a group of IDU women who have multiple male partners but do not self-identify as being sex workers. While many of them report always using condoms with casual partners, only a very small proportion of these women report always using condoms with their regular partners (Millson et al., 2001).

The rate of HIV infection among commercial sex workers in Phayao, Thailand, is about 60 per cent
UNAIDS/Shehzad Noorani

Lack of information

Because of social pressures and cultural norms, women may also have limited access to information about HIV/AIDS, sexuality and reproductive health. These norms may include an emphasis on women's innocence about sexual matters and girls' virginity. Rural women from South Africa and urban

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Box 6: Rising Prostitution in Asia

Prostitution has increased in Asia because of the worsening economic situation in the region. Lack of education and economic opportunities drive young girls and women to large cities in the hope of earning an income. Sometimes they have to prostitute themselves to pay off loans their families had accepted from their future employers. They may also be kidnapped or lured into the sex industry by men whom they trust.

Child prostitution is on the increase, partly because customers are under the mistaken impression that sex with juvenile prostitutes is safer than sex with adult prostitutes. Refugees from political conflicts, sex tourism, local cultural perceptions of manhood, corruption and gender inequality contribute both to the thriving sex industry and the feminisation of poverty. Most sex workers have difficulty protecting themselves against HIV infection because of economic dependency and the threat of physical force. Lesions and injuries in sexual intercourse, especially when they start young, also make them more prone to infections.

Source: **Shahabudin, 2000**

women from India reported not liking condoms because they feared that if the condom fell off inside the vagina it could get lost and perhaps travel to the throat or another part of the body (Gupta, 2002). Lack of information about their bodies may prevent women from identifying and getting treatment for sexually transmitted infections (STIs), and the overall morbidity and mortality for women from STIs is 4.5 times that of men (UNIFEM, 2001).

At the same time, very little is known about HIV in women as men have formed the vast majority of subjects in studies that form the foundation for the treatment of HIV and opportunistic infections (Nath, 2001a). Women's health is also being "compromised by under-investment in research and product development for female-controlled methods of protection and prevention" (Shahabudin, 2001) and by lack of access to treatment for either HIV/AIDS or the infections associated with it.

Stigma and discrimination

Women may only be tested for HIV/AIDS when they are pregnant, and then only as a measure to protect the unborn child. Since the fathers may not have been tested, the women come to be blamed as the vectors of the epidemic (to partners and children) even though it is almost invariably the husband who passes the HIV infection to his wife. She may be labelled as promiscuous, abused, abandoned or even killed. The man may then seek to marry again, often a younger woman who is believed to be uninfected and therefore safe and who, in turn, will be exposed to HIV.

If her spouse dies, inheritance laws in many countries mean that a woman does not have any rights to the family property and loses her access to land. Alternatively, in many patrilineal African communities, the cultural custom of *levirat* dictates that she has to marry one of her dead husband's brothers in order to continue having access to land and food security. If the husband has died of AIDS, this custom increases the risk of spreading the disease.

In cultures where HIV is seen as a sign of sexual promiscuity,

Workers and patients from The TASO Centre in Kampala, Uganda use drama to provide information about HIV and AIDS.
Michael Jensen, 2001

Box 7: HIV/ AIDS and Women

- Of the 40 million adults living with HIV/AIDS, 48 per cent – or 17.6 million – are women.
- 48 per cent of adults newly infected with HIV in 2001 were women.
- 49 per cent (1.1 million) of adult AIDS deaths in 2001 were women.
- Since the beginning of the epidemic, over 10 million women have died from HIV/AIDS-related illnesses.
- 55 per cent of all HIV-positive adults in sub-Saharan Africa are women. Teenage girls are infected at a rate 5 or 6 times greater than their male counterparts.
- In one Kenyan study, over one quarter of teenage girls interviewed had had sex before 15, of whom one in 12 was already infected.
- A Zambian study confirmed that less than 25 per cent of women believe that a married woman can refuse to have sex with her husband. Only 11 per cent thought they could ask their husband to use a condom.
- 50 per cent of all HIV-positive adults in the Caribbean are women.
- In Trinidad and Tobago nearly 30 per cent of young girls said they had sex with older men – as a result, HIV rates are five times higher in girls than in boys aged 15–19.
- In the mid-1990s, more than 25 per cent of sex workers in India tested positive for HIV – by 1997 the prevalence rate reached 71 per cent.

