



Facing

the challenges of

HIV

AIDS

STDs :

**a gender-based
response**

Understanding gender issues

Strategies to deal with HIV / AIDS

Interventions that work

Personal testimonies

Additional reading

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Editorial Advisory Committee

Teresita Bagasao, Kabalikat ng Pamilyang Pilipino (The Philippines); Marge Berer, Reproductive Health Matters (United Kingdom); Mabel Bianco, Fundación para Estudio e Investigación de la Mujer (Argentina); Michele Bird, International Community of Women Living with hiv/aids (United Kingdom); Aine Costigan, Interagency Coalition on aids and Development (Canada); Nel Druce, Ahrtag (United Kingdom); Jacques du Guerny, Chief, Population Programme Service, Women's and People's Participation Division, fao (Italy); Jane Galvao, Abia (Brazil); Hannah Jansen, Positive Women Section, hiv Association (The Netherlands); Ethel Kapyepye, unv Mansa (Zambia); Olusegun Obasanya, Federal Ministry of Health Lagos (Nigeria); Sunanda Ray, Women and aids Support Network (Zimbabwe)

Facing the challenges of hiv/aids/stds: a gender-based response

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Text written/compiled by: Maria de Bruyn, Helen Jackson, Marianne Wijermars, Virginia Curtin Knight and Riet Berkvens

Photographs from: Roel Burgler, G. Diez, kit, who

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EXECUTIVE SUMMARY

» This publication aims to provide policy-makers, planners and programme implementers with information and ideas on how to incorporate a gender-based response to HIV/AIDS and STDs into their policies and programmes.

After outlining the global epidemiology of HIV infection, AIDS and STDs, it explores the concepts of gender and a gender-based response. The focus of the next section is the impact of the epidemic, elaborating on how gender-related factors affect HIV-infection risks and obstacles to prevention and care. Then gender-based responses and strategies are suggested and described.

Personal testimonies and brief descriptions of programmes and interventions personalize the text, show the impact of gender inequality on female and male risk and coping, and provide examples of effective responses.

To conclude, a checklist is provided for assessing the gender-based focus of existing or planned programmes and interventions.

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Why gender and HIV / AIDS / STDs?

» *“One of the most striking features of the response to the HIV epidemic to date is how few of the policies and programmes we have developed relate to women’s life situations. The daily lives of women and the complex network of relationships and structures which shape them are well known to women and well documented. Despite this, our theories, research agendas, policies and programmes have not been grounded in and informed by these experiences.”*

E

As the HIV/AIDS epidemic and sexually transmitted diseases (STDs) continue to advance worldwide, we are learning ever more about how they affect individuals, households, families, communities, organizations and nations. The individual loss has been enormous, particularly in those countries and regions affected early on. AIDS is increasingly recognized in developing countries as a serious concern for socioeconomic development as a whole. Its impact is seen in family and community structures and relationships and in sectors as varied as education, employment, health care, social welfare, agriculture and the judiciary.

Economic consequences are already apparent. In highly affected countries, the business sector is experiencing increased absenteeism as employees fall ill, care for the sick or attend funerals. Loss of experienced and skilled workers in the formal and informal sectors may lead to lower productivity, savings and investments. In subsistence and small-scale agriculture, loss of labour may result in changes in farming patterns and food shortages.

Strategies to prevent the spread of HIV have focused on the promotion of condom use, reduction of numbers of sexual partners and treatment of STDs [2]. Many of these responses, however, have failed to address social, economic and power relations between women and men, among men and among women. These relationships, together with physiological differences, determine to a great extent women’s and men’s risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic:

- Women are physiologically more vulnerable to HIV infection than men. Young women are especially at risk and AIDS death rates are highest in women in their 20s.
- Stereotypes related to HIV/AIDS and STDs and their association with marginalized groups (e.g., sex workers) contribute to blaming women for the spread of HIV. Fear of stigmatization inhibits people from taking preventive measures and leads women and men to assess their own risks inadequately. Moreover, many ideas and expectations regarding male and female (sexual) behaviour neither encourage men to act responsibly and protect themselves and their partners from infection nor stimulate women to challenge notions of female inferiority and social structures which keep them vulnerable.
- Low social status and economic dependence prevent many women

and young people (e.g., street-children) from controlling their own risk. With little negotiating power, they are often unable to insist on safer sex; disproportionately poor, they may have little choice other than to barter sex for survival.

– As society's traditional care-givers, women carry the main psychosocial and physical burdens of aids care. Yet they have the least control over and access to the resources they need to cope effectively; few men share domestic responsibilities and family care with their partners.

Although the necessity of focusing on women's needs has been highlighted time and again, especially since 1990 when the theme of World aids Day was "Women and hiv/aids", women continue to bear the brunt of the epidemic and to be highly vulnerable to infection. Reducing their – and men's – risk of infection demands gender-based responses that focus on how the different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic. This involves analysis of gender stereotypes, redefinition of male and female relationships and roles, promotion of cultural beliefs and values supporting mutually responsible behaviour and exploration of ways to reduce inequalities between women and men. A supportive environment can be created thereby, enabling women and men to undertake prevention and cope better with the epidemic.

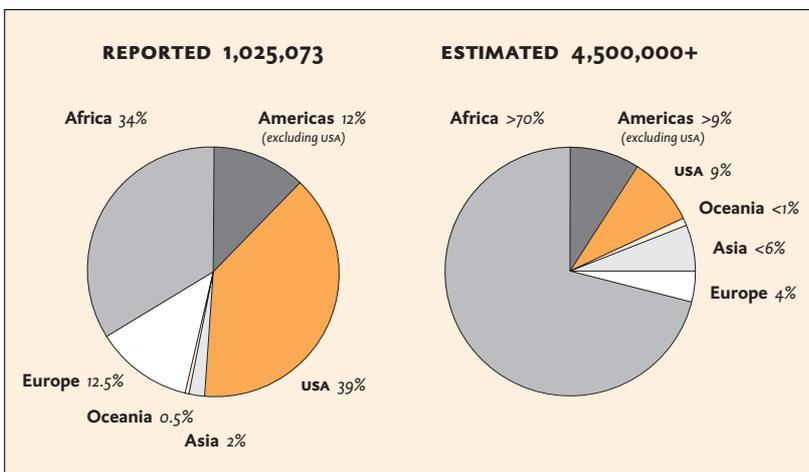
Women and men both have much to gain from increased gender sensitivity in general development policy, planning and programmes, and particularly by national aids/std programmes, aids service organizations and related services. At all levels a gender-based focus on problems and solutions is urgently needed.

This publication aims to provide policy-makers, planners and programme implementers with information and ideas to help them incorporate a gender-based approach to hiv/aids and stds into their policies and programmes. It highlights the nature and scale of the epidemic, explores the concepts of gender and a gender-based approach and the ways hiv/aids and stds affect and are affected by gender. Suggestions are made for approaches and strategies to address some of the problems.

It is hoped that the analysis, information, ideas and examples will help stimulate many more gender-sensitive initiatives to help us cope with hiv/aids and stds more successfully.

A gender-based response to HIV/AIDS and STDs focuses on how different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic. It analyses gender stereotypes and explores ways to reduce inequalities between women and men so that a supportive environment can be created, enabling both to undertake prevention and cope better with the epidemic.

How extensive are HIV/AIDS and STDs?



At the end of 1994, a cumulative total of 1,025,073 aids cases (adults and children) worldwide had been reported to who. The actual number of aids cases is unknown because of under-diagnosis, incomplete reporting and reporting delays. However, an estimated 4.5 million aids cases have occurred in adults and children since the beginning of the epidemic (Fig. 1).

An estimated 18 million adults (13-15 million alive) and 1.5 million children have been

Figure 1 Total numbers of reported and estimated AIDS cases (adults and children) from the late 1970s/early 1980s until late 1994 (Source: WHO/GPA)

infected with hiv. Of the adults, 7-8 million are women (most of child-bearing age, Fig. 2). who forecasts that, by the year 2000, 30-40 million hiv infections will have occurred, 90% in developing countries. Moreover, an estimated 5 million children under 10 years of age will be orphaned, losing one or both parents.

Figure 2 Estimated distribution by region of total HIV infections in adults (bold) and women (italics) from the late 1970s/early 1980s until late 1994 (Source: WHO/GPA)



The proportion of women with hiv and aids has increased dramatically. By 1994, women represented 40% of all new aids cases; up to 50% of all new hiv infections were in women, mainly those aged 15-24 years.¹ Female vulnerability has become increasingly clear in Africa and Asia. By the year 2000, an estimated 14 million women will have been infected with hiv and about 4 million will have died of aids.

hiv is transmitted predominantly through sexual intercourse (70-80% of infections). Mother-to-child transmission and needle-sharing by drug users each account for 5-10% of all hiv infections, while needle-stick accidents among health workers account for less than 0.01% of reported cases.

Higher proportions of young women than young men acquire hiv infection through sex. Their exposure to the virus at an earlier age, coupled with physiological factors, increases their risk (see page 10). In countries with high hiv prevalence, the greatest numbers of reported aids cases occur among women aged 15-34 years and men aged 25-44 years (Fig. 3).

hiv infection due to blood transfusion is more common in women than men. Women more often have blood transfusions because of anaemia and complications during pregnancy and childbirth. Perinatal transmission occurs during pregnancy, delivery or breast-feeding. The chance that a child of a seropositive woman will also be infected with hiv-1 is 33% overall, with transmission reported to be as high as 48% in some developing countries^[3].

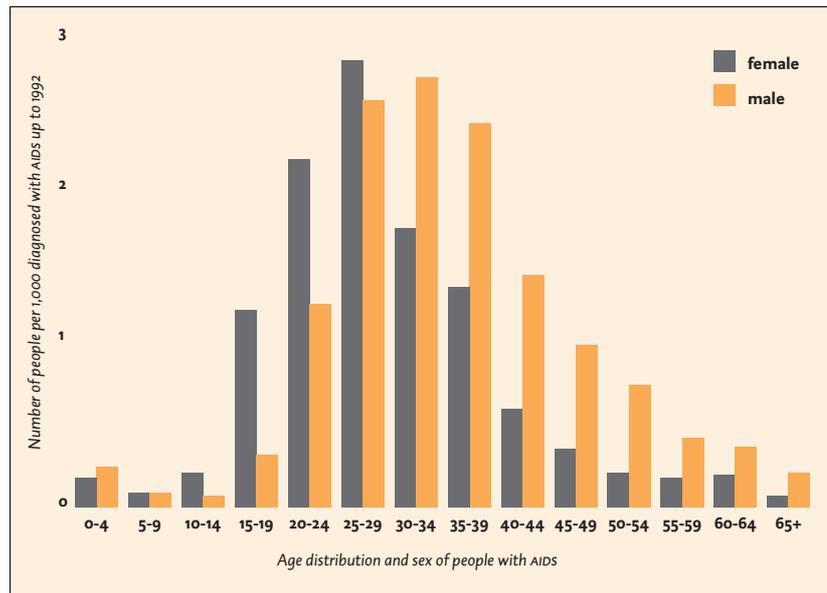


Figure 3 Age and sex distribution of cumulative totals of people reported to have AIDS (Source: "Young people first!", AIDS Action, 1994, 25, p. 2)

REGIONAL PATTERNS

In regions where initially more men than women were infected, there is now a marked increase in infections transmitted through heterosexual intercourse. In Europe, 15.4% of new infections in adults in 1993 were due to heterosexual transmission. In France, heterosexual transmission increased from 19% in 1991 to almost 25% in 1993. In 1993 in the USA, AIDS cases in women were almost 10% higher than in 1992; in nine major cities AIDS has become the leading cause of death among women of childbearing age.

In sub-Saharan Africa, HIV has been transmitted predominantly through heterosexual intercourse since the beginning of the epidemic. More than half of newly infected adults are female (11-12 women for every 10 men). The annual number of infections is still increasing. In Francistown, Botswana, for example, HIV prevalence in pregnant women rose from 8% in 1991 to about 35% by 1993. In some countries, e.g., Côte d'Ivoire, Zaire and Uganda, AIDS has become the leading cause of adult death^[4].

¹ All figures are based on who reports unless otherwise indicated.

Seroprevalence rates in North Africa and the Middle East appear relatively low but are increasing. In Djibouti, for example, hiv prevalence has reached 14% among men attending std clinics and 4% among women seeking antenatal care.

In Latin America and the Caribbean region, a shift from transmission through primarily homosexual intercourse to bisexual and heterosexual transmission as well as injecting drug use has taken place since the early 1980s. In Brazil, one woman was infected with hiv for 100 men in 1984; by 1994 this was one woman for four men.

Half of the newly infected adults in Asia are women. In a border town in Shan State, Myanmar, 6-10% of women registered at public maternal and child health centres were already seropositive in early 1995 [5].

Figure 4 (above) *New cases/year of curable STDs in the world (Source: WHO/GPA)*

Figure 5 (below) *Estimated new cases/year of treatable syphilis, gonorrhoea, chlamydia and trichomonas (Source: WHO/GPA)*

SEXUALLY TRANSMITTED DISEASES

std rates remain high in much of the world. Each year about 330 million new cases of stds occur, of which more than 90% are in developing countries (Figs 4-5). Overall infection rates for stds are higher in women than men. Ulcerative stds, including syphilis and chancroid, and stds causing inflammation, such as gonorrhoea and chlamydial infection, facilitate transmission of hiv in both women and men.

Women, however, are disproportionately affected. As with hiv, women often acquire stds at an earlier age than men. Gonorrhoea and syphilis are asymptomatic in 50-80% of women against less than 10% of men. In women, they often go untreated, especially in countries with inadequate std programmes. The secondary health consequences of stds are more serious for women as they may contribute to infertility, ectopic pregnancy, cervical cancer, premature delivery, stillbirth, low birth weight and neonatal infections. Ectopic pregnancy, cervical cancer and sepsis following pelvic inflammatory disease can be fatal.



What does a **gender-based response** involve?

What changes are needed to create an environment enabling women and men to protect themselves and each other? How can they collaborate equally in providing adequate care and support for those directly affected by the epidemic? Gender-based approaches can help us answer these questions in a way which orients programmes towards promoting social changes supportive of hiv/aids and st d prevention and care.

Gender refers to widely shared ideas and expectations (norms) about women and men: ideas about “typically” feminine and masculine *characteristics* and *abilities* and expectations about how women and men should *behave* in various situations. These ideas and expectations are learned from families, friends, opinion leaders, religious and cultural institutions, schools, the workplace and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.

