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WOMEN AND HIV/AIDS *

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A. INTRODUCTION

In a December 2002

"The HIV/AIDS pandemic and its gender implications", organized by the United Nations Division for the Advancement of Women in Namibia in 2000, concluded that inequality and women's disempowerment at different levels – in families, in decision-making at community and other levels, in education, in employment and economic opportunities – can be linked to the rate of spread of infection and the severe impacts on families, communities and countries (UN Division for the Advancement of Women, 2000).

Women must, however, not be seen only as vulnerable. Women and girls are also actors and change agents. The active mobilization of women and support to their efforts can enhance the social, economic and political empowerment of women, and as a result support more effective preventative strategies and appropriate approaches to address the consequences of HIV/AIDS.

B. CAUSES AND IMPACTS OF HIV/AIDS ON WOMEN AND GIRLS

There are critical differences and inequalities between women and men to consider in relation to prevention of HIV/AIDS; the risks of infection, including factors identified as increasing vulnerability, such as health and nutritional status and poverty; the social impact and socio-economic consequences of infection on individuals at both household and community level and possible means of addressing these; as well as access to and quality of care.

Health-based approaches to HIV/AIDS initially failed to give adequate consideration to the critical social, cultural, and economic factors underlying the spread of HIV/AIDS and to understand its differential impacts. While there are important physiological reasons for women's susceptibility to infection, there are also major socio-cultural and economic factors which need to be identified and addressed. Today, there is recognition of the need to move beyond the epidemiological dimensions to also identify and address the wide range of driving factors in a holistic manner, which includes a human-rights approach. Increasing the effectiveness of existing strategies and approaches requires greater explicit attention to the situation of women and girls. Progress in responding effectively to HIV/AIDS is dependent on what is done for women and girls (UNAIDS, 2003).

The lack of control by women and girls over their own bodies and sexual lives, in the context of more general socio-economic and political inequality and subordination they face, is a critical factorTc 11.98pC to the situation of rm007 Tc -026 20.0007 Tc -0.0018 Tw 11.988 0 0 11.988 71.9996sc

stereotypes, attitudes and beliefs about both women and men remain a serious obstacle to preventing the spread of HIV/AIDS. One example is the commonly held belief in some cultures that having a variety of sexual partners is acceptable for men and even considered an essential aspect of masculinity (ibid). A study of women from over ten countries revealed that "*Though many women expressed concern over the infidelities of their partners, they were resigned to their lack of control over the situation. Women from India, Jamaica, Papua New Guinea, Zimbabwe and Brazil report that raising the issue of their partners' infidelity can jeopardize their physical safety and family stability*" (Gupta and Weiss, 1993).

Male violence against women – based on existing inequalities and power disparities in societies – is one of the critical stumbling blocks in the development of effective prevention strategies for HIV/AIDS. In violent relationships, women and girls have little means of protecting themselves from infection. Women may have to put themselves in situations of risk of HIV infection rather than risk injury or death for themselves or their family members at the hands of a violent partner. As a result, many women and girls live in intolerable environments of fear – fear of the violence itself and fear of the consequences of not being able to say no, to make demands and to protect themselves.

The links between HIV/AIDS and poverty are complex but critical. Poverty is not only a cause but also a consequence of HIV/AIDS (UN Division for the Advancement of Women, 2000). While poor and non-poor alike are affected, the persistent poverty in many parts of the world facilitates the spread of HIV/AIDS. People living in poverty are more likely to become sick and can die more quickly due to malnutrition and lack of access to appropriate health care (Collins and Rau, 2000). Poverty can reduce access to treatments for opportunistic infections and the dietary supplements required to strengthen the immune system (UN Division for the Advancement of Women, 2000). The consequences of HIV/AIDS epidemics are most severe in regions where deep poverty and economic inequality exist, gender equality is pervasive and access to public services is limited (Collins and Rau, 2000).

The vast majority of the total number of people living with HIV are in the developing world, with 71 per cent of the men, women and children infected living in Sub-Saharan Africa (UNAIDS, 2002). The gender perspectives in terms of causes of poverty, impacts of poverty and potential for developing adequate coping strategies, need to be given more serious consideration in work on HIV/AIDS. Poverty may prevent women from accessing information on safe and responsible sexual relationships and the risks of HIV/AIDS, as well as on their rights and the support mechanisms available. Poverty may also prevent women from se. Po

find it difficult to live a life of dignity and freedom. Stigmatization can lead to violation of human rights in relation to continued education or employment, as well as at the level of privacy, confidentiality and freedom of movement. Stigmatization can be more extreme for women and girls because of existing stereotypes, inequalities and patterns of discrimination in society, and HIV-infected women can find their human rights at greater risk. In the context of reproductive health, women face new risks. Control over reproductive health choices for HIV-infected women may be exerted by healthcare workers, without the full involvement of the women themselves (Seidel and Tallis, 1999). Women can also face judgemental and hostile attitudes from service providers or even be denied access to services (Manchester and Mthembu, 2002).