Source: UNAIDS *Report on the Global Epidemic*, June 2000; *AIDS Epidemic Update*, December 2000; *Special Session Bulletin 1*, June 2001

HIV-positive women face greater stigmatisation and rejection than men. Those with least access to information or capacity for protection can be excluded from health benefits and treatments and sometimes held to a higher level of responsibility and blame for infection. In Canada, many HIV-positive First Nations women live in secrecy because of the multiple forms of stigma associated with the disease, including being branded 'promiscuous', 'a bad mother' and 'deserving of HIV/AIDS' (Ship and Norton, 2001).

In many countries, men are more likely than women to be admitted to health facilities. Custom and tradition may prevent a woman from travelling alone or receiving medical treatment from a man. Family resources are more likely to be used for buying medication and arranging care for ill males than females (UNDPI and UNAIDS, 2001). Unequal access to health care and the gender gap in medical knowledge contribute to a situation where women in both developed and developing countries have shorter life expectancies than men after a diagnosis of AIDS (UNAIDS, 1997).

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Women's caregiving role

As social services prove unable to cope with the AIDS epidemic, women are subsidising the public sector by caring for the sick. The societal expectation that women will be the prime or only caregivers to their infected family members creates disproportionate social and economic burdens on them. The cost, time and emotional burden of the disease takes a toll on women that leaves them with little means of protecting themselves or their children from long-term material deprivation.

With the growing infection and death of women from HIV/AIDS, many millions of children will lose their mothers and/or both parents to the epidemic. Many of them will be taken in by grandmothers or other female family members whose care burden is thus increased. The economic costs of care in actual terms by way of medicines and treatment are very high. Families with people living with HIV/AIDS become poor not only because their incomes decline, but because their health expenses increase. Poorer families spend disproportionately more of their income on such expenses. In Kerala, India, it has been estimated that the monthly costs incurred by the family on the treatment

of opportunistic infections for an HIV infected child is three times the monthly income of the family (Nath, 2001b). Women head a growing number of poor households.

In rural areas, where women often account for 70 per cent of the agricultural force and 80 per cent of food production, caregiving has been shown to reduce farm output for family consumption and sale (UNAIDS, 2001a). Studies by the Food and Agriculture Organization (FAO) reveal that the pandemic decreases sustainable agricultural production and increases food insecurity. AIDS illnesses and deaths can mean severe labour shortages and loss of productive resources through the sale of livestock to pay for sickness, mourning and funeral expenses (UNFPA, 2000a). This also erodes the family's capacity to provide education and other services to children, and girl children in particular may be taken out of school to help in the home.

Box 8: The Burden of Care

Sixty-six per cent of informal caregivers in Canada are women, representing approximately 14 per cent of all Canadian women over the age of 15. Research among women providing care in rural Nova Scotia found that:

- **The majority of the family caregivers reported they were on duty 24 hours a day, seven days a week, caring for people whose ages ranged from four years old to nearly 100.**
- **Fifteen per cent provided 24-hour care 'with no relief', while 63 per cent received only 'occasional relief'.**
- **While some had been providing care for only a few months, others had been doing so for as long as 40 years. Many of these caregivers had given up employment in order to provide care; fewer than 25 per cent had paid employment.**
- **Fifteen per cent of caregivers reported not having enough money to feed all members of the household.**

Source: **Maritime Centre of Excellence for Women's Health, 1998**

Harmful practices

There are also harmful traditional and customary practices that make women and girls more vulnerable, such as early marriage, wife inheritance and wife cleansing. In some parts of the world, women insert external agents into their vaginas, including scouring powders and stones, to dry their vaginal passages in the belief that increased friction is sexually more satisfying to men (Nath, 2001b). This 'dry sex' can cause inflammation and erosion of the vaginal mucosa. Female genital mutilation (FGM) puts girls at risk of HIV if unsterilised instruments are used for several patients in succession. It can also lead to excessive bleeding and tearing when intercourse is attempted (KIT/SAfAIDS/WHO, 1995).