Status and power affect the individual’s risk of infection and communities’ abilities to cope with the epidemic. The low status and power of women and young people lead to their subordination and restrict their possibilities of taking control of their lives in relation to hiv/aids and st ds. Societal pressures also make it difficult for men to change their behaviours in this regard. Their sexual behaviour may be influenced by their relations with other men and women (e.g., fathers, sons, mothers, sisters, peers) ^[6].

Below, three examples show how gender is related to norms affecting hiv/aids and st d prevention and care. The examples are simplified. In-depth gender analysis would also consider other differences that interact with gender to create situations of dominance and subordination, such as age, class, ethnicity and religion ^[7].

NORMS CONCERNING PARENTHOOD

In most societies, women’s primary role in life is to bear and nurture children. Although responsible fatherhood may be promoted,

Gender refers to widely shared ideas and expectations (norms) about women and men: ideas about “typically” feminine and masculine characteristics and abilities and expectations about how women and men should behave in various situations. These ideas and expectations are learned from families, friends, opinion leaders, religious and cultural institutions, schools, the workplace and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.

men's main duty is seen to be earning a living and dealing with the broader society on behalf of the family.

Such norms have two broad implications in relation to hiv/aids and stds. First, a false division is made between "reproductive" (women's) and "productive" (men's) roles [8]. The expectation that women must care for the children is extended to all household members needing support, e.g., the elderly, those who are ill with hiv/aids and/or orphaned children. Men are not usually expected to undertake care roles.

This supposed division does not correspond entirely to reality, however. Almost universally, women have always undertaken productive as well as reproductive work; it has simply been unpaid, unrewarded materially and unrecognized. In many African countries, for example, well over half of the agricultural work is undertaken by women (68% in Central African Republic and the Congo, 70% in Gambia). Yet women do not gain equal access to educational opportunities or the paid labour market, both of which may contribute to social and economic independence and more self-assurance.

A second consequence is that childless women are not viewed as "fully adult" or may be considered deviant. Their social status is often low. If their childlessness is due to infertility, they may not know this or refuse to accept the diagnosis and try repeatedly (even with a variety of partners) to become pregnant. This of course implies that they have unprotected sex, thereby increasing their risk of exposure to hiv/stds.

Moreover, when childless women express their opinions about community measures needed for hiv/std prevention and care, their suggestions may not be fully respected or accepted by other community members. The voices of women who are mothers may also be given less credibility, because they are expected to confine themselves to household matters.

NORMS CONCERNING SEXUALITY

Among the numerous norms related to sex, many societies share ideas that women seduce men into having sex and that because male sexual needs are so strong, men cannot resist this. Such notions make men appear to be governed by their instincts, unable to control their behaviour and victims of female power. As a result, men are not expected to behave responsibly, while women's sexuality and behavior are controlled. For example, in many countries, girls who become pregnant must leave school, while boys who father children can continue their education with no requirement to contribute to child care. To protect men from themselves, social rules may also deprive women of the freedom to move about freely and lead to situations in which women, instead of their attackers, are blamed for sexual abuse.

These ideas form an obstacle to hiv/std prevention because they absolve men from taking responsibility

Sample statements reflecting the idea that women lure men into sex:

» "Women should wear purdah [head-to-toe covering] to ensure that innocent men do not get unnecessarily excited by women's bodies and are not unconsciously forced into becoming rapists. If women do not want to fall prey to such men, they should take the necessary precautions instead of forever blaming men" (comment by a member of Malaysia's parliament during debates on the reform of rape laws [9]).

» "The child was sexually aggressive" (reason given by a Canadian judge for suspending the sentence of a man who had sexually assaulted a 3-year-old girl [9]).

» "The female condom will increase immorality among women and single mothers. It is worse than the male condom, giving women the opportunity to do what they want. We are going to preach against these condoms - the church cannot condone their use" (parish priest in Kenya [10]).

for their sexual behaviour. They may also prevent women from taking measures to protect themselves. For example, women may be reluctant to buy and carry condoms because they will be accused of wanting to “entice” men into having sex. Women may be reluctant to report abuse because they fear this will affect their position in society: if it becomes known that a young girl has been sexually abused (the result of a trial), in some countries she will have difficulty marrying because both women and men see her as “spoiled”.

NORMS CONCERNING POWER IN RELATIONSHIPS

In many societies, men are expected to control women in all aspects of relationships. This involves decision-making on when and whom a girl/woman will marry, when and how she will have sexual relations, when and how many children she will have, household expenditures, etc.

This type of male power is supported by tradition and social norms. Women learn, for example, that their first loyalty must be to their kin and families, causing them to act in ways that reinforce rather than challenge female subordination. Often, female family members enforce community norms saying, for instance, male relatives must assume authority over widows. In addition, men may impose their will on women, even resorting to violence to do so. Coupled with economic dependence on men, ideas and expectations concerning so-called “proper” male and female roles make it difficult or impossible for women to demand that men share responsibility for preventing sexual and perinatal transmission of hiv/st ds.

Gender analysis and gender-based programmes can help women and men redefine their relationships in a mutually beneficial way. As women move into traditionally “male domains”, men can be encouraged to begin sharing responsibilities in the “female domain”. Some women already exert considerable power, if often in subtle ways. Their existing strengths should be recognized and their self-confidence and social skills expanded. Men can be helped to see how their privileged position and social roles orient them more towards relationships involving authority and competition (and, perhaps, conflict) than collaboration. As the dynamics of male-female relationships change, communities will be able to benefit from the potential of all their members to minimize the impact of hiv/aids and st ds.

» “Right now I’m pregnant. It was an accident, I was planning to go to the clinic but my husband took away my card. He wanted more children so I became pregnant” (woman in Kenya ^[11]).

» “I told my husband that it was better to use condoms, the doctor said so. The doctor had also given me some to use at home. My husband became very angry and asked who gave me permission to bring those condoms home” (woman in Kenya ^[12]).

Men as well as women are trapped by the social and cultural conventions that require women to be subservient. They both need to be freed from the constraints of their social conditioning and helped towards a fairer – and less dangerous – relationship with one another (Photo: G. Diez, WHO)



Why do HIV/AIDS/STDs affect women more?

Women's vulnerability to hiv/aids and stds is partly determined by physiological factors. It further reflects their wider social, sexual and economic vulnerability. The central issue is inequality. Economic need, lack of job opportunities, poor access to education and training and cultural expectations of female submissiveness and male dominance combine to prevent women from actively making choices and decisions about their lives, particularly with regard to limiting sexual risks and protecting their and their families' health. For the same reasons, men are led to deny risk and avoid responsibility, not only for their partners but for themselves. For both sexes this situation needs to change.

PHYSIOLOGICAL VULNERABILITY

Women and men

Researchers estimate that women's risk of hiv infection from unprotected sex is at least twice that of men. Semen, which has high concentrations of virus, remains in the vaginal canal a relatively long time. Women are more exposed through the extensive surface area of mucous membrane in the vagina and on the cervix through which the virus may pass. In men, the equivalent area is smaller, mainly the entrance to the urethra in a circumcised man plus, in an uncircumcised man, the delicate skin under the foreskin. Circumcision in males (not in females!) appears to have some protective value against stds, including hiv. Men and women's risk of hiv escalates manyfold if stds are present^[13].

Young women

Young women are at even greater risk than mature women (except for menopausal women in whom thinning of the vaginal mucosa increases susceptibility to infection). A teenager's vagina is not as well lined with protective cells as that of a mature woman. Her cervix may be more easily eroded, potentially enhancing risk of hiv infection. She also faces potential bleeding at first intercourse through tearing of the hymen. In cultures where sex with very young girls is condoned, sexual intercourse is especially likely to cause trauma. In some countries, girls as young as 12 may be married to men three times their age. In addition, girls aged 17 years or younger who have unprotected sex are at increased risk of developing cervical cancer. Sexually active young women may easily

contract herpes simplex and human papillomavirus infections.

All these factors make young women especially vulnerable at a time when their negotiating and economic power is least, making them easier targets for sexual coercion and exploitation. This situation is worsened when more men, especially in high hiv-prevalence areas, seek out ever younger female partners in the belief that they are least likely to be infected. This is the most risky pattern of sexual partnership, as a group more likely to have hiv already (older men) transmits the virus to a group with low levels of infection (young girls).

Sexually transmitted diseases

who estimates that about 330 million cases of treatable stds exist worldwide at any time. Yet women may have these infections without realizing it; some 50-80% of stds in women are asymptomatic or go unnoticed because they are internal. Women are much less likely than men to seek timely treatment for stds for this reason. Stigma attached to stds, especially for women, inaccessibility of clinics, lack of money and too many other responsibilities further prevent them from getting treatment. Negative attitudes of health workers towards women presenting with stds may be another major deterrent to their seeking treatment or even contraceptive advice. This is true of teenage girls in South Africa, for example [14].

Cultural practices

Certain cultural practices may exacerbate women's physiological risk of hiv infection, especially when hiv is widespread in the population. Many women actively support these practices because they enhance their social status and security with their partners. Examples:

- In some parts of the world, women use herbal and other agents in the vagina to cause dryness, heat and tightness. This practice is carried out because people believe men prefer "dry sex" (in which women feel like virgins) and because they think that female secretions are unclean. The substances used can cause inflammation and erosion of the vaginal mucosa, making it easier for hiv to enter.
- Excessive rubbing of the genitals during foreplay and intercourse, or "rough sex", can lead to sores in the mucous membrane.
- Anal intercourse carries higher risks of hiv transmission because of frequent lesions. Although it is often associated with homosexual contacts, heterosexual couples practise it to preserve virginity, to protect against pregnancy, for (usually male) sexual pleasure and in a search for sexual variety.
- Female genital mutilation (circumcision) is practised in various countries. Infibulation (in which the labia minora and majora are cut away and the vulva is sewn shut leaving a pinhole opening for urination and menstruation) leads to extensive tearing and bleeding when sexual intercourse is attempted. It may also cause couples to practise riskier anal sex instead. The procedure itself could be risky if unsterilized instruments are used for several patients in succession. Less extreme circumcision, like removal of the clitoris hood, carries little risk during sex, but the procedure itself is potentially risky. Bleeding after circumcision may lead to the need for blood transfusions with unscreened, possibly contaminated, blood.

>> Shyamala, India:

"From one end of the room, partitioned by a curtain, a voice, loud and haranguing, came through the silence. It was unmistakably the doctor's. 'Spread your legs!... Tell me, where is it paining? Now tell me properly! Is it or isn't it paining? How are we supposed to understand anything if you won't talk? OK. Now you can go'... Suddenly the nurse's voice boomed: 'Everybody go and pass urine and come back!' I quickly followed three other women towards the single toilet... Back in the waiting room, some men had appeared. Two seemed to have come with their wives and two others... were hospital orderlies. I noticed their eyes stray towards the gap in the curtain" [15].

GENDER-RELATED VULNERABILITY AND OBSTACLES TO PREVENTION AND COPING

Male sexual priority

Commonly, though not universally, male sexual needs are acknowledged to a greater extent than female needs. This may be reflected in the very terminology describing male sexual desire, genitals and partnerships compared with female equivalents. Many cultures use words to describe male sexuality in a positive way and female sexuality in a more negative and judgemental way. Many women and men define sex largely according to what they believe gives men pleasure, particularly penetration. Often women do not explore, let alone assert, their own preferences, because this is considered inappropriate.

“Everything is centred around the pleasure of the man,” says a Zimbabwean woman at a market. She sells herbs which, when put in the vagina, cause dryness and tightness. “So if these substances are harmful or even if discomfort is caused, it doesn’t matter to the woman. She’s doing what she thinks he wants. This is how we have been conditioned” [16].

The dominance of male needs and denial of female needs impedes open discussion between the sexes and limits people’s chances of achieving mutually satisfying, respectful and safe forms of sexual behaviour. To curb hiv transmission, both partners should be able to express their worries about infection and use protective measures such as condoms out of respect and affection rather than as a sign of mistrust.

Sex within marriage, in particular, needs to be a source of mutual pleasure and bonding, rather than only a duty and a condition for procreation. However, it is within marriage or with regular partners that women may have most difficulty negotiating safer sex, such as condom use, as this implies lack of trust and infidelity. But it is essential that they be able to do so, as most hiv-infected women have been infected by their husband/regular partner.

Men living separately from their families for months at a time often have unprotected sexual relations with several partners, increasing their risk of infecting themselves and, subsequently, their wives or girlfriends (Photo: G. Diez, WHO)



Economic vulnerability and sexual services

For women and men struggling with daily survival, concern about a disease that may kill 10 years hence is a luxury they can ill afford. Women’s economic dependence makes them vulnerable and, for many, training and employment opportunities are few. If selling sex enables them to survive today, long-term concerns remain out of focus. A Ghanaian woman engaged in sex work in Abidjan, Côte d’Ivoire, commented, “I need to feed and clothe my children now. How can I worry about something that may not affect me for many years?” [17].

A ready market for sexual services exists almost worldwide and is a significant factor promoting the HIV epidemic. In some countries, it is reportedly the norm for young men's first sexual experiences to be with sex workers. Demand for sexual services is fuelled by cultural attitudes condoning or even encouraging male sexual freedom while repressing female sexuality. Migration, with its associated disruption of family life, partly promotes the demand for and supply of sexual services. Members of the armed forces away from home, displaced populations and affluent sex tourists from Europe, Japan, the Middle East, North America and the Pacific region further contribute to demand.

At the same time, the boundaries of sex work are often blurred: payment and intimacy may range from a brief anonymous sex act for a specified fee through a gradation of casual and commercial interactions. In many societies, not only those with marked gender inequality, men entertain women or provide them with desired goods in return for sexual access on a one-off, short- or long-term basis. Sex may be demanded or bartered in the workplace to gain a job, promotion or trade permit. This is not usually considered sex work but is nonetheless related to economic need. Unfortunately, sex in these situations is often unsafe.

Control over sexual relations within and outside marriage

Marriage may be viewed as a social and economic commitment between individuals and families. Sexual access, procreation, child-rearing and other services are universal to social expectations of marriage; romantic love and affection are not. Because of this, as well as lower social status and economic dependence, married women may be unable to challenge their husbands' extra-marital affairs or insist on condom use for themselves even when they know they are at risk. One philosophy professor used the Bible to justify this, arguing that women vowed to follow their husbands "in sickness and in health". In his view, this absolved husbands of the need to protect their wives; it did not apply the other way round.