Stigma and discrimination on the basis of HIV status stifles open discussion on causes of HIV/AIDS and appropriate responses (Aggleton and Parker, 2002). It can lead young women to neglect their reproductive health needs, to fail to access necessary information, and to postpone seeking treatment and care. Women who are HIV-infected, or suspected to be infected, can be subjected to discriminatory treatment such as abuse and rejection by their families and communities or dismissal from employment (Tallis, 1998). Women may also lose their rights to property or even their children (UNAIDS, 2003). Where women's value is linked to their children, women may risk infection to become pregnant rather than face the stigma of childlessness. To reduce risk of stigmatization, women may choose to continue to breastfeed their babies rather than disclose their infection status (BRIDGE, 2002). Gender-based violence can also increase where women are blamed for the spread of the virus and stigmatized as promiscuous. Factors such as age, disability, socio-economic position, membership of a particular ethnic, racial or religious group can lead to increased forms of discrimination for women and girls, particularly in relation to HIV/AIDS. Failure to address the differences between groups of women can obscure serious issues of double discrimination for some groups of women.

It is important to understand and highlight the direct impact of the roles of women and men and the relationships between them on the responsibilities imposed by infection of women or men themselves or of family members. Women bear a huge responsibility of care in relation to HIV/AIDS, in both the formal and informal sectors. Inability of healthcare systems to cope with the demands of caring has pushed responsibility into the domain of the family and community. While community and family-based care can be a very effective and humane support strategy, it often relies to a very large extent on the inputs of women. Caring for sick family members, in addition to the other reproductive and productive responsibilities women have, can have severe physical, emotional, social and economic consequences, including leading women to neglect their own health and wellbeing.

Coping with the medical costs of HIV infection and providing for families economically following the death of males in the family also places a large burden on women, Women and girls do not have the same access to economic resources, including land, and this can make survival precarious in many rural areas. Inadequate access to labour, income and food supplies also hinder women's efforts to provide for their families. This results in children, particularly girls, being withdrawn from school to provide different forms of support. In urban areas, women may lack the support of extended families or other social support systems. In areas with high death rates of women and men in productive years, older women face enormous responsibilities without financial and other resources to ensure the survival of their grandchildren and other relatives.

There are gender differences and inequalities in access to health information and health care, including access to more expensive drugs and treatments. Factors such as economy, time, mobility and attitudes of healthcare workers can negatively impact women's access to adequate and appropriate treatment and care. In developing countries, men working in the formal sector may also have greater access than women to workplace clinics and medical benefits (Tallis, 2001). Gender disparities in access to education in many areas – which can be exacerbated in areas with high infection rates as girls are taken out of school to provide care – can reduce the effectiveness of information programmes through schools. In some cases gender stereotypes, particularly related to cultural images of aggressive, dominant masculinity and stereotypes of women as hopeless victims, have been utilized to get HIV/AIDS advocacy messages across, which can entrench existing stigma, stereotypes and discrimination. This can include, for example, advocacy materials which focus negatively on sex workers as the source of infection (Gupta, 2000).

Although women were diagnosed with HIV/AIDS in the early 1980s, there has been little investigation of the differences between women and men in disease progression, opportunistic infections and disease management strategies. By the end of 1999, women accounted for only 12 per cent of trial participants (BRIDGE, 2002). Some research has shown that there are differences between women and men in length of survival, levels of viral load and drug toxicity. Differences in disease progression for women and men cannot be ignored in treatment. Antiretroviral treatment and opportunistic infection management has to be tailored specifically for women and men (ibid).

As well as addressing the socio-cultural, economic and political factors operating at local and national levels – including urbanization, violence and lack of security, discrimination of specific groups, religious beliefs and practices – it is equally critical to identify the impact of global and regional factors such as the increased trafficking of women, and situations of armed conflict, on the spread of HIV/AIDS and the particularly vulnerable position of women and girls in these situations. In armed conflict and its aftermath, women and girls can be subjected to rape and other forms of sexual exploitation, including trafficking, which are linked to political instability and lawlessness, lack of adequate protection of women's human rights and impoverishment.