Empowering women

Research done by the International Center for Research on Women (ICRW), USA, has identified six sources of power: 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. To empower women (Gupta, 2000b), it is necessary to:

- Educate women and give them the information they need about their bodies and sex;

Sex workers in Calcutta, India have organised themselves into a union that provides information on HIV/AIDS.
Michael Jensen, 2001

The Masese Women Self Help Project started in a slum area affected by the AIDS epidemic and now sells building materials to projects all over Uganda.
Michael Jensen, 2001

- Provide women with skills-training in communication about sex and how to use a condom, and foster inter-partner communication;
- Improve women's access to economic resources and ensure that they have property and inheritance rights, have access to credit, receive equal pay for equal work, have the financial, marketing and business skills necessary to help their businesses grow, have access to agricultural extension services to ensure the highest yield from their land, have access to formal sector employment, and are protected in the informal sector from exploitation and abuse;
- Ensure that women have access to health services and to HIV and STI prevention technologies that they can control, such as the female condom and microbicides;
- Support the development of an AIDS vaccine that is safe and effective, and accessible to women and young girls;
- Increase social support for women who are struggling to change existing gender norms by giving them opportunities to meet in groups, visibly in communities; by strengthening local women's organisations and providing them with adequate resources; and by promoting sexual and family responsibility among boys and men;

- Move the topic of violence against women from the private sphere to the public sphere, ensuring it is seen as a gross violation of women's rights and not a personal issue;
- Promote women's decision-making at the household, community and national level by supporting their leadership and participation. To give them a voice, they need to be provided with the opportunity to create a group identity separate from that of the family since for many women the family is often the social institution that enforces strict adherence to traditional gender norms.

. . . policy-makers and managers need to recognise how health care reform, privatisation and the shift from institutional to home and community-based care affect the lives of women.

To reduce the stigma and discrimination faced by women who give birth to children with AIDS, it is important to use the terminology 'parent-to-child transmission (PTCT)', rather than 'mother-to-child transmission (MTCT)'. MTCT focuses attention on the mother as the immediate source of infection, "yet it is well documented that the majority of women have acquired their infection solely through a monogamous relationship with their partner" (Matlin and Spence, 2000). PTCT is a gender-neutral term and hence more appropriate.

Women should be given adequate information about the risks associated with breastfeeding, as well as its benefits, so that they can make an informed decision. HIV passes via breastfeeding to about 1 out of 7 babies born to an HIV-infected woman. However, in many situations where there is a high prevalence of HIV infection, the lack of breastfeeding is also associated with a three-to-five-fold increase in infant mortality (Linkages, 2001). Where there is little or no access to safe water, let alone formula or the money to buy it with, breastfeeding is likely to be the safest method of infant feeding (Machel, 2000).

As women are the majority of HIV/AIDS care providers and deliver most of the unpaid health care within the home, it is important for policy-makers to be aware of how HIV/AIDS health care planning and policy reform affect women and men differently – both as care providers and care recipients. Furthermore, policy-makers and managers need to recognise how health care reform, privatisation and the shift from institutional to home and community-based care affect the lives of women, especially as care-giving affects women's health, productivity and economic security over the life span.

Box 9: Empowering Older Women

A pilot project was undertaken in Botswana to strengthen the role of older women in the prevention and control of HIV/AIDS. The empowerment of older women through education, specifically peer education, was seen as important for AIDS prevention. First, older women were able to apply the new knowledge to prevent their own infection with HIV/AIDS, an area that had been neglected due to the incorrect assumption that older women were not sexually active. Second, the women became an important health resource because they learned how to discuss and negotiate with others and educated their families, neighbours and communities about HIV/AIDS prevention and care.