Double standards – different sets of sexual rules for women and men – also may hold for other informal long- and short-term relationships. Various societal institutions may promote fidelity, on the one hand, yet also transmit the message that women should not question male unfaithfulness. Thus, heavy peer pressure may make it difficult for

VULNERABILITY TO SEXUAL EXPLOITATION

» **Nhlangwane, South Africa:** "A woman may go to look for employment all day and fail. On her way back home she might meet a man who wants to have sex with her. She will accept any amount of money in exchange for sex in order to purchase meals for herself and her children. She could get AIDS from that person" [18].

» **In Asia,** daughters may be sold by the family to the sex industry because they need the income.

» **In Fiji,** 8 out of 10 domestic workers reported that they are sexually abused by their employers. Female industrial workers are paid a pittance; some are also sexually abused by supervisors and employers. Because of these problems and increasing poverty, more of the women (often deserted wives) are engaging in sex work. As one sex worker said: "Why put up with your boss demanding sex and receiving \$30 a week when you can get more a day by selling your body?" [19].

» **Havinei, Zimbabwe:** "[My husband] told me he'd been going with all sorts of women. He said that he couldn't see a woman passing by without falling in love with her... He always told me that I was lucky to be his wife. He said the ladies that he'd fallen in love with could fit into four or five buses, but he never took any of them as his wife. He told me to pray to God to say thanks for the husband that I'd been given" [20].

» **Richard, Uganda:** “After dropping out of school at age 17, I made friends with four boys who were prominent. We had quite a lot in common, only they engaged themselves in business and sexual life. We used to have evening walks from place to place, especially where there was entertainment and drinking. At such places, these boys could meet more than one sexual partner. They tried their best to persuade me to do what they were doing, by sending me different girls so that we could exchange a word or two relating to sexual activity. I usually had fears and shyness. I didn’t know how to start: what could she think of me and what could she say afterwards? How would I engage in actual physical intercourse?

After all their pressures, the group was not happy with me at all. They felt that I didn’t belong and started to tease me with a lot of embarrassing questions and statements like: ‘You will suffer from backache because of not releasing the semen. Richard, you seem to be impotent – were you castrated?’ To sum it up, they deserted me on those grounds” [21].

» Young girls who may be raped by a male relative or who are married off as children are especially vulnerable to HIV/STD infection. At a maternity hospital in Lima, **Peru**, 90% of the young mothers aged 12-16 years had been raped by their (step)fathers or another close family member. In **Jamaica**, 40% of pregnant girls between 11 and 15 years of age reported that their first intercourse was “forced”. Meanwhile, in **India**, nearly 16% of 133 middle- and upper-class postgraduate students said they had been sexually abused before the age of 12 years [2].

» In **Papua New Guinea**, various factors in tribal life combine to place women in situations of HIV/STD infection risk. Customs encourage strong male bonding mechanisms that are played out during frequent group sex events. Many men participate in having sex with one woman and several other men. Even though this is often against the woman’s will, it is not considered rape in the legal sense or condemned [24].

boys to resist experimenting with multiple pre-marital partners, while girls are expected to remain virgins until marriage or at least to remain faithful to one partner.

A further potential source of risk is polygamy, usually meaning multiple wives rather than multiple husbands. If no partner has sex outside the group, this can be a safe system but if any one is infected, all may be at risk.

To curb the epidemic, marriage should be squarely acknowledged as a major risk factor for women in many societies. The simplistic message of lifelong monogamy is a poor one if one partner already has hiv infection and will not use condoms. It has been observed that

some men who learn or fear they have hiv infection marry to ensure someone will care for them when they become sick [22].

Violence against women

Violence against women, especially rape, is a risk factor that is inadequately recognized or addressed. In South Africa, an estimated 370,000 women are raped every year; in the United States, the Department of Justice reports that a woman is raped every six minutes [23]. Ironically, marital violence is more tolerated by society than violence outside marriage, to the extent that rape within marriage is not a recognized offence in many parts of the world. The woman’s word is usually given less credit than that of the rapist. It is also traumatic and difficult for women to report rape and secure a conviction; the extreme is reached in some Islamic countries where a male witness to the rape is required.

Violence against women is sometimes socially condoned. Many would argue that widely distributed films and television portrayals of women as sex objects and victims of abuse reinforce the acceptability of violence against them. In some countries ritualized violence, including rape, is condoned in certain circumstances.

In the worst situations, physical and sexual violence against women are commonplace. Wars and armed conflicts, generally accompanied by widespread rape, now have the added risk of

spreading hiv and st ds. The physical trauma of violent sex, often multiple rape, makes transmission particularly likely. Indeed, any coerced sex increases the likelihood of micro-lesions in the vaginal mucosae which may then be entry points for hiv.

Blame and rejection

Despite the realities of infection patterns, gender stereotypes allow women to be blamed for spreading hiv/st ds. Men are often reported to be infected by sex workers or casual girlfriends, who may be castigated by men and women alike, while less blame tends to fall on men than women who have multiple partners. Indeed, in some African and Asian cultures, it is believed that men must regularly release semen to avoid ill health.

Although for both sexes alcohol consumption reduces a sense of responsibility and leads to risk taking, women are more likely to be criticized for this. Male drunkenness is widely tolerated, men being excused for giving way to “natural urges”.

Men in some societies may boast about st ds because these show they are “real men” who have sexual relations. For a boy growing up this may be part of his initiation into manhood. But for a woman the story is different; she is more likely to be looked down on as loose or unclean. In much of southern Africa, for example, st ds are derogatorily termed “women’s disease” and men blame women for their infections. A doctor’s wife in Australia with pelvic inflammatory disease was told by her health worker that she should be ashamed of herself: “someone in your position coming in with a problem like this” [26].

If hiv infection is discovered first in a wife, perhaps because she is the first tested when a baby falls sick, she is readily blamed. Her husband may refuse to be tested or, if found positive, accuse her of infidelity to cover his own behaviour. She may equally be blamed by other relatives, regardless of whose infection was discovered first.

At the same time, the denial of women’s sexuality and the social assumption that they must be “pure” make it hard for women to acknowledge any other sexual experiences they may have had even before marriage. To do so is to court divorce or blame, even from female relatives. This blocks women from assessing their own risk and discussing risk behaviours and situations with their partners. Women living with hiv (perhaps more so than men) are even expected to become sexually inactive.



» *Married women in Palembang, Indonesia, who knew little about AIDS, associated it with “loose women” rather than believing themselves to be at risk. They believed that AIDS was contracted through “sexual contact with the lower class of commercial sex workers” and that the high class had usually been protected from STDs. They also said that AIDS comes from “promiscuous women and multiple partners” [25].*

BLAME AND REJECTION

» *Sylvia, The Netherlands: “I only dared tell my two sisters after a year. One thought I might be imagining it because I still looked healthy, didn’t I? My other sister felt it was my fault. If I had lived well, with a complete family [including a husband], it wouldn’t have happened to me... My ex-partner told others, too... Because people gossiped about me, the vice police started following me; they had heard I was whoring around and infecting everyone. Of course, they couldn’t prove that” [27].*

» *Reina, The Netherlands: “When a person is infected with HIV, that does not mean that sex disappears from her or his life, even though some people think those living with HIV/AIDS should never have sex again. Of course, none of us of living with the virus wants to pass it on to others... We want to have sex for the same reasons you do: because we like it, to express love, to gain consolation or security. In that, we are like everyone else” [28].*



Blame can also lead to institutionalized human rights violations, e.g., the compulsory screening of sex workers. Women carrying condoms may be charged by police as sex workers; thus even when they act to safeguard themselves, this may backfire.

Lack of information

Many women have poor understanding of their own bodies, mechanisms of hiv/std transmission and their level of risk in unprotected sex. Many men also lack adequate information about their own bodies and tend to have even less information about women’s bodies and needs.

Addressing these gaps in information and understanding is difficult because many poor men, and even more women, have low levels of education and literacy and have little access to printed information on hiv/aids and stds. Men are more often able to gain information from radio and television. Consequently, women hear about hiv/stds later and not infrequently have little or incomplete information about transmission. This may prevent them from assessing adequately their own risks. A female merchant in Senegal commented: “I don’t need condoms because I am not a prostitute. I have a husband and children. It is rare that during my travels I fall to the advances of a man. When I do, it is with someone I trust. I only choose to have sexual relations with men who are clean and visibly healthy, polite, and capable of respecting me. These men know me, trust me and know that they don’t need to use condoms with me” [29].

Communication

Poor communication between parents and children and between partners about relationships, male and female sexual needs and responsibilities exacerbates risk. Youth as well as adults can be taught to discuss sex-related issues (health, needs, relationships); ideally, this should become an accepted norm.

Family stress

Women’s traditional family roles are arduous. Rural women in many parts of the world are primarily responsible for subsistence agriculture and, in rural

COMMUNICATING CAN BE HARD

» **Somchai, Thailand:** “I want someone to talk to, but it is very difficult to open up. I cannot talk to my wife about this. She does not have much to say about it and rarely exchanges conversation with me. I don’t really know how she feels or what she really thinks. She is a very good wife but we cannot be friends”

[3 0]

» **Woman, South Pacific:** “I was aware my husband was having casual sex when not with me, but I was too ashamed to ask him to take precautions. I kept telling myself, next time. My advice to young mothers is, ‘Don’t ever wait for next time.’ Now I have big regrets. I’m so lucky that I didn’t have any more children after I was infected”



» **In an African country,** when Janet’s husband learned that she had HIV infection, he threw her out with their two small children. Janet’s father had died of AIDS and her mother was sick but trying to look after Janet’s seven younger siblings. The logical outcome was for Janet to return to her parents’ home and help. Her mother has since died, leaving Janet to

care for all nine children. None are in school, all are malnourished. They live in one room, a corner of which is partitioned off and rented out to provide a small income. This, and what the older girls can earn from selling sex, keeps the family alive. No help has been forthcoming from Janet’s husband nor from other relatives on either side.

and urban areas, informal sector activities. Women usually undertake most household tasks, go through pregnancy, childbirth and lactation, and rear children. Large numbers of women are in fact household heads but lack sufficient authority, money and material resources, family and formal support to provide adequately for their children and themselves. aids-related stigmatization and the extra care burdens brought on by the disease worsen existing gender inequalities, increasing women's vulnerability and exploitation.

The impact of aids on the family may be devastating, with both parents and sometimes one or more children becoming ill and dying. Girls may be withdrawn from school to look after their families, thus increasing their economic and social vulnerability when they grow up. The elderly also take up an increasing care burden when they themselves may be frail.

» A nurse: "In many countries in **Africa** families admit they have had to disrupt the schooling of the girl children; first, because they need another pair of hands to help them in caring for the sick, and second, because the family resources are reduced and the little funds available go into meeting the basic survival needs of the family... They seem to see this as one big disadvantage of the home-care programme activities" [3 2].



Young girls are kept from school to help with care, e.g., to get food and medicines (Photo: Roel Burgler)



Elderly grandparents may face the responsibility of raising their grandchildren (Photo: Roel Burgler)

aids makes decision-making about child-bearing, abortion and breast-feeding much more difficult. Available services may or may not provide helpful advice or be sensitive to the stress women face around these and other sexual health issues. In fact, women and couples may face humiliation and misinformation in the very centres and at the hands of the so-called professionals supposed to help them.



» **Pung, Thailand:** “It all happened with my first pregnancy when I had a blood test. The nurse asked me some questions and finally told me I was infected with the HIV virus... I brought my husband in for testing and he tested HIV-positive... I remember crying when both of us sat in front of the nurse. She asked us what we wanted to do with our unborn child. She suggested aborting the child and added that it would be free of charge. If I agreed to do so, I was also required to have a hysterectomy.

I talked to my husband and we both agreed to have an ultrasound to see if our child was healthy. The technician said the child was healthy and strong. Then she looked at my HIV status and suddenly replied: ‘No, no you cannot keep the child’; her voice was so

threatening. ‘You must abort the child’, she insisted.

My husband said it is probably better to abort the child, letting go now was better than losing it when the child grew and became as lovely as our dreams. I was not sure myself but was in a state of shock. I asked the nurse if I could have a sterilization that was reversible. She looked at me with surprise and asked if I still had hope for a cure. On the form there was only a hysterectomy so she wrote that I wished not to have a permanent sterilization operation.

I had my child aborted, with a special deal: abortion with sterilization – free of charge. But I still don’t know what kind of sterilization I got. I am not sure if it is a reversible or permanent sterilization. I have no way of knowing what has been done to my own body”

[

3

Home care

In areas where the epidemic is already severe, particularly sub-Saharan Africa, hospitals cannot cope and much patient nursing is done at home. Numerous home-care programmes have been developed by church and community groups or as hospital outreach programmes. AIDS service organizations provide counselling, material and practical help, spiritual support, nursing care and advice. Excellent work is performed by dedicated staff, yet coverage remains low, often under 10%. Visits from support teams may be on a fixed and infrequent schedule, and cost-effectiveness and sustainability remain serious concerns. The extra burden inevitably falls on the family, in particular on women.

In other regions, such as Latin America, the Middle East and Asia, some hospitals, clinics and social services do not provide care because staff are still afraid to accept people with HIV/AIDS. Stigmatization and discrimination may also prevent families and community members from providing support.

The growing orientation towards home care may, in fact, worsen women's situation, particularly as men are often the first to become sick.

The wife may have to nurse her husband while her own health deteriorates, but the main expenditures are for his care. There may be no appropriate care-givers to nurse her through her sickness. Rather than an excessive focus on home care, developing a continuum of care between hospital, clinic, local hospice and other community care is preferable, a strategy supported by WHO. This enables health workers at the local clinics, community health workers and neighbours to help when appropriate and when requested by the family.

Men need to be motivated to assume stronger care roles in the family, both for the sick and in general around child care. Health and welfare concerns cannot remain women's preserve. If this can be achieved, husbands may be less likely to desert women who are found to have HIV and will write wills or otherwise provide for their families when they themselves are dying.

Legal and human rights

At present, women's rights in many countries are curtailed. They may have little right to land, to inherit property, even to keep their own children when their husbands die. AIDS throws these problems into stark relief because more women are being widowed at a young age and will themselves face an early death. Safeguarding their children's future may be a desperate worry for these women, yet they may lack the means to provide for them without extended family support. In some countries, women are traditionally inherited by the deceased husband's brother. Their economic and social survival may depend on their acquiescence.