C. IMPACTS OF FEMALE MORBIDITY AND MORTALITY

AIDS is now the leading cause of death in Sub-Saharan Africa and the fourth cause of death globally (UNAIDS, 2002). The latest figures indicate an increasing impact of the HIV/AIDS epidemic on women and girls (UNAIDS, 2003). Apart from the impacts at individual level, there are serious social, economic, political and demographic consequences which need to be addressed in a gender-sensitive manner.

education and development of girls as they are forced to take over many of the responsibilities of their mothers. These negative consequences for individual girls can have more long-term impact on development at family and community levels. Older women – grandmothers and other relatives – may have to take over the raising of children and to provide for young orphaned relatives.

In developing countries, particularly in Africa, women play a crucial role in agricultural production. HIV-infected women may find they are unable to maintain normal levels of production, with health and nutrition implications for themselves and their families. In female-headed households, the lowered production levels through HIV infection or death of the head of household has serious developmental impacts for families and communities.

Since the work of women in the home, the community and in informal sectors is not

not go far enough. It is important to ensure that the information required to address the critical gender perspectives identified is collected and used in analysis and policy making and planning processes. Ensuring that gender perspectives are an integral part of all research requires that terms of reference for studies take up gender perspectives specifically; that researchers are briefed adequately on requirements for incorpor

Some form of institutional development – through the appointment of gender specialists or establishment of capacity-building activities – is usually needed.

Activities such as education for HIV/AIDS prevention must take into account the realities of women, men, boys and girls, be adapted to their needs and be accessible to all. Policy development and planning in the provision of care must consider the roles and responsibilities of women and men, particularly in terms of the care provided in the home, and the impact of the burden of care on the survival of the rest of the family. Gender perspectives need to be identified in relation to access to different types of medical treatment and services. Development interventions to support households and communities suffering negative socio-economic impacts of the epidemic must consider the roles, responsibilities and needs of women as well as men, particularly in relation to extension services, credits and other resources.

Ensuring appropriate and effective strategies and approaches to prevent the spread of HIV/AIDS is dependent on the adequate involvement of women as well as men. Women should be consulted and involved in the establishment of priorities, the development of overall policies and strategies, and the design, implementation and monitoring of programmes and projects. Women's groups and networks should be given a stronger voice in decision-making at all levels.

In conclusion, there are some positive developments which can contribute to ensuring that future work on HIV/AIDS is informed by an understanding of the realities, contributions, needs and priorities of both women and men and lead to more effective strategies. The gender perspectives of HIV/AIDS and the particularly vulnerable situation of women and girls, have been highlighted in major United Nations events over the past few years and clear goals and targets have been defined. The Millennium Summit in 2000 established the target to have halted and begun to reverse the spread of HIV/AIDS by 2015, and to provide special assistance to children orphaned by HIV/AIDS. The Millennium Development Goals also provide an opportunity for giving greater attention to the situation of women. The sixth Millennium Development Goal focuses on combating HIV/AIDS, malaria and other diseases. While promotion of gender equality is a separate Millennium Development Goal, Goal 3, it is critical to incorporate gender perspectives into all other goals. In this respect it is necessary to closely link Goal 3 on promoting gender equality with Goal 6 on combating HIV/AIDS, malaria and other diseases and to identify and address gender perspectives in the implementation of Goal 6.

The United Nations General Assembly Special Session on HIV/AIDS in June 2001 highlighted the centrality of gender inequality an

and eliminate discrimination in different areas of women's lives, by legislative change, policy development as well as specific programmes and projects. The Convention addresses the need for women and girls to receive information on reproductive health. The general recommendations on HIV/AIDS, women and health and violence against women prepared by the Committee on Elimination against Women provide further guidance to States parties, emphasizing the need for increased public awareness of the risk of HIV infection and AIDS, especially among women and children. The Committee has repeatedly raised the issue of HIV/AIDS in considering reports of States parties and made specific recommendations, particularly related to increased information, education and services.

UNAIDS recently established a Global Coalition on Women and AIDS, involving both the United Nations and NGOs, which aims at increasing the visibility, effectiveness and synergy of efforts related to women and AIDS and creating a global movement to mitigate the impact of AIDS on women's daily lives. The Coalition recognizes that sustained changes in the vulnerability of women and girls to HIV/AIDS will require fundamental shifts in the relationships between men and women and in the way societies view women and value their work and contributions. It highlights the factors making women and girls vulnerable as being largely related to the behaviour of others, to their limited autonomy and to social and economic inequities beyond their control. Zero tolerance on violence against women, protection of the property and inheritance rights of women and girls and attention to men and boys are

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