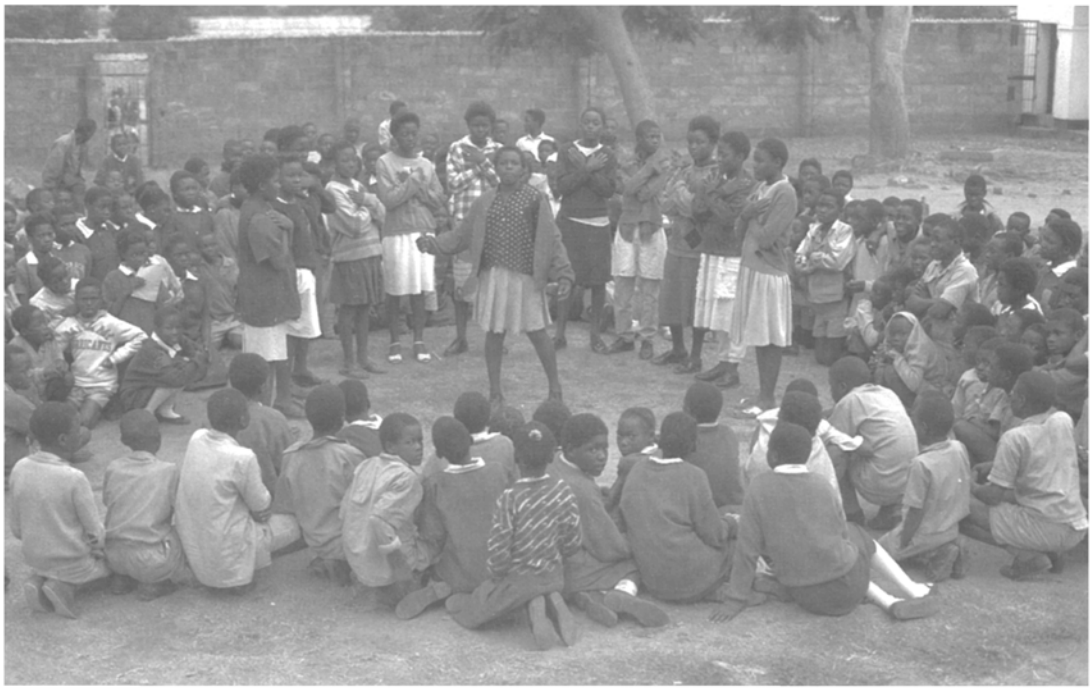
Source: **Tlou, 2000**

HIV/AIDS and Young People

In many of the heavily affected countries, young people represent the most rapidly growing component of new HIV/AIDS infections, with girls outnumbering boys by a substantial factor. Every minute, six people under the age of 25 become HIV positive. Half of all new HIV infections are in young people aged 15–24. In eight African countries, AIDS is expected to claim the lives of at least a third of today's 15-year-olds. In Botswana, according to the Human Rights Watch website, a 15-year-old boy now has an 85 per cent chance of dying of AIDS.

The reasons for this vulnerability include factors relating to poverty, lack of information, lack of economic and social empowerment, and lack of availability of protective methods. One of the most glaring deficiencies in many countries is the complete absence of adolescent sexual and reproductive health services. Young people often find it difficult to get accurate and practical information on sexual matters from their parents, teachers or health professionals and are forced to rely on inaccurate or incomplete information circulating in peer groups.

Many young women and men tend to ignore risks, falsely



Adolescent members of the anti-AIDS club at a primary school in Zambia perform for younger students in the school playground.
UNICEF/HQ96-1233/Giacomo Pirozzi

believing that a stable relationship is protection enough. In a number of countries where AIDS is epidemic, nearly half of sexually active girls between the ages of 15–19 believe they face no risk of contracting the disease (UNICEF, 2002). Often, young people will not communicate about sex in early sexual encounters since this maintains "an ambiguity between partners as to whether sex will actually happen" (Kumar, Larkin and Mitchell, 2001) and hence the young man's dignity and the young woman's innocence. Sexual relations may also be unplanned or coerced; young people who are the victims of sexual abuse and exploitation (including incest, rape and forced prostitution) are especially vulnerable to HIV infection (UNDPI and UNAIDS, 2001).