» ASPANE, in **Mexico**, helped Yolanda, 26 years old. She lived in a "house" of carton near a garbage dump in a Mexico City suburb with her 3-year-old son and 5-year-old daughter. When her partner died of AIDS and her neighbours discovered that Yolanda was also HIV-positive, they tried to drive her away. Yolanda sought refuge with her mother-in-law, but her daughter was sexually abused by a brother-in-law in that household.

« In desperation, Yolanda turned for help to a charitable organization for abandoned children. After proving that her children were HIV-negative, so that the organization would accept them, the Department of Social Welfare helped Yolanda to transfer custody of the children legally to the organization. They went there when she died.

VIOLATIONS OF HUMAN RIGHTS

» ASPANE in **Mexico** helps Rosa, who contracted HIV from her bisexual husband. He abandoned her and their four children when he learned that she, too, was HIV-positive. Rosa's in-laws blamed her for the HIV infection and consequently refused to offer her any help or information about her husband, who went into hiding for fear of being made legally responsible for child support.

» Deborah in **Uganda** lost her husband to AIDS and is herself very sick. Her brother-in-law tried from the very beginning to inherit her, but she categorically refused so as not to infect him and his wife. He repeatedly told her he does not care that she has AIDS and is willing to take the risk of becoming infected. He harassed her for almost a year; when she held firm and refused, he cut off all financial support to her and her four children. Once she refused him, she was ostracized by the entire family and cannot rely on them for anything, even moral support. Now, he is trying to claim the land that his brother left jointly to them [34].

» “When life became difficult in her native village of Melamchi in the **Nepali hills**, Geeta moved to Kathmandu where she worked as a housemaid. When her cousin promised her a better job in a carpet factory in India, she jumped at the opportunity: ‘I didn’t realise that I was sold to a Nepali brothel keeper in India until the lady told me to engage in business... I wept and wept. I was shocked to be sold by my own relative. I went mad. They admitted me into a mental hospital. After a year, I was ultimately forced into prostitution. I never liked it – that was not what I had wanted. But you can’t fight against luck and fate.’

Geeta was sent home with 200 Indian rupees (US\$ 6.50) for her transport after she tested HIV-positive. Back in Melamchi, she found her mother had died and her father refused to take her back. Determined to begin a new life, she rented a liquor shop with her savings. The shop was successful until her HIV status became known in the village – then business collapsed and she was forced to close down” [36].

On the other hand, after the death of a husband, women around the world may be disinherited by the husband's relatives, particularly if they blame the woman for his death.

At another level, married women's confidentiality may be broken with relative impunity leading to violence or desertion if their husbands blame them for infection. Meanwhile, women may not be informed of their partners' hiv status. The right of partner notification versus strict confidentiality is being debated in many countries and different policies are being developed. For women the outcome is particularly crucial as infection often enters the family through the husband. Uninfected wives could, in theory, protect themselves but only if access to information is accompanied by the economic, social and legal means to take preventive action.

The rights of women living with hiv to bear children or seek an abortion are hotly debated. A British woman living with hiv was angered and upset by accusations that her choice to have a baby was selfish as the child risked infection or, if it lived, would certainly be orphaned fairly young [35]. In many developing countries a woman's status is highly dependent on motherhood; much more than in Britain it may be of great importance to an hiv-positive woman to have a child.

The issue of sex work also raises difficult legal and ethical problems. While soliciting remains illegal in most countries, sex workers remain vulnerable to abuse, are difficult to reach with hiv/std prevention and support programmes, and face increased stigma. Yet arrangements for sex work may involve minors, abduction and coercion; these aspects of the trade must be stopped. aids is giving rise to increased public outrage about these human rights violations.

Another neglected area is the rights of homosexual women and men to social acceptance, child care, mar-

riage and inheritance. Lesbian relationships are a preferred lifestyle for some women and generally carry a low risk of hiv infection. However, societal intolerance precludes many women from exploring this option even if they would like to. Male gay relationships are more common in some societies, but their very existence may be denied or condemned, leading gay men to marry and engage in bisexual contacts even if they prefer only to have sex with men. “Talk to any African government about homosexual issues and the spread of aids, and they simply tell you that homosexual activities only go on in the Western world,” said Obi Zikora, president of Gentlemen Alliance, in Nigeria [37]. “The stigma attached to homosexuality frightens away many who should be examined from going to doctors.”

As with sex workers, legal rights for homosexuals and lesbians need to be strengthened and societal intolerance challenged if they are to cope better with hiv and aids and not be driven underground.

Structural patterns

Economic policies widening the gap between rich and poor countries and rich and poor people within nations exacerbate the conditions for hiv/std transmission. For example, economic structural adjustment programmes may have a negative impact on rural and urban poverty, national debt and trade relations. These policies hamper countries’ capacity to provide social, educational and medical support to affected families and communities, especially if food subsidies are cut and social, welfare and health expenditures are reduced.

The epidemic hits hardest the developing world and the poor inner cities of industrialized countries, which are least able to cope. Furthermore, poverty increasingly has a female face: undp estimates that 70% of the world’s poor are women. As prevention efforts are

*The epidemic hits hardest among the world’s poor, 70% of whom are women
(Photo: Roel Burgler)*



stepped up, communities' abilities to cope must also be strengthened. Only through improving coping capacity will fear and stigma around aids be reduced, allowing prevention strategies to really work.

Within this framework, empowering women and reducing gender inequalities are critical. The structural basis of gender inequality must be challenged by promoting personal attitude and behaviour change. Women must gain access to the education, training and employment they need to achieve sexual relations on equal terms and to control their risk of hiv/st ds. Cultural expectations that exonerate men from taking responsibility for health and welfare concerns must be transformed, along with the structural conditions of work, housing, migration, etc., that prevent this from becoming a reality.



» **Woman, Zimbabwe:** “My husband passed away from AIDS when he was 35; he was ill for six months. He used to work as a general labourer in a big firm and only came home at weekends. We had eight children, but the last two both died. This leaves me with six children to feed. It is very hard. The two eldest have had to leave school to try and earn money, but I am trying to keep the youngest four in school.

In the early stages of my husband's illness we could cope. It became difficult when he lost his job. We had to spend a lot of his savings on special food for him, and he lost his medical aid cover. I grow maize and try to make money selling crochet work, but it is not sufficient. I cannot get a proper job – in these days it is even more difficult as a woman because it is men who are expected to work.

My husband's workplace helped with the funeral and will pay me a small pension for four years. But he had not worked there long so the amount is low. My husband's brother is supposed to take care of us. He knows our problems but did not help at all during my

husband's illness nor after his death. Now he wants to marry me, but I think it is in order to take my husband's estate, not to help us. I am lucky because my husband left a letter instructing that his property was to remain with us and that I should not marry his brother in the traditional way. Fortunately, the headman and the other village elders support this decision because they know that this brother did not help us when my husband was alive. Otherwise it would be very hard for me to refuse. I have to think of my children. But by refusing to marry I lose any hope of help from him.

If I die, the oldest children will have to take care of the young ones. I cannot trust my husband's brother, and I do not think his first wife would treat them well. My own two sisters cannot take the children because their husbands will not allow this. It is not traditional and they have their own families. The women take care of the children, but it is the husbands who must make the decision about this.”

Can women and men reduce risks and share responsibilities?

The goal of our response to hiv/aids and st ds is to decrease vulnerability to infection, reduce stigmatization and discrimination and curb the epidemic's socioeconomic impact. This will be best achieved through gender-based approaches promoting shared responsibility for prevention and care between women and men.

Gender-sensitive strategies must address both short- and longer-term needs and goals. Short-term strategies may focus on people's immediate needs in specific communities, including obtaining basic information about hiv/aids and st ds, gaining access to sexual health education, acquiring condoms and obtaining back-up support for home-based care.

Longer-term strategies are directed at underlying cultural and social structures. They aim to promote mutual respect between men and women and equal access to all types of resources. The goals of longer-term strategies include, but are not limited to:

- changing ideas and social norms that keep women in an inferior social position
- achieving shared decision-making power between women and men at all levels: in relationships, community affairs, political and economic bodies, etc.
- creating structural changes to give women equal access to education, training and income-earning opportunities
- reallocating work responsibilities so that women and men share them fairly
- encouraging legalization of traditional marriages or unions where this would strengthen the rights of women to property, inheritance and children.

Governments and ngos are now beginning to integrate a gender perspective into their hiv/aids/std programmes. Women living with hiv/aids are playing an increasingly important role in this process. Below, examples from programmes around the world show how a gender-based response is being developed. The examples are randomly grouped in action areas. Gender-sensitive strategies must be developed simultaneously in all of them:

- creating a supportive and enabling environment

To ensure wider development and implementation of gender-sensitive strategies, collective action is required. Women's organizations and networks can help by reinforcing such strategies, sensitizing and mobilizing women and men, and making linkages to other gender-based initiatives in society. Collaboration and coordination between UN system agencies, governments and NGO networks may further serve to reinforce gender-sensitive responses.

- research
- facilitating access to information and services
- changing the way we think and act
- sensitizing and mobilizing men
- combating discrimination
- developing gender-sensitive care and support
- living positively with hiv/aids.

A SUPPORTIVE AND ENABLING ENVIRONMENT

The social environment must enable people to achieve effective prevention and care. Policy, legal and human rights, economic, social, cultural and educational structures are needed that benefit women to the same extent as men. If such structures are developed, then women and men will have a much better chance to change the social norms and values oppressing them in their daily lives. Although structural changes take time to achieve, strategies must be developed to address them at the same time as grass-roots initiatives improve women's daily life situation.

*Increasing girls' access to education and vocational training is an important part of a gender-based response
(Photo: Roel Burgler)*



Structural measures

Decreasing women's economic dependence is an important step towards enabling them to reduce infection risks for themselves and their families. A credit scheme established by the Grameen Bank and Bangladesh Rural Advancement Committee (brac), for example, enables rural women to establish an independent income by offering them loans. The programme has enhanced women's autonomy and self-confidence and led to increased contraceptive use^[38].

In addition to income-generating schemes, other structural measures are necessary. These include guaranteeing women:

- better access to schooling, vocational training and higher education
- equal access to employment and equal pay for equal work
- equitable access to social and health services
- legal and human rights protection equal to that of men
- better representation in political and economic bodies
- freedom from restrictive cultural expectations and practices.

Political and community support

Broad political and bureaucratic support is necessary if governments are to implement the measures outlined above. This can be facilitated if naps are made intersectoral, involving not only the health sector but also ministries and departments such as women's affairs, education, labour, justice, agriculture, defence and social affairs. By creating links among these sectors, the hiv/aids epidemic can illustrate why women must gain greater access to education, paid employment and social services. naps can further mobilize support for a gender-based response by formulating policies that provide various ministries and ngos with a framework for action.

Governmental and ngo programmes mobilizing communities to

INCORPORATING GENDER AND WOMEN'S CONCERNS INTO NATIONAL RESPONSES

» *The first generation of National AIDS Programmes (NAPS) were gender neutral in their approach. Health education messages ignored gender disparities and roles in sexual and family relations. One and all were simply urged to "stick to one partner", avoid casual sex, reduce the number of sexual partners or use condoms.*

As awareness gradually developed, NAPS started to address specific issues confronting women in relation to HIV/AIDS. The initial approach was to "mobilize women" through women's NGOs as agents of health education and information. When concern arose about women's heightened vulnerability to HIV, interventions were developed to enable women to talk about sexual safety and condom use with their partners. This approach was criticized because it neglected men and the fact that men control the circumstances under which most women are exposed to risk or protected from infection.

Analysis of gender disparities and women's disadvantaged socioeconomic status is now being incorporated into national HIV/AIDS policies. The challenge is to integrate gender considerations into all aspects of programme development.

Botswana's National Information, Education and Communication Strategy for HIV/AIDS Prevention places gender prominently among factors related to HIV/STD spread. Guidelines for gender interventions for men and women are a key component for district programme planning. By determining how gender disparities affect women throughout their lifetime, interventions can be facilitated at community, school and workplace levels to ensure that girls do not grow into adults with increased vulnerability to HIV/STD infection.

Interventions also need to take account of women's responsibility for providing family and community care. Programmes developed by social welfare agencies, NGOs, employers, etc. should make provision for these responsibilities. Education and communication programmes should encourage sharing of domestic responsibilities and tasks between men and women.

Only when countries address gender disparities squarely in their economic, political and social development strategies will incorporation of gender and women's concerns into HIV/AIDS programmes have a sustainable impact.

TSHIDI MOETI, former **Botswana** NAP manager

» “The most critical decision of my life was to reveal to representatives of **Caribbean** media that I had tested positive for the AIDS virus. Coming face-to-face with a battery of journalists was a nerve-racking experience. I decided to impose this agony on myself in an effort to dispel some of the myths surrounding HIV-positive people... During my presentation, information that would usually be regarded by journalists as a ‘juicy story’ was instead treated as a moving commentary. On the admission of some of the journalists, my presence and commentary were edifying and represented their first opportunity to understand the plight of HIV-infected persons.”

A WOMAN LIVING WITH HIV [39].

CREATING A SUPPORTIVE ENVIRONMENT

» When sex workers in Calabar, **Nigeria**, wanted their customers to use condoms, they failed to get support from the people who influence their working conditions, such as hotel owners, managers and chairladies (head sex workers). The Cross River State AIDS Programme (CRSAP) therefore approached them on the sex workers’ behalf.

A special STD clinic was established to serve the women near their working sites. Collective actions were fostered to protect the sex workers’ interests. The hotel managers and chairladies began backing the women’s demand for higher fees and their right to refuse clients who wouldn’t use condoms. The sex workers also were able to retain fees when clients attempted to renege on condom use. Harassment and extortion by security agents decreased, too.

The women reported more confidence in handling problems with clients, hotel owners and the police. They also organized a self-help group called Nka Iban Uko (Women of Courage), which focuses on skills training and services for their children [40].



create conditions for effective prevention and care need expansion. Besides serving as a channel for information on hiv/aids and stds, the media can mobilize public support for gender-sensitive programmes by highlighting the effects of the epidemic on women. Media workers may also be enlisted to help create a climate tolerant towards those affected by or responding to hiv/aids.

Policy-making and agenda-setting

To ensure broad-based support, all agencies and government ministries must add hiv/aids and stds to their action agendas. In this way, alliances for policy-related advocacy as well as new initiatives will arise at the national and community levels:

- After a national workshop in Malaysia where women were trained to organize hiv/aids awareness workshops, such meetings were held even in the most remote parts of the country. By linking women’s umbrella organizations, duplication of effort was avoided and time and money saved [41].
- In England, regional seminars were organized on the theme “Women, aids and the Future” in collaboration with local women’s organizations. Activities carried out by participants afterwards included: reporting on hiv/aids to local organizations; planning similar seminars in their area; talking with men, family, friends and colleagues about hiv/aids; writing advocacy letters to government ministers; holding study days/meetings with church groups; and writing articles for the press [42].
- The Society for Women and aids in Africa (swaa) raises political

awareness concerning gender in relation to hiv/aids and st ds and provides a voice for women in many parts of the continent. swaa has national member organizations in more than 20 countries.

RESEARCH

Biomedical studies – e.g., on opportunistic infections in women and ways to reduce perinatal transmission (including through breast-feeding) – are increasing in scope but need expansion. More support is required for research on female-controlled methods to prevent hiv/st d infection, including the female condom. The current research priority is to develop microbicides, which appear to have great potential for acceptance. Other important topics for a gender-sensitive research agenda include:

- barriers to female control over hiv/st d risks and ways to overcome them
- how young women and men define personal risk in relation to different types of relationship
- how men and women currently protect themselves against infection
- barriers to female and male st d treatment and how to improve access
- improving contact tracing for st ds
- the effects of hiv infection during various phases of a woman's life cycle (e.g., in relation to onset of menstruation and menopause)
- the appropriateness of counselling messages and methods in meeting women's and men's specific concerns
- partner notification, confidentiality and information sharing
- the division of labour concerning reproductive and productive tasks at the household and community levels and how these contribute to maintaining women in their current lower status and increase their burdens related to care.

ngos and research institutes have not waited for international leadership and donor funding to undertake studies in these areas. Research must be demystified so that more local organizations develop their own research agendas. Some of the most useful findings come from simple



Participatory action research by community members can explore differences in knowledge as well as use of information sources, traditional communication channels and inter-generational communication. (Photo: Photo Bureau, KIT)

small-scale studies, especially when their results are linked directly to the implementing service agencies.

Exciting developments are taking place through participatory action research in which community members explore topics such as differences in knowledge and information sources for boys and girls, traditional communication channels used by women and men and inter-generational family communication. The findings indicate how educational programmes can be better structured and channelled.

Dissemination of research results urgently needs expansion. This can be facilitated by linking researchers and ngos. The International Center for Research on Women (usa) worked with Comprehensive Health for Women (sipam) and the Programme in Gender Studies of the National Autonomous University in Mexico to document and analyse studies and programmes on women and aids in Mexico. A forum held to discuss the results with ngos, researchers and government institutions resulted in the formation of a permanent researcher-ngo network^[43].

Establishment of “inter-country” projects is another approach. For example, feim in Argentina and the Movimiento Paulina Luisi in Uruguay together planned action research and an intervention to increase gender awareness and prevention possibilities for poor and lower middle-class women^[44]. They then compared their findings, identifying concerns that are country-specific and broader in scope.

Donor organizations can contribute to dissemination of research findings by funding the publication of research reports and researchers’ participation in national and international meetings. Many un agencies have distribution channels that might be expanded to include dissemination of studies carried out by governments and ngos.

FACILITATING ACCESS TO INFORMATION AND SERVICES

Information dissemination

Printed materials can be improved by involving women and men in creating more appropriate messages and materials that address their specific concerns. Funding is also needed for translation of texts into local languages to allow greater access to printed information.

Including hiv/std information in a variety of health programmes, such as mother and child health and family planning, reaches more people. The Guatemalan Association for the Prevention and Control of aids conducted educational sessions and small-group workshops on health and sexuality, self-esteem, partner communication and communication with adolescent children for women waiting at antenatal clinics^[45]. Fears that discussions about hiv/stds would cause the women to worry, increasing their stress levels during pregnancy, were not encountered. In fact, some women reported that they felt relaxed and less apprehensive in talking about condoms, infidelity, stds and aids with their partners. More than half of those interviewed post-partum said they shared written materials with their partners.

Information channels other than health services are also available. Traditional community counsellors, women and men’s associations, church-based groups, sports and recreational clubs provide entry points for individual and group educational sessions. Other possibilities

REACHING OUT TO WOMEN

Both existing and new communication channels can be used to reach out to women and girls.

TRADITIONAL ASSOCIATIONS

» Researchers from the Cheikh Anta Diop University in **Senegal** mobilized members of a well-respected women's association, the Dimba, to help organize community education sessions. Dimba membership is restricted to women who have experienced difficult circumstances, like infertility problems, repeated miscarriages and adopting orphans. They are influential because their members have thorough knowledge of women's and infants' illnesses. The researchers also worked with women of the Laobe ethnic group, who provide advice about sexuality. Laobe women are traders who make and sell products designed to enhance sexual pleasure; they were persuaded to sell condoms as an erotic product [29].

ADOLESCENT GIRLS

» World Vision designed a sex and family education programme for low-income adolescent girls in Bombay, **India**. The girls had little information about reproduction and almost none about HIV/STDs. They seemed trapped in a "culture of silence" that did not permit them to voice their opinions, feelings or concerns on any issue.

Parental and community support were essential to permit the girls to participate (e.g., providing child care for younger siblings). A community AIDS/STD awareness programme was therefore implemented, including meetings with mothers, teenage boys and young men, and a

street play dramatizing women's status at different stages in life. The meetings stressed the value of educational interventions for the girls.

Topics discussed with the girls included: being a woman, female puberty, sexuality, sexual exploitation and harassment, health problems (with specific reference to HIV/STDs) and the development of an action plan to protect oneself against infection. The programme had to encourage the girls to talk. As the sessions progressed, they became more self-confident, freely voicing their opinions, suggestions and criticisms. The feedback was very positive, with the girls asking for more sessions [46].

WOMEN PRISONERS

» "My partner used a condom because he saw the signs on my arms. That hurt me. Now I know something more about AIDS and I have changed my mind: I think that he did the right thing because both of us ran less risk." This comment came from a participant in the "Women, AIDS, Information" Project at the women's prison Le Nuove in Turin, **Italy**.

The 3-month project was initiated at the prisoners' request. The project team helped the women discuss HIV-testing, how to reduce infection risks and how to live with seropositive persons without fear or rejection. The women then developed a story that could be used as the basis for a video.

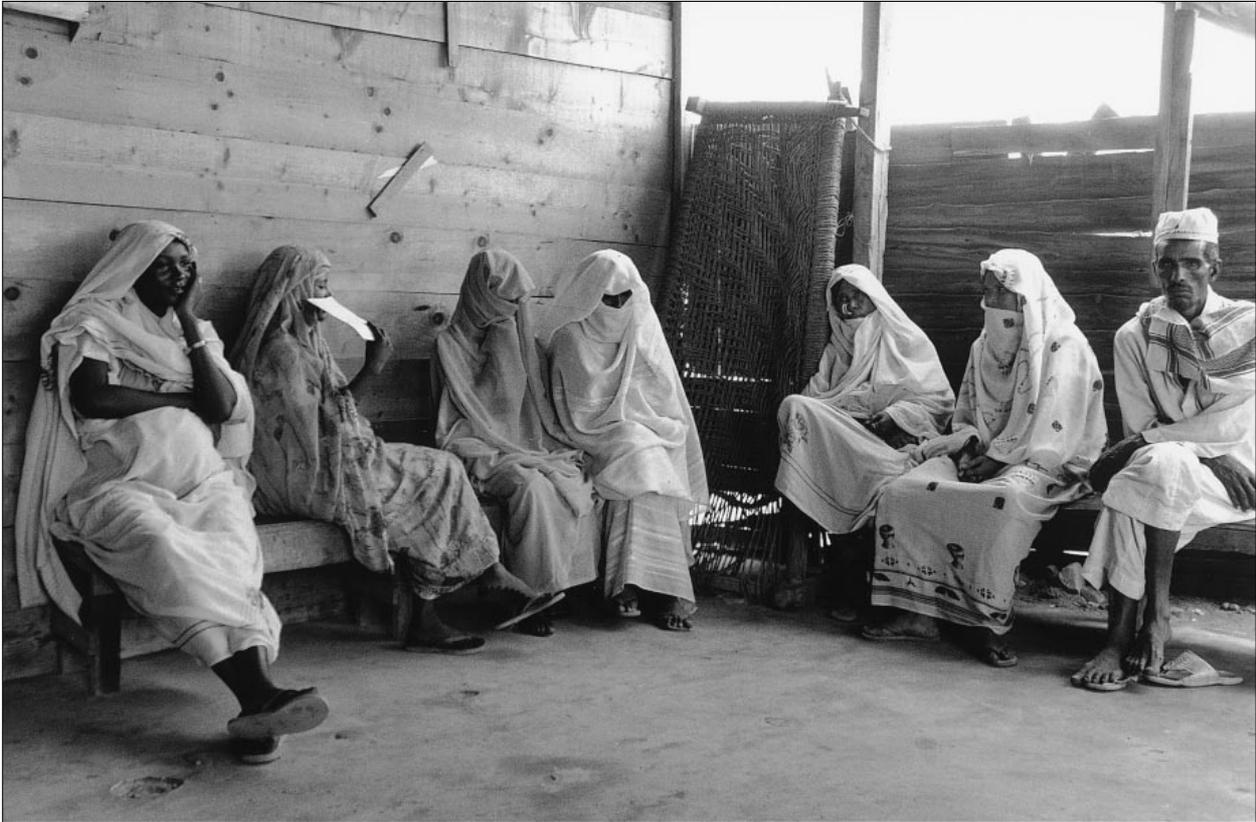
The intervention enabled the women to share their experiences as equals and realize they were capable of carrying out such a project. They began discussing the possibility of having relationships with other groups working on AIDS both inside and outside prison [47].



include labour and trade unions and groups participating in agricultural and small-enterprise projects. Training peer educators has proved particularly effective among women from various walks of life. ngos have further explored ways to reach women whose mobility is restricted, e.g., girls living in slums and female prisoners.

Reorientation of services

naps, local governments and ngos are reorienting services to better meet the needs of women and men. They are providing information and



Reorientation of services is required to better meet the needs of women and men
(Photo: Roel Burgler)

condoms to men and women at sites they regularly visit (e.g., clubs, cafés, hairdressers). Clinics are being located where people live (e.g., st d clinics located in sex worker districts, mobile clinics). This enables people to acquire what they need without much effort.

- A programme in Haiti, which sells condoms in places where women feel comfortable buying them, aims to give women skills in negotiating social and cultural barriers to condom use. Product packaging is discreet, with advertising stressing women's right to control their sexuality [48].
- Government and ngos in Calcutta, India, have increased female sex workers' access to st d services and health care for their children by opening a general health clinic in a local youth club. The clinic runs during the day and the club at night. Peer educators participate in outreach activities [49].
- The Filipino ngo Kabalikat provides comprehensive services to female, male and youth sex workers by training peer educators, running a drop-in centre, offering short-term shelter and nutritional support and providing medical and residential care to those who need support [50].
- In Colombia, profamil ia runs male family planning clinics, emphasizing that family planning is a right. The men are offered general counselling, st d/hiv diagnosis, vasectomies and a free hotline. The programme has resulted in more early consultations related to stds and increased condom use [51].

These types of programmes need to be replicated, along with increasing efforts to make the female condom and spermicides more accessible and affordable.

std diagnosis and treatment are of special importance since stds increase vulnerability to hiv. Because most st d diagnostic tests are too

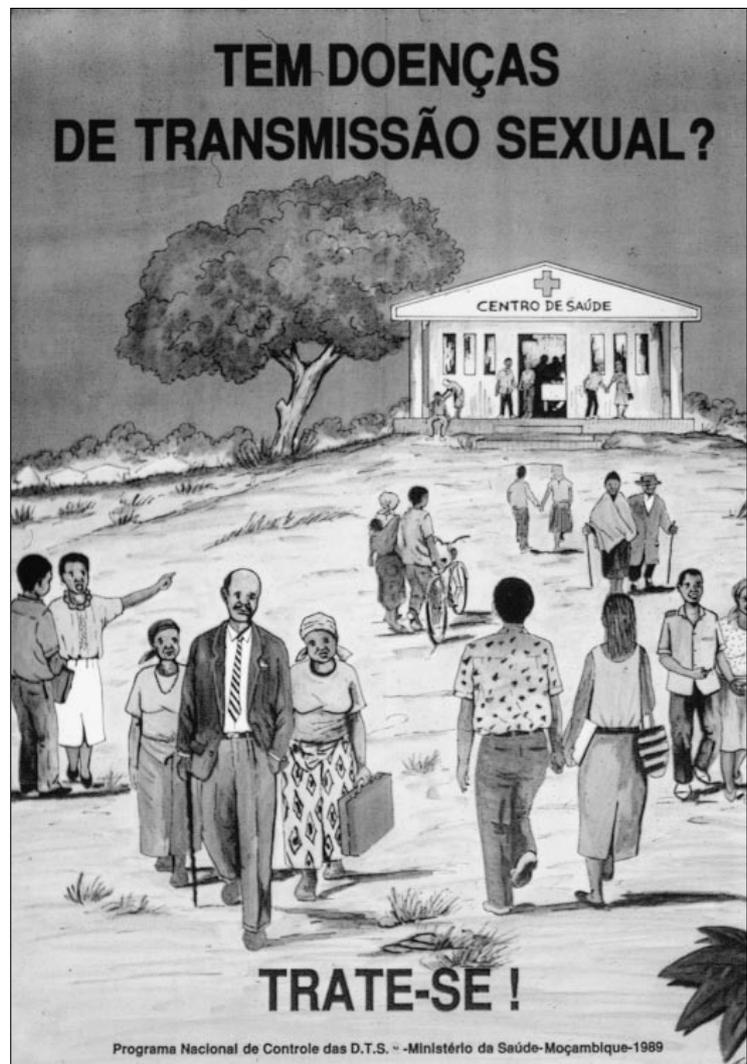
costly or require equipment unavailable at the primary health care level, who recommends syndromic management based on the identification of collections of std signs and symptoms (syndromes). Any woman presenting with a particular syndrome is treated for all std infections commonly associated with those symptoms.