Where sexual and reproductive health services exist, young people find it hard to use them because of lack of money, inconvenient opening times, shame and embarrassment, concerns about privacy and confidentiality, laws that prevent unmarried girls and boys using contraception or require parental consent, and negative and judgmental attitudes of service providers. Young people will avoid seeking STI treatment or contraception if they think that the service providers

will not treat them with respect (Commonwealth Secretariat and Healthlink Worldwide, 2001).

An estimated 13.2 million children have been orphaned by AIDS worldwide since the beginning of the epidemic. As well as possibly being infected themselves, they face greater risks of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes (UNAIDS, 2001b). Marginalised young people (including street children, refugees and migrants) may also be at particular risk because of stigma, their exposure to unprotected sex (in exchange for food, protection or money) and the use of illegal drugs (UNDPI and UNAIDS, 2001). Injecting drug use is rising in young people in some countries, increasing the risk of HIV transmission through sharing contaminated needles and syringes (Commonwealth Secretariat and Healthlink Worldwide, 2001).

Young women

Young women often have less decision-making power regarding sexuality than adult women, especially because they tend to have older male partners. These men may be better off and able to provide the women with things that they cannot otherwise afford: clothes, cosmetics and even school fees. The relationship may be encouraged by parents in some instances

Adolescent girls in a slum in Mumbai, India, listen to a woman discuss ways to refuse unwanted sexual advances as part of a local initiative for girls who are not enrolled in school.
UNICEF/HQ00-0111/
Alexia Lewnes

because of financial benefits for the family. These older partners can dominate the young women because of their age and gender, and may have had many previous partners and be infected with STIs. Sometimes they actively seek out young girls because they hold the erroneous belief that sex with a virgin can cure a man of infection. Girls also marry at an earlier age than boys.

Young women who show knowledge about sex and reproduction may be seen as promiscuous and risk getting a "tarnished sexual reputation" (Kumar, Larkin and Mitchell, 2001). For many young women, discussion around the subject of sex is limited to warnings about its dangers and about the importance of preserving their 'honour' (Rivers and Aggleton, 1999a). Their parents may strictly control their possibilities of accessing services such as contraceptives and condoms (De Bruyn, 2000). Young women are also often expected to be passive, which leaves them with little control over when, where and how sexual activities occur, including the use of condoms (UNAIDS, 2001a).

Biologically, 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. Social expectations may also lead adolescent girls to engage in anal sex to preserve their virginity.

Young men

Like young women, young men are in the phase of establishing their sexual and gender identities, and face various pressures regarding the exercise of their sexuality not only from society at large (parents, religion, the media) but also from their peers (De Bruyn, 2000). Unlike young women, however, young men, are expected to be sexually knowledgeable, which may deter them from seeking information for fear of appearing ignorant. They are also expected to be aggressive and in control of sexual relationships. 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. There is a lot of pressure on them from their friends and society.

In many countries, a number of young men have their first

Quiz shows and a radio programme, and condom demo and distribution, attract young people in Gaborone, Botswana.
UNAIDS/G.Pirozzi

sexual experience with other men, sometimes because of the restrictions placed by their culture on socialisation between the sexes (Rivers and Aggleton, 1999a). For a few young men, trading or selling sex to other men may offer a means of survival, and they face many of the same risks as women in a similar position.

While mothers may sometimes take their daughters to clinics for family planning, it is rare for them to take their sons. Boys and young men think that these clinics are for women, and men's sexual health is given a low priority in many countries (Commonwealth Secretariat and Healthlink Worldwide, 2001).

Empowering young people

Engaging young people in addressing HIV/AIDS has become essential; they are the key to controlling the epidemic. Adolescence is the optimum time to develop attitudes and behaviour, and is the critical phase 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.