To increase the accessibility and acceptability of std services, stigmatization and the negative attitudes of staff must be reduced. Contact tracing procedures guaranteeing confidentiality also need further development.

CHANGING THE WAY WE THINK AND ACT

Programmes can facilitate community exploration of how gender is related to prevention and care by addressing the following kinds of question:

- *Beliefs*: how can people be assisted to re-examine ideas related to hiv/aids/stds and sexuality which hinder prevention, e.g., men need to release semen to stay healthy, women must receive semen to promote an unborn baby's growth?
- *Relationships*: how are relationships defined, e.g., what kind of contact do the partners have in casual, regular and other types of relationship? What makes a relationship good? Who usually makes decisions in relationships? What circumstances in relationships increase or decrease risks of hiv/std infection?
- *Sexuality*: why, with whom and in what circumstances do women and men engage in sex? What needs and desires do women and men have regarding sex and what do they understand of each other's needs? What types of sexual practices and needs are or are not considered normal and why? How do various aspects of sexuality affect risks of hiv/std infection?
- *Power between women and men*: how should power relations between women and men be changed? How can women gain greater control over their lives and situations contributing to their risk of hiv/std infection, e.g., condom use, types of sexual activity, extra-marital sex?
- *Care and support*: who provides what types of care and support to family members and needy people in the community? Why is care-taking divided between women and men in a particular way? What needs to be done to ensure that women and men both participate actively in providing care and support?



In Mozambique, STD treatment is de-stigmatized by showing it is for all community members.

CREATING GENDER AWARENESS AND BUILDING SKILLS TO ACT ON IT

Around the world, communities are becoming more conscious of gender issues and acting to address them:

» Women, Children, Citizenship and Health (MCCS), an NGO in São Paulo, **Brazil**, recruits women for sensitization workshops from mothers' clubs, unions, political parties, professional associations, community groups and feminist organizations. MCCS adapted its approach to safer sex when it was recognized that family planning programmes have emphasized use of "long-term" and "inexpensive" methods, such as sterilization and the pill. Barrier methods, such as condoms and spermicides, are frequently identified as inefficient, inappropriate for lower-income groups and too complex for use by uneducated persons. MCCS encourages women to think about contraception in relation to HIV/STDs in the broader context of their overall health [52].

» Juliet Awino, a widowed mother in **Uganda**, stars in "Strings Attached", a play portraying her personal experience with HIV/AIDS. It emphasizes practices that undermine women's role in society and the home, making them vulnerable to HIV transmission, such as: male pre- and extra-marital sexual activity, hostility from in-laws who blame wives for family problems, abandonment without rights and property if a woman refuses sexual "ritual cleansing" when she becomes a widow.¹ The drama has contributed to an increase in people writing wills to regulate inheritances [53].

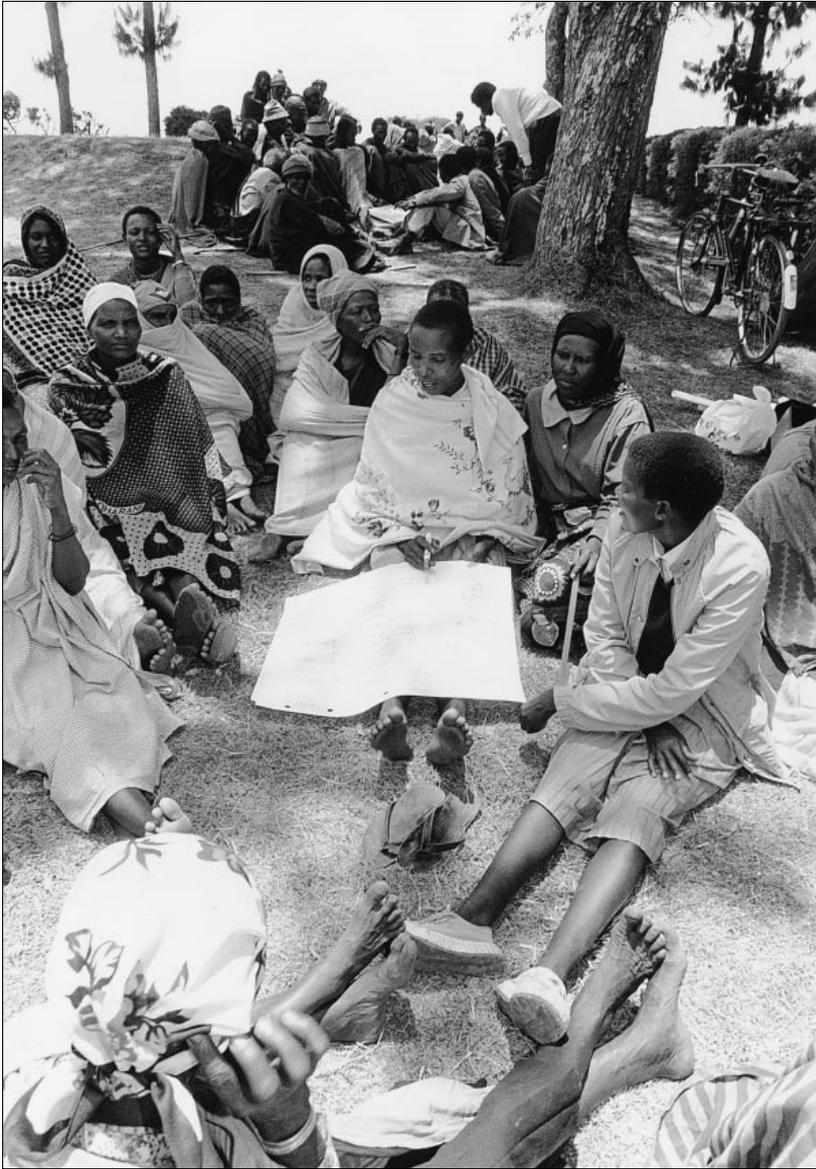
» In Kalabo, **Zambia**, women aware that girls in their area were especially vulnerable to HIV formed a committee to focus on communal attitudes towards

sexuality and behaviours affecting women. They organized seminars for more than 600 women, through churches, hospitals and health centres, to stimulate extensive community discussions about female sexuality and gender roles. As a result, the traditional initiation ceremony for girls was revised to include information on reproductive health and HIV/STDs [54].

» In **Mali**, a primary health care project (SSP-Ségou) and programme focused on improving women's status (PROFED) generated discussions on gender and sexual health among the general community and young women in particular during a needs assessment study. To break down barriers against discussing sexuality, they developed a drama with the villagers about a woman who has problems giving birth. It was acted out for the entire village, following an introduction by a male village leader concerned about women's situation. The audience became highly involved, worrying about the sick woman and giving advice to the husband. In this climate male and female researchers could address all kinds of topics from the perspective of both sexes. Some previously taboo subjects, like the negative consequences of female circumcision and sexual violence against women as a risk factor for HIV/AIDS, were dealt with publicly for the first time. The group discussions were geared towards analysing the villagers' problems and mobilizing them into action. The first step was to re-establish a village pharmacy [55].

¹ Ritual cleansing is a custom among some African cultures wherein the spouse of a deceased man or woman has sexual intercourse with a member of the spouse's family in order to allow the dead person's spirit to attain rest; it also ensures that the spirit will not bother the surviving spouse.

Participatory group methodologies increase awareness and motivate adults and youth to devise solutions to the gender-based problems they identify. Skills building needs to be an important component of such approaches so that women and men learn how to talk about sex and relationships, resist pressure from peers and partners to engage in unwanted practices and stand up for their rights (e.g., resisting service providers' pressure to have an abortion or sterilization). The capacity to



Community work is helping women and men explore gender issues through exercises which “map out” risk situations in their villages (Photo: Roel Burgler)

practise such skills is based on a sense of self-worth, a perception of oneself as capable and assertive. Examples of approaches that build self-esteem and gender awareness include:

- using drama and visual arts to help women “discover” their abilities and talents
- role-play (e.g., to develop safer sex negotiation skills)
- vocational training and education (e.g., production skills, relating skills, managing skills)
- peer education programmes.

Changes in attitudes need to begin in childhood. Although parents are expected to play the primary role, in many societies talking about sexuality and related issues between parents and children is difficult. A study in Zimbabwe, for example, found that parent-child communication is severely limited, especially in the case of fathers, who are often absent, remote and moody ^[56]. Research in Mexico showed that adolescents want more communication about sex with their parents than they actually have. Obstacles included parental time/work constraints, not being



Changes in attitudes must begin in childhood (Photo: Roel Burgler)

able to reach agreement, lack of trust and knowledge and embarrassment ^[57]. Such studies indicate that parents want help to improve their ability to communicate, for instance, through ngo and church training activities for couples.

When questioned, many parents indicate they are willing for others to deliver prevention messages to their children as long as they are informed about the content. Media campaigns can help create a supportive environment for this. ngos and schools can offer courses and activities for schoolchildren and out-of-school youth that explore gender relations, values, sexuality and related issues. Stressing the effects of positive as well as negative peer pressure is an important component of such programmes. As few teachers and youth workers have been trained to deal with such subjects, organizations such as unicef, who and unesco, as well as ngos, are assisting governments to develop appropriate materials and training programmes for them. Training of youth peer educators has also shown promising results.

HELPING YOUNG PEOPLE

Two programmes in Asia and Africa are teaching young people the skills needed to insist on safer sex. One programme focuses on pre-marital abstinence and fidelity within marriage and the other on condom use.



Care International in Kenya promotes respect for girls in a publication for schoolchildren

» In Africa, Aid for AIDS fosters the creation of positive self-images among boys and girls, emphasizing respect for girls. “It’s great to be a girl” is an attitude crucial for boys and girls to absorb. The programme uses drama, role-play and discussions to teach young people how to resist peers who try to make them do things they don’t want to do. The idea of positive peer pressure is promoted through Anti-AIDS Clubs, in which friends help one another stand by mutually agreed behaviours, e.g.: 1) We will make friendships with lots of other boys and girls more important than “pairing off”. 2) We will commit ourselves to avoid sex before marriage. 3) We will especially help and care for any of our friends who have HIV infection.

» The University of Chiang Mai in Thailand developed special materials for young female factory workers. Research had shown that a lack of communication between women and men, reluctance to discuss condom use (“men’s business”) and misconceptions about moral goodness and AIDS (if someone looks and acts good, they are perceived as HIV-free) were major obstacles to prevention. Two booklets with discussion starters addressing these factors are

used by female peer educators trained to facilitate group discussions and lead group activities.

A romantic illustrated novel shows the consequences of not discussing sexual behaviour. It tells the story of factory worker Lamyai, who falls in love with Tong Dee. Because he is good, she doesn’t ask about his past. Despite warnings from a co-worker, they have unprotected sex. When Tong Dee enters military service to earn money for their marriage, he is tested and found HIV-positive; Lamyai also has the virus and, after working on for a few years, eventually dies.

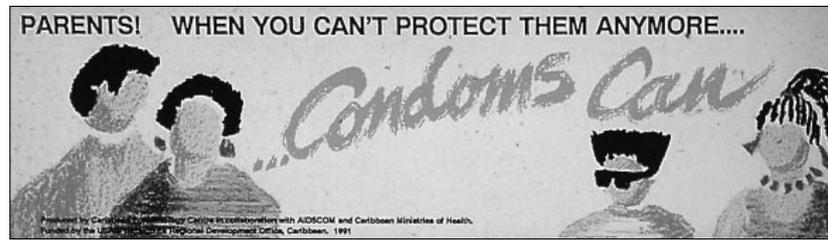


A Thai comic book uses humour to persuade young women to discuss condom use

To demonstrate what girls can say to negotiate condom use, a humorous comic book focuses on a young woman named Jon Di. Before she leaves to work at the factory, Jon Di prays to the Spirit of Good Health: “Please turn something near to me into a living thing – to be my friend – to protect me when I go to Chiang Mai.” The Spirit does so, producing Brother Protector Condom, an invisible flying condom. The Spirit promises that if Jon Di and Brother Condom save five young women from AIDS, she will make Brother Condom into a real friend. Jon Di completes the assignment successfully, whereupon the Spirit changes Brother Condom into a young man with a condom head. After protest from Jon Di, the Spirit makes him a completely human companion.

DAVID CUNNINGHAM, Zimbabwe,
KATHLEEN CASH, BUPA ANASUCHATKUL and
WANTANA BUSAYAWONG, Thailand

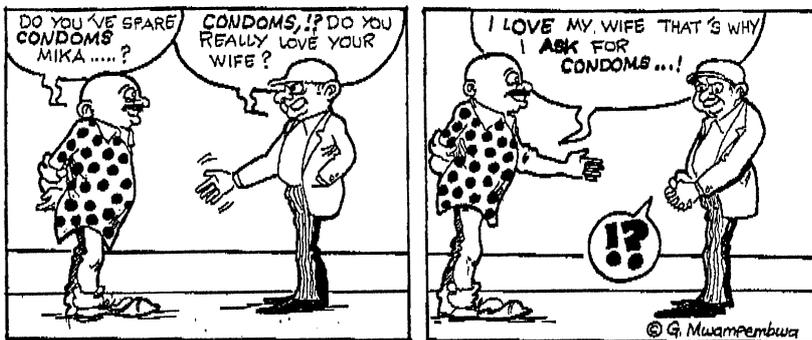
An NAP campaign in St. Vincent and the Grenadines urged parents to accept condom use for teenagers



SENSITIZING AND MOBILIZING MEN

Men must be sensitized and mobilized to a greater extent for an effective response to hiv/aids and stds. Since men occupy most positions of influence, their participation in advocating gender-sensitive policies and programmes is essential.

Comics published in African newspapers urge men to protect their partners



Some men are, of course, already aware in this regard. Others, however, have not yet thought about the factors placing women at a disadvantage. A Filipino ngo, hasik, has developed a gender training programme for male staff in various types of organization to address this [58]. Through games, exercises, song, dance and discussions, the men articulate their own ideas about why women are oppressed. Then they address how to change the institutions that determine gender roles, concluding with the formulation of action plans which help the men translate what they have learned into organizational/professional goals and schemes.

ENLISTING INFLUENTIAL MEN

» The **Thai Health Project for Tribal People (HPTP)** has trained influential male community leaders as health educators for isolated hill tribe communities. The headmen, who also act as village counselors, already have the respect, position and credibility necessary to promote new information. They are also experienced in talking to large groups.

The training seminars include practice teaching sessions. One headman, for example, used a picture of a young girl being sold into sex work to talk about the man who had taken her away and what happened to her once she was in town. HPTP teams visit the headmen several months after the seminars to ask about any problems they have using the materials and what is going well.

Knowledge changes are occurring in villages taught by the headmen. In one tribe, the initial survey showed that 85% of the people had heard of AIDS, but none understood that it could be transmitted from mother to child. After teaching by the headman, 98% of the villagers understood this.

LORI ROWE, Thailand

The collaboration of village headmen, male religious authorities and businessmen in educational interventions and home- and community-based care is most important. They act as role models for the community and can set the example for acceptance of “new” ideas concerning men’s and women’s responsibilities in preventing hiv transmission and coping with aids.

ADDRESSING MEN'S PREVENTION CONCERNS

Two projects in the Asia/Pacific region have demonstrated how men's specific concerns around HIV/STD prevention can be addressed:

» The AIDS Research Foundation of **India** (ARFI) works with sex-worker clients in Madras, emphasizing the health benefits of condom use. Truck drivers keep condoms in their trucks to fix radiator hose leaks. ARFI used this practice to start small groups talking about how "leaks during sex" can be fixed. Condoms are provided through transit-stop shops, where they are sold together with items men frequently buy. The truckers also receive key chains containing a compartment for a condom. Since most of the transit-stop teashops play music, a cassette on safety (both on the road and at roadside), "It's all in the rubber", has been distributed with funds from a truck tyre manufacturing company.

Peer opinion leaders tell port/dock workers a story about a man who practises safer sex. To reinforce the message, posters on condom use are displayed in wine shops and barber shops, where the dock workers read the evening newspaper. Some men have been recruited as condom depot holders; a dispensary at the port provides free STD services. Short street plays reinforce the safer sex message. Since the programme started, condom sales have increased at the transit-stop and port shops [59].

» The Heterosexual Men's Project in New South Wales, **Australia**, conducted focus-group discussions with building workers aged between 17-60 years to determine what was important to them in preventing HIV infection. The groups comprised men from English- and non-English speaking backgrounds and included single, divorced, separated and single men, men in long-term relationships and fathers. Two issues highlighted by the workers were the role of alcohol in promoting unsafe behaviour and difficulties in communicating about sex with women.

Based on the men's suggestions, a campaign was designed using messages on beer coasters and toilet stickers in pubs and clubs. The beer coasters used

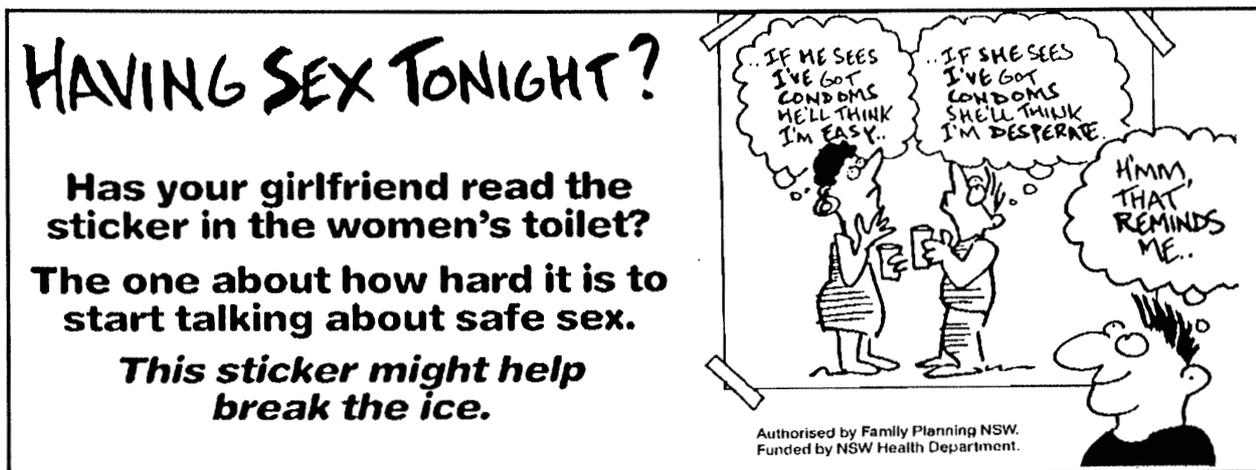


Beer coasters (mats) in Australia use humour to challenge male sexuality myths

"themes" to demystify safe sex and challenge some male sexuality myths. The toilet stickers aimed to facilitate discussion of condom use between men and women by providing humorous ice breakers. Billboard, bus and magazine advertising messages addressed the link between STDs and HIV/AIDS.

Evaluation showed that 50% of the men familiar with the campaign saw it as personally relevant: 19% of those who had read the beer coasters and stickers said they were helpful in providing conversation starters on safe sex with their partners; 27% said it led them to discuss this with their colleagues. Generally, the campaign messages were best recalled by men 18 to 24 years old, single men and condom users. Recommendations made for future campaigns included:

- tailor messages to emphasize that condoms promote health rather than prevent disease
- employ humour to challenge aspects of male culture that do not support safer behaviour
- develop dynamic and flexible approaches to address men's sexual health needs in the context of changing life roles
- use medical centres, youth services and sexual health centres to provide information and resources
- use the media, particularly men's magazines, to support sexual health education
- locate future campaigns in venues where alcohol is consumed such as clubs and pubs [60].



Wall stickers in Australia aimed to help men address HIV/STD prevention with their female partners

Information and behavioural change programmes specifically targeting men and boys need replication. Objections that men are hard-to-reach have been disproved by experiences worldwide. Men can be approached through workplace programmes at businesses, factories and settings such as military compounds. Others are targeted by interventions for sex workers' clients, school-based programmes and activities carried out through churches and recreational groups. Strategies aiming to help men examine current male and female social roles and the benefits of changing these in relation to hiv and stds need more development.

COMBATING DISCRIMINATION

Women and men living with hiv/aids, their families and people negatively associated with the epidemic (e.g., homosexuals, sex workers, street-children, migrants and foreigners) still face stigmatization and discrimination. Combating this is an important public health strategy. If people are to engage in safer sex, they must feel confident that they will not be abused or abandoned by their partners. If potential care-providers condemn those living with the virus, adequate care and support cannot be given and the burden of care will be borne by a few.

One of the reasons why stigmatization arises is that aids programmes appear to suggest that some categories of people (e.g., gay men, sex workers and migrants) are more likely to get aids than others. This may be partly true from the epidemiological perspective but naps need to present the epidemic to the general public in a way which does not reinforce such perceptions.

Educational messages can emphasize the need for solidarity with those who are discriminated against. A first step is to explain how hiv is and is not transmitted, debunking myths and associated fears. These messages can be communicated through printed materials, newspaper and magazine articles, radio and television programmes, community education sessions, hotlines and word of mouth. Health workers should be taught the principles of universal precautions that should apply to blood and body fluids from all patients, not only those they know or suspect to be hiv-infected.

Personalizing the epidemic also works well: when people tell

their stories, they provide concrete examples rather than distant images of “aids victims” or “hiv carriers”. The first woman to speak out publicly in the Philippines greatly increased the impact of the nap campaigns, helping raise the general public’s awareness in a positive way. Persons living with hiv are often in the forefront of actions to challenge discrimination. A woman working for a care agency in Canada, for example, sued her employer after she was dismissed because her serostatus became known. She won her case, simultaneously giving other seropositive women encouragement to stand up for their rights^[61].

ngos can play a useful “watchdog role” regarding human rights violations. The International Gay and Lesbian Human Rights Commission, for example, publishes an *Action Alert* bulletin to publicize discrimination and stimulate responses to specific abuses. Amnesty International and many ngos document discrimination cases so that these can be brought to the attention of the government and press. Lobbying for changes in discriminatory laws and the passage or endorsement of protective ones (e.g., the un Convention for the Elimination of All Forms of Discrimination against Women) is another important action area. Many ngos also publish hiv/aids rights charters and refer persons suffering discrimination to legal services so that they can pursue their rights.

Further work must be done to change customary and written laws so women have legal recourse in cases of abuse, loss of maintenance and discrimination over inheritance. Many women are unaware of their rights and don’t know that they are legally protected against certain abuses. This knowledge gap is slowly being filled by lawyers’ groups and ngos worldwide through “legal literacy” programmes, making the law accessible to women and promoting their capacity to understand and assert their rights^[62].

DEVELOPING GENDER-SENSITIVE CARE AND SUPPORT

A first step towards making care and support systems more sensitive to the specific needs of women and men is to re-evaluate

PROMOTING LEGAL LITERACY

» “Ugandan women have almost the same rights as men according to the law books, but in reality tradition rules”, says Winnie Sekadde of FIDA, a legal aid organization for women in **Uganda**. “It means for example that they have no right to property and income.”

The HIV/AIDS epidemic has presented FIDA with a growing number of cases regarding property and succession rights, although maintenance money is still the biggest issue. “Women get into trouble when their husbands die because of the gap between traditional customs and official laws. Women in rural areas are not aware of the written laws. Even if they are, the pressure to comply with tradition is enormous.”

According to the traditional customs, when a woman marries, her father receives a bride price from her husband. She then belongs to her husband’s clan. She must take care of his household and work his land; any earnings go to her husband. “Women are economically and socially completely dependent on their husbands,” Sekadde says. “If a man dies, she loses everything to his clan, even the right to custody over her children.”

According to written laws in Uganda, women have a right to their own income and a small inheritance. In practice, however, women almost never get this. The amount is divided if a man has more than one wife, which is common in Uganda. Other family members can also claim possessions. In case of doubt, judges may also fall back on customary law, often to the detriment of women. FIDA is therefore lobbying for a women-friendly law, with fewer opportunities for interpretation by judges.

Because not many women know about laws, FIDA educates them through village seminars, radio and television programmes and newspaper articles. FIDA has also formed a team to persuade villagers to write wills.

Cases relating to sexual abuse of children are increasing. Children are regarded as “safe partners” because generally they are not yet infected. Girls have been abused by grandfathers, uncles and teachers. To make pupils aware of these problems, FIDA performs education theatre at schools^[63].

policies and assess whether they are gender sensitive. Training programmes for care-providers and counsellors need adaptation so that, for example, they respect women's wishes and needs regarding pregnancy, breast-feeding, abortion and sterilization and deal with the potential negative consequences of testing women but not their partners for hiv.

Follow-up counselling and support for women and men living with hiv/aids requires expansion. Social and legal assistance must be available even when people cannot pay. Women's lack of money worsens their burden when they care for family members and yet lack care for themselves, especially if the husband dies first. Seropositive women especially need ways to generate an income despite suffering periodic bouts of illness: "When my husband died of aids, I found it difficult to make ends meet. I decided to grow tomatoes, but did not have enough money to start the project. When I had almost given up hope, I got into conversation with some women in my village who were in a similar situation as myself. One of them suggested we pool our resources to support one another. The plan worked out quite well. I am now able to take better care of myself and my family. Our group's plan also ended up being an inspiration to other women in the village" (Tanzania) ^[64].

LIGHTENING THE BURDEN OF CARE

» Communities in sub-Saharan **Africa** recognize that as more households are affected by the epidemic, community life suffers unless affected women and children are supported in coping ^[65]:

» In Rakai District, **Uganda**, men developed an income-generating project to help them support 26 children orphaned due to AIDS. They registered as an association and received training and a loan from the NGO World Vision for a bee-keeping project. In their first season, the association harvested nearly 25 litres of honey to raise funds needed to help them in their role of care-takers.

» The University Teaching Hospital in **Zambia** used to test children suspected of being HIV-positive, then gave the test results only to mothers. Fathers who later learned their children were HIV-positive blamed the mothers and refused to be tested themselves. SWAA helped change this policy. Now, when children show clinical symptoms suggesting HIV infection, the parents are called in together for counselling and both parents and child are tested simultaneously. The test results are given to the parents together during additional counselling. This process has reduced blaming and tension between spouses.



Because much of the care and support for people affected by hiv/aids now falls on women's shoulders, a major task is to find ways of lessening women's extra workload. One way is to provide help with home-care nursing. In south Thailand, nurses are assisted by La Trobe University (Australia) in sharing skills with village women so that they can manage those sick with infectious diseases (including hiv/aids and stds) more effectively and efficiently ^[66].

Analysis of successful programmes is needed to determine what it is that motivates people (especially men) to volunteer their time, energy and resources to community- and home-based care and support.



Men's collaboration in AIDS care needs further encouragement (Photo: Roel Burgler)

Insights then need to be shared widely so that new initiatives can benefit from them and volunteer support can be maintained long term.

LIVING POSITIVELY WITH HIV/AIDS

Women and men around the world often feel isolated when they learn of their diagnosis. Women especially have difficulties in contacting peers in the same situation. Yet this provides great psychological benefits: "When the woman at the clinic said, 'Would you like to meet another woman with hiv?' and gave me her phone number, I couldn't wait to get home... As soon as I met her, it just changed my life. I realized I hadn't done anything wrong, I wasn't a criminal... We've formed a women's group... I can talk about problems that have happened. Not just to do with hiv... Just supporting each other, having good fun, having a laugh" (England) ^[67].

Associations of women living with hiv/aids are helping participants find ways to cope. They also give the epidemic a human – and female – face when their members speak out on how hiv/aids affects them. In 1992, the International Community of Women Living with hiv/aids (icw) was created at the International Conference on aids in Amsterdam. Since then, this coordinating body has provided women most directly affected by the epidemic with a voice at global and regional levels. Through a network of worldwide representatives, they provide policy input to un agencies.

icw has also inspired the formation of associations of seropositive women in many other countries. At the national and community levels, seropositive women are joining together to make the ideal of living positively with the virus a reality:

- The National Women and hiv Project in Canada created a coalition of hiv-positive women by supporting regional networks and developing communication tools ^[68].
- The Argentine Network of Women Living with hiv/aids (anw) gives women information about aids, helps access treatments and medications through state and private services and makes referrals to ngos and governmental social services ^[69].

- Many seropositive women who care for their households alone must also plan for their families' future, especially the children. Due to discrimination and frequent illness, their access to the labour market is also restricted. Women Touch in São Paulo, Brazil, helps provide them with work, an income and special protection [70].

Such initiatives demonstrate that women and men living with hiv/aids are not the problem but part of the solution. To prove we truly care – not only in the sense of caring for but also caring about people living with hiv/aids – we must ensure that our response to the epidemic gives these women and also men a central role in policy and programme formulation, implementation and evaluation.