A first step towards effectively protecting adolescents from STIs/HIV is to acknowledge that considerable numbers of

Box 10: Programmes with Young People

Young Men

Working with young men gives them the chance to talk about their feelings and get answers to questions that they cannot risk asking because of expectations that they should know everything. It can also allow them the opportunity to think about what girls and women feel and to practice communication skills. Chogoria Hospital in Kenya conducted a survey of boys coming for circumcision to find out what they knew about HIV and safer sex. There was a lot of misunderstanding and fear, and a strong feeling that after circumcision it was their right to have sex. The hospital introduced an education programme during the week when the boys stay in hospital after the operation which encouraged the young men to consider topics such as becoming a man, sex, STIs/HIV, gender issues and community expectations.

Young Women

In Mumbai, India, World Vision implemented a sex and family life education programme for 76 low-income adolescent girls, the majority of whom were students with additional heavy domestic workloads. The NGO first gained the support of the girls' parents and the wider community through focus group discussions, interviews and the simultaneous implementation of an AIDS awareness programme for the entire community. The programme for the girls ensured that they would be able to attend sessions by providing childcare so that they had time off from caring for their siblings. Highly participatory teaching methods such as story-telling and games focused on helping the girls become more self-confident and able to express their own feelings, opinions and criticisms. Evaluations showed that the girls improved their knowledge about menstruation, reproduction and HIV/AIDS. About 62 per cent had talked to others about HIV/AIDS as well.

Source: Commonwealth Secretariat and Healthlink Worldwide, 2001; UNAIDS, 2001a

Box 11: Seven Principles for AIDS Action among Young People

At the 1995 International Conference on STI/AIDS in Kampala, a group of young Africans from 11 countries put forward a series of seven principles which they saw as essential for effective AIDS action:

- The participation of young people in programme planning, implementation, monitoring and evaluation;
- Provision of youth-friendly services and centres where young people can access information, support and referral;
- Parental involvement in giving better communication, guidance and support to young people;
- Promotion of skills-based education about HIV/AIDS;
- Protection of girls and women against sexual abuse and exploitation, and sensitisation and education of boys and men about their sexuality and behaviour;
- Establishment of networks for young people, including those living with HIV/AIDS, for prevention, protection of human rights and promotion of acceptance by society;
- More commitment and more responsible decision-making by young people themselves about their sexual behaviour and influence on peers.

Source: Matlin and Spence, 2000

young men and women around the world are sexually active. Young women and men need to receive sex education so that they are well-informed about the reproductive process as well as the positive and negative consequences of sex (De Bruyn, 2000). Sexuality education has to de-stigmatise the issue of HIV infection, so that condom use and the risks of unsafe sex can be openly and rationally discussed in the community.

Ideally, education programmes should start before young people become sexually active and should be combined with education about women's rights. By reaching pre-teens and older children, programmes can affect their emerging norms.

Participants in the Caravan of Artists and Youth Against AIDS in Haiti.
The Panos Institute/Fritznel Octave

For example, the very young (6- to 10-year-olds) can be exposed to messages about healthy body image, body sovereignty (good touch versus bad touch) and support of people living with HIV/AIDS (Family Health International, 2001a).

Education can also impart negotiation and decision-making skills that young people can use to prevent unwanted sexual relationships and protect themselves from exploitation and violence (UNFPA, nd). Far from sex education promoting promiscuity, numerous studies complied by UNAIDS and its co-sponsors (UNICEF, UNDP, UNFPA, UNDCP, ILO, UNESCO, WHO and the World Bank) have found the opposite to be true. They show that when people have information about sex, they tend to delay sexual intercourse or use condoms, and that it is ignorance that increases their vulnerability to infection (UNAIDS, 2001b).

Discussing cultural taboos around sex, reducing embarrassment and making information and protection available are key factors in achieving better outcomes. Where social and sexual inequities are learned cultural norms, these need to be addressed. It can be counter-productive for educational programmes to ignore the role such norms play in preventing young people from protecting themselves. Calling attention to

Two secondary school students take part in a role-play about condoms at a meeting of a youth health development programme in Namibia.
UNICEF/HQ00-0103/
Giacomo Pirozzi

them can result in breakthrough behaviours and the gradual acceptance of role changes. Where prevention efforts focus on both young men's and women's responsibilities to prevent disease, the common idea that young women are solely responsible for prevention is gradually weakened. When young women are helped to negotiate personal safety in sexual activity, respect for sexual activity as a mutual decision between equals is reinforced.