A PERSONAL TESTIMONY

» “I became pregnant with my fourth child in 1988. My health deteriorated and I had persistent vaginal itching and abnormal pains. I complained during antenatal check-ups but didn't get proper treatment for my vaginal infection. They took my blood for an HIV -test without my consent.

After I delivered, they tested my child, too. Then the doctor just told me that they had taken our blood and the results for both of us were positive. When I broke the news to my husband, he left me that very same night, after calling me names and accusing me of being unfaithful and a prostitute. I later learned that he had already been tested and was HIV -positive but didn't have the courage to tell me.

I confided my HIV status to my sister, a nurse. Because of stigmatization and discrimination, she told me not to tell anyone else. I kept quiet but felt as if everybody knew that I was HIV -positive. I was so lonely, isolated and afraid of leaving my children without any information on

A S I D . I spent most of my time crying and the loss of my child at five months made my condition worse. Fortunately, I didn't have to give up my job because it was my only source of support.

In 1992, I was invited to attend a conference organized by Dutch seropositive women. I accepted though I was afraid to talk about my status and had never been involved in

A I D
S activi-
ties. I went because I wanted to meet people who
were also dying of
A I D
S .
But I was wrong about that. The conference gave me

How gender sensitive is your work?

The enormous cost and suffering caused by the hiv/aids epidemic is forcing serious re-evaluation of norms, values and conditions related to gender. Such analysis may lead to fundamental improvements that can benefit millions of people – women, men and children – in societies around the world.

The following checklist is designed to help policy implementers and programme planners assess the gender sensitivity of their hiv/aids and std policies and programmes. First determine which areas pertain to your type of activities. Responses to the questions may then be answered “yes”, “somewhat” and “no”.

RESEARCHERS	YES	SOMEWHAT	NO
» Do you explore the implications of gender inequality in relation to hiv/aids and stds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Does your research focus on issues of special relevance to women and men:			
– Women controlling their risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Women’s scope for decision-making in different situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Women’s right to control fertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Factors motivating men to share decision-making regarding fertility control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– hiv transmission through breast-feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Female-controlled prevention methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Factors motivating women and men to discuss mutual responsibility in relation to prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Factors facilitating women’s and/or men’s ability to undertake prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Women’s and/or men’s access to health services that address their specific concerns (including std treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Rape and violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Sex work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Sexual practices facilitating hiv transmission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Female circumcision in relation to hiv/stds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Female care roles and their impact on production and education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	SOMEWHAT	NO
- Factors motivating men to participate in domestic tasks and care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Inheritance rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do you explore which information channels are most appropriate for different age and gender groups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do you use these channels to communicate research findings and other information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Have you researched barriers to women's participation in programme activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

POLICY-MAKERS, PROGRAMME DEVELOPERS AND IMPLEMENTERS

» Are all programme implementers able to address gender issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Are women's organizations involved in policy and programme development and decision-making processes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do women and men share programme goals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your interventions combat violence against women and girls (active policy goals, educational programmes, legislation)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your programmes consider differences in gender roles, access to resources and decision-making that affect women's and men's abilities to protect themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your programmes consider differences in male and female life experiences?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your programmes differentiate between male and female health needs throughout the life cycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your programmes call for gender-based sexual health education in school curricula?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your programmes encourage couples, parents and/or children to discuss sexual health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your programmes address the need to motivate men to inform their wives if they are hiv-positive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your interventions aim to develop and strengthen men's concern and caring for their families?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your education and communication programmes encourage men to share domestic responsibilities and tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do your programmes encourage social welfare agencies, ngos, employers, etc. to provide or make allowances for child and patient care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROGRAMME ACTIVITIES

» Do you organize activities at locations and times convenient to both women and men?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do you provide child-care services during activities and meetings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do you create situations in which women and/or men can talk freely about their opinions, feelings and needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» Do you try to ensure that men and women hear and respond to one another's concerns and needs in a constructive manner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROMOTING SAFER SEX	YES	SOMEWHAT	NO
Do your programmes:			
» challenge double standards between men and women regarding a) teenage sexuality, b) casual sex, and c) sex outside marriage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» address difficulties in condom use from women's and men's per- spectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» teach both women and men how to use condoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» promote easy access to condoms for women and men?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» enhance women's and men's skills in negotiating safer sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» enhance women's self-confidence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» address sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» promote attitudes to relationships that meet women's and men's sexual needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROVIDING HEALTH AND CARE SERVICES			
Do your programmes:			
» ensure equal access by men and women, particularly for st d treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» make family planning services attractive and accessible to men?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» encourage men to take on greater care roles in the family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» address inheritance laws and customs where these put women and children at a disadvantage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» address the different financial problems affecting women and men?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» ensure that girls' care roles and lack of money do not exclude them from school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
» include men as volunteers in providing community and home care services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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ahrt ag, Farringdon Point, 29-35 Farringdon Road, London ec 1m 3bj,
United Kingdom

Body Positive, Mashambanzou, 40 Sandown Road, Waterfalls, Harare,
Zimbabwe

etr Associates, Publishers, p.o. Box 1830, Santa Cruz, ca 95061-1830, usa

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Kingdom

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Kingdom

Sex Information and Education Council of the United States (siecus),
130 West 42nd Street, Suite 2500, New York, ny 10036, usa

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Lane, Kidlington, Oxford ox5 1gb, United Kingdom; usa: Elsevier
Science Inc., 660 White Plains Road, Tarrytown,
ny 10591-5153.

Taylor and Francis, 4 John Street, London wc 1n 2et, United Kingdom

undp, hiv & Development Programme, 304 East 45th Street, Room
ff 986, New York, ny 10017, usa

University of Sussex, Falmer, Brighton bn1 9rh, United Kingdom

vu University Press, De Boelelaan 1105, 1081 hv Amsterdam,
The Netherlands

Westview Press, 5500 Central Avenue, Boulder, co 80301-2847, usa

Women and aids Network, 5 Elm Row, Suite 112, New Brunswick,
nj 08901, usa

Women and aids Support Network, p.o. Box 1554, Harare, Zimbabwe

Women in Industry and Community Health, 83 Johnston Street, Fitzroy,
Victoria 3065, Australia

World Health Organization, ch 1211 Geneva 27, Switzerland

Yale University Press, 302 Temple Street, New Haven, ct 06511, usa

List of contributors

- Bupa Anasuchatkul and Wantana Busayawong, Chiang Mai University,
Faculty of Education, Chiang Mai, Thailand
- Julliet Awino, c/o taso, p.o. Box 10443, Kampala, Uganda
- Riet Berkvens, Information, Library and Documentation Department,
Royal Tropical Institute, Mauritskade 63, 1092 ad Amsterdam,
The Netherlands
- Mabel Bianco, Fundación para Estudio e Investigación de la Mujer,
Paraná 135, p 3 “13”, 1017 Buenos Aires, Argentina
- Clara Blaauw (Kalabo, Zambia), c/o Bernard Kraal, Koeriersdienst,
p.o. Box 20061, 2500 eb The Hague, The Netherlands
- Kathleen Cash, 644 Grand Street, Morgantown, wv 26505, usa
- Winnie Chikafumbwa, napham, Private Bag 355, Lilongwe 3, Malawi
- A. Chuaprapaisilp, Faculty of Nursing, Prince of Songkla University, Hat
Yai, Thailand
- David Cunningham, Scripture Union Aid for aids, 45 Heyman Road,
Suburbs, Bulawayo, Zimbabwe
- P.R. Dasgupta, National aids Control Organization, Ministry of Health
and Family Welfare, Red Cross Society Building, 1 Red Cross Road,
New Delhi 110001, India
- Maria de Bruyn, Information, Library and Documentation Department,
Royal Tropical Institute, Mauritskade 63, 1092 ad Amsterdam,
The Netherlands
- Liz Dibb, National aidsTrust, 14th Floor, Euston Tower, 286 Euston Road,
London nw1 3dn, United Kingdom
- Eka Esu-Williams, Cross River State aids Control Programme,
University of Calabar, P.M.B. 1115, Calabar, Nigeria
- Esther W. Gatua, Christian Health Association of Kenya (chak), c/o
Kenya aids ngo Consortium, p.o. Box 69866, Nairobi, Kenya
- Helen Jackson, saf aids, 17 Beveridge Road, p.o. Box A509, Avondale,
Harare, Zimbabwe
- Suzana Kalckmann, Mulher, Criança, Cidadania e Saúde, Rua Santo
Antonio 446, Sala 33, São Paulo, sp, Brazil cep 01314-000
- Sue Laver, Department of Community Medicine, University of
Zimbabwe, Box A 178, Avondale, Harare, Zimbabwe
- Tshidi Moeti, unicef, p.o. Box 44145, Nairobi, Kenya
- Claire Parsons, La Trobe University, Centre for Research in Public Health
and Nursing, Bundoora, Victoria, Australia 3083
- Patricia Pérez, Red Argentina de Mujeres Viviendo con vih/sida,
Santiago del Estero 454 9° “35”, Buenos Aires, Argentina
- Karen Potts, National Women and hiv Project, #201, 11456 Jasper
Avenue, Edmonton, Alberta t5k 0m1, Canada
- Rita Prochaska, Hofmark 381, 1355 jh Almere, The Netherlands
- Rakesh Rajani, kul eana, p.o. Box 27, Mwanza, United Republic of
Tanzania

- Florencia Roitstein and Julie Becker, ippf Western Hemisphere Regional Office, 902 Broadway, 10th Floor, New York, ny 10010, usa
- Irma Rosado, aspene A.C., Av. Rivapalacio No. 125, Col. Pavón, Cd. Nezahualcóyotl, Mexico, df
- Lori Rowe, Health Project for Tribal People, 113/6 Thanuchpong, Tambon Nongpakrang, Ampur Muang, Chiang Mai 5000, Thailand
- Gill Seidel, Africa Research Unit, c/o Postgraduate Secretariat ses, University of Bradford, West Yorkshire bd7 1 dp, United Kingdom
- Richard Serunkuuma, c/o t aso Mulago, p.o. Box 10443, Kampala, Uganda
- Celia Szterenfeld, Instituto de Estudos da Religião (iser), Ladeira da Glória, 98, Rio de Janeiro, rj, Brazil
- Maria Teresa Urban, Kabalikat, 3rd Floor, B & M Building, 116 Aguirre Street, Legaspi Village, 1229 Makati, Manila, The Philippines
- Teun Visser, Rostocklaan 1, 1404 ad Bussum, The Netherlands
- Ellen Weiss and Rekha Mehra, icrw, 1717 Massachusetts Avenue NW, Suite 302, Washington, d.c. 20036, usa
- Marianne Wijermars, Information, Library and Documentation Department, Royal Tropical Institute, Mauritskade 63, 1092 ad Amsterdam, The Netherlands

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The Royal Tropical Institute (KIT), Southern Africa AIDS Information Dissemination Service (SAFAIDS) and World Health Organization (WHO) would like to hear readers' opinions of *Facing the challenges of HIV/AIDS/STDs: a gender-based response*. Your comments and suggestions would greatly contribute to and become part of shared knowledge. They will be incorporated in possible future editions of this publication, as well as other materials using parts of it.

We invite you to share with us:

- which parts of *Facing the challenges of HIV/AIDS/STDs: a gender-based response* you find most useful
- how you have used parts of the book (in teaching and training, by reproducing parts for local use or in any other way)
- whether you missed particular issues or topics
- any other comments, criticisms and recommendations
- anyone else you think would benefit from receiving a copy.

Please send your comments to:

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Mauritskade 63, 1092 AD Amsterdam, The Netherlands

The **Royal Tropical Institute** (kit) aims to contribute to the sustainable development of non-Western countries and to inform the Dutch public on the tropics and sub-tropics. Research results and information on health, rural development and culture are disseminated through training, publications, library services, documentation, international congresses, exhibitions and theatre performances. kit's approach is marked by cooperation between institutes, international networking and support of development processes. Its partners are institutes, governmental and non-governmental organizations and the business community.

kit's activities related to hiv/aids/stds and gender issues include: the management of an aids resource centre, epidemiological research and development of aids prevention interventions based on action research; technical assistance in establishing aids resource centres; evaluations of ngo hiv/aids programmes; training on hiv/aids in international courses; support to the development of gender-sensitive health and agricultural programmes and training programmes on gender and development. Regular publications in these fields include the quarterly newsletter *aids/std Health Promotion Exchange* and *Critical reviews and annotated bibliographies: Gender, society and development*.

The Southern Africa aids Information Dissemination Service (saf aids) is a non-governmental organization first established as a project under the Southern Africa Foundation for Economic Research (safer) in 1993. Initially called Zimbabwe aids Information Network (zainet) and providing a nationally-based service from Harare, the organization now has a wider focus, serving primarily the southern Africa region. Its objectives are to: disseminate information on hiv/aids; promote policy and planning around hiv/aids in all sectors; support and initiate research on the socio-economic impact of aids, aids prevention and support; advocate an ethical response to the epidemic.

saf aids tries to meet its objectives through activities including: the operation of a resource centre; co-production of the *aids/std Health Promotion Exchange* with kit; production of a quarterly bulletin, *saf aids News*, and other materials; mounting and participating in workshops, conferences and other forums; and organization and information networking. Three areas of particular concern are employment, gender and community care.

The World Health Organization (who) is a specialized agency of the United Nations with the primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of some 185 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, who promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of human resources for health, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member countries; promoting the health of mothers and children; combating malnutrition; controlling malaria and other communicable diseases including tuberculosis and leprosy; coordinating the global strategy for the prevention of aids; having achieved the eradication of smallpox, promoting mass immunization against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Royal Tropical Institute

Mauritskade 63

1092 AD Amsterdam, The Netherlands

Telephone: 31-20-5688-288

Fax: 31-20-6654-423

E-Mail: acb@kit.support.nl

Southern Africa AIDS Information Dissemination Service

17 Beveridge Road, P.O. Box A509, Avondale

Harare, Zimbabwe

Telephone: 263-4-336-193

Fax: 263-4-336-195

E-Mail: safaids@healthnet.zw

World Health Organization

Global Programme on AIDS

CH 1211 Geneva 27, Switzerland

Telephone: 41-22-791-4655

Fax: 41-22-791-4191

E-Mail: gpainf@who.ch

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