Young people are empowered when "they acknowledge that they have or can create choices in life, are aware of the implications of those choices, make an informed decision freely, take action based on that decision and accept responsibility for the consequences of that action" (Commonwealth Secretariat, 1998). They are the best resource for tackling the challenges and problems facing them and should play a central role in AIDS prevention and care programmes. Strategies need to be developed that utilise their energies and expertise, and make them active partners in the design, delivery and evaluation of such programmes. Innovative approaches need to be developed in dealing with different groups of young people, espe-

cially those with special needs. Television, radio, street dramas, plays, art, games and the Internet are effectively being utilised to reach young people with messages consistent with their needs. Young people are more likely listen and retain what is being taught when they are also having fun (Family Health International, 2001a).

Since young people respond best to other young people – where they work, study, and play – peer education/promotion/motivation is a crucial outreach strategy (Family Health International, 2001a). Initiatives such as the Commonwealth Youth Programme's 'Ambassadors for Positive Living' have demonstrated that peer counselling, including that by young people living with HIV/AIDS, can have a powerful effect. These Ambassadors have set up networks of support among HIV-positive youth and meet with their peers in schools, youth groups, churches and military establishments in East and Southern Africa. They have also raised awareness among ministries of youth and health through persistent advocacy and campaigning.

The Role of Gender-based Violence in the Spread of HIV/AIDS

Gender-based violence is a serious problem and an issue both of social justice and human rights and of health and human welfare. It takes many forms and can include physical, emotional or sexual abuse. While both males and females can suffer from gender-based violence, studies show the women, girls and children of both sexes are most often the victims (UNAIDS, 2001a).

One in every three women in the world has been beaten, raped, coerced into sex or physically abused in some way, usually by someone she knows (UNFPA, 2000b). According to the World Bank, gender-based violence accounts for more death and ill health among women aged 15 to 44 worldwide than cancer, traffic injuries and malaria combined (Rose, 2001). The experience of violence, or fear that it might take place, disempowers women in their homes, workplaces and communities and limits their ability to participate in and benefit from initiatives for HIV prevention and AIDS mitigation (Southern African AIDS Training Programme, 2001).

The most pervasive form of gender-based violence is that committed against a woman by her intimate partner.

Domestic violence

The most pervasive form of gender-based violence is that committed against a woman by her intimate partner. Between 10 and 50 per cent of all women worldwide report physical abuse of this kind (WHO, 2000a). Violence between intimate partners is often connected to marital rape, coerced sex or other forms of abuse that lead to HIV risk. A study in Tanzania, for example, showed that women specifically avoided raising the issue of condoms with their husbands for fear of violent retaliation, while fewer than 25 per cent of Zambian women agreed that a woman could refuse to have sex with her husband, even if he was known to be violent, unfaithful or HIV positive (UNAIDS, 2001a). Research amongst HIV-positive African-American women in the USA and poor HIV-positive women in Canada has also found violence to be a central feature of their lives (Albertyn, 2000).

The worldwide prevalence and tolerance of violence against women at individual and systemic levels seriously limits their abilities to protect themselves or their children from sexually transmitted infections. All forms of coerced sex – from violent rape to cultural/economic obligations to have sex when it is not really wanted – increase the risk of microlesions and therefore of STI/HIV infection (WHO, 2000b). Young women are especially vulnerable since their immature genital tract is more likely to tear during sexual activity.

A study of young women in South Africa revealed that 30 per cent reported that their first sexual intercourse was forced, 71 per cent reported having had sex against their will and 11 per cent reported being raped (UNAIDS, 1999). A recent study by Sakshi, an NGO in India, has shown that 60 per cent of the 13–15-year-olds in schools studied had been victims of some kind of sexual abuse, 40 per cent within families, and 25 per cent were victims of serious abuse such as rape (Nath, 2001b). Women later in life are also particularly vulnerable to violence as a result of economic insecurity and, in some societies, diminished social status. Violence against older women can include rape, posing a risk of HIV transmission (UNAIDS, 2001a).

Box 12: Health Canada Initiatives on HIV and Sexual Violence Against Women

Since 1997, Health Canada has funded a series of initiatives on HIV and sexual violence against women. The main objectives of these initiatives are to raise awareness of the links between HIV and violence against women and to provide counsellors and survivors with up-to-date information in this area. The initiatives include:

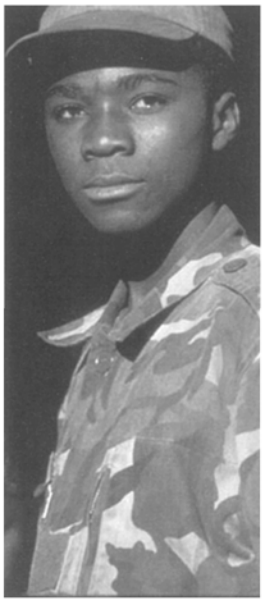
- a guide for counsellors that addresses the connections between HIV and various forms of violence against women, and related issues such as risk reduction, HIV testing and post-exposure treatment;
- a training manual that provides information on how to plan and implement community training related to HIV and sexual violence;
- a brochure on HIV and sexual assault for survivors, and Asian, Aboriginal and Inuit ethno-cultural adaptations of the brochure.

These are available from the Canadian HIV/AIDS Clearinghouse website at www.clearinghouse.cpha.ca/clearinghouse_e.htm (Toll free phone: 1-877-999-7740, fax: 613-725-1205)

Situations of armed conflict

Gender-based violence is particularly prevalent in armed conflicts, with hundreds of thousands of women raped in wars during the last century. Women and girls make up 75 per cent of the world's 22 million refugees, asylum seekers or internally displaced persons, putting them at particular risk of such violence. Women can be raped by all sides in a conflict. The 10-year-old civil war in Sierra Leone, for example, was characterised by many instances of physical and sexual abuse of women and, in some rural areas, women were forced to give sexual favours to their 'protectors', whether rebels, soldiers or Civil Defence Forces (Forster, 2000).

Military personnel tend to have rates of STIs – which can



A child soldier in Luena, Angola. Soldiers can be at major risk of acquiring and passing on HIV.
UNAIDS/Chris Sattlberger

increase the risk of HIV – two to five times higher than those of the civilian population even during peacetime. During armed conflict, the rate can increase by 50 times. In Sierra Leone, over 60 per cent of the soldiers tested were reported to be HIV positive (Forster, 2000). Since soldiers are typically young, sexually active men, they are also likely to seek commercial sex (Machel, 2001), increasing the spread of infection.

The social upheaval caused by armed conflict – including loss of local social systems and mass migration – also contributes to the spread of the disease. War breaks up families and communities. It destroys the health services that could identify the diseases associated with HIV/AIDS or screen the blood transfusions that might transmit it, and destroys the education systems that could teach prevention and slow the number of infections (Machel, 2000). It forces women to sell themselves as a means of survival. HIV/AIDS also serves to prolong conflict as it places new strains on health and economic infrastructures and destabilises family and social structures (Kristoffersson, 2000). The links between AIDS and conflict thus run in both directions and reinforce each other, and both are exacerbated by poverty and the gender dimensions of conflict and the pandemic (Machel, 2000).

The UN has declared AIDS to be a security issue because of the potential of conflicts to create the enabling environment for the spread of HIV and other STIs (Forster, 2000). The UN Security Council Resolution on Women, Peace and Security (United Nations, 2000) asks states to incorporate HIV/AIDS awareness training into their national training programmes for military and civilian police personnel, as well as guidelines and materials on the protection, rights and the particular needs of women. It recommends that civilian personnel of peacekeeping operations should receive similar